

+-----+
 | ADMINISTRATIVE DIRECTIVE |
 +-----+

TRANSMITTAL: 97 ADM-24

TO: Commissioners of
 Social Services

DIVISION: Temporary
 Assistance

DATE: November 19, 1997

SUBJECT: Child Assistance Program (CAP): Impact of the Welfare
 Reform Act of 1997

SUGGESTED
 DISTRIBUTION:

Income Maintenance Directors
 Medical Assistance Directors
 Food Stamp Directors
 CAP Coordinators
 CSEU Coordinators
 Fair Hearing Staff
 Accounting Staff
 Staff Development Coordinators

CONTACT
 PERSON:

Regional County Team Representative
 at 1-800-343-8859, Region I ext. 3-0332;
 Region II ext. 4-9344; Region III ext. 4-9307;
 Region IV ext. 4-9300; Region V ext. 3-1469;
 Region VI (212) 383-1658

ATTACHMENTS:

Attachment I - Request for Information Notice
 - available on line
 Attachment II - FA Earned Income Thresholds
 - available on line
 Attachment III - Transitional Medical Assistance Fact
 Sheet (English and Spanish)
 - available on line

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
97 ADM-23			SSL 131(z),	CAP	
90 ADM-30			Part 366	Operational Manual (COM)	

DSS-296EL (REV. 9/89)

I. PURPOSE

This directive advises Social Services Districts (SSDs) of the policy changes and required action for the Child Assistance Program (CAP) resulting from the "Welfare Reform Act of 1997" (WRA).

II. BACKGROUND

CAP is a program designed to encourage Family Assistance (FA) recipients to get and keep employment and to obtain child support orders. Since 1988, it has been piloted in a number of districts throughout the State.

The WRA requires that CAP be operated as a district optional component of New York State's Family Assistance (FA) program. Accordingly, the Department has informed and received approval from the Department of Health and Human Services to terminate CAP as a federal demonstration effective November 1, 1997. A local commissioners memorandum (LCM) will be released shortly informing SSDs that CAP is now available statewide and outlining the procedures that must be followed for a SSD to be approved as a CAP district.

There are a number of additional program changes to CAP resulting from the enactment of the WRA and the termination of CAP's demonstration status. This ADM addresses those changes specific and distinct to CAP. Districts should see 97 ADM-23 for a review of general FA program changes (i.e., 42% earnings disregard, drug/alcohol screening etc.) resulting from the WRA to determine the impact of those changes on CAP. The Department added Part 366 - "The Child Assistance Program" to the Department regulations to comply with the WRA, and to initiate CAP policy which is distinct from FA policy on October 27, 1997.

The program changes outlined in this directive will be included in the next update of the CAP Operational Manual (COM). The COM provides a detailed overview of CAP policy.

III. ORGANIZATION AND CONTENT

The policy changes presented in this directive cover several different areas. The changes by topic and the location of each in this directive are:

CONTENTS

<u>Subject</u>	<u>Page</u>
A. Modification of Child Support Order Eligibility Prerequisite	3
B. CAP Filing Unit	5
C. Employability Requirements	6
D. Termination of Experimental Design	8
E. District Withdrawal From CAP	9
F. CAP/MA Delinkage	10
G. CAP Administrative Expenditures	14

IV. PROGRAM IMPLICATIONS AND REQUIRED ACTION

Program implications and required action are outlined under each specific policy topic.

A. Modification of Child Support Order Eligibility Prerequisite

1. Program Implications

Previously, CAP eligibility was limited to FA families in which the custodial parent possessed a child support order for each child enrolling in CAP. In addition, the non-custodial parent named in the child support order was required to be absent from the home.

The WRA modifies this eligibility prerequisite. Now, the custodial parent must possess a child support order for each child enrolling in CAP, and the parent named in the order must be absent from the home, except where failure to obtain a child support order is due to one of the following:

- a. The absent parent is deceased. To meet this exception, if paternity has been acknowledged or adjudicated, the custodial parent must simply document that the non-custodial parent is deceased. If paternity has not been established, the custodial parent must cooperate with the Child Support Enforcement Unit (CSEU) and provide as much information on the putative deceased parent as is possible (e.g., where and when death occurred and the death certificate).
- b. The custodial parent has demonstrated to the satisfaction of the district that a diligent effort was made to obtain a child support order, including providing the district with the name of the non-custodial parent and a verifiable address at which service of process can be made; but, due to reasons outside the control of the custodial parent, a child support order is not available in a reasonable period of time.

To meet this exception, the CSEU must determine that the custodial parent is cooperating with the CSEU, as required by Department regulations, in establishing paternity and obtaining a child support order; and that the custodial parent has made a diligent effort to obtain a child support order including providing the CSEU with the name of the non-custodial parent and a verifiable address at which process can be served, but for reasons beyond the control of the custodial parent, a child support order cannot be obtained in a

period of four months. The four month period begins the date the custodial parent provides the CAP case manager, or the FA examiner, with the name of the non-custodial parent and a verifiable address.

If, after enrolling in CAP, it is established by the CSEU that the putative parent is not actually the parent, then the child is no longer eligible for CAP. Before this family can enroll this child in CAP a second time, it will be necessary that paternity first be established.

- c. The custodial parent has good cause for not cooperating with the CSEU as required under Department regulations. To meet this exception, it must be documented that IV-A has actually determined that good cause for not complying exists.
- d. The child resides with both parents; and paternity has either been acknowledged by both parents or adjudicated.

This change will mean that current PG-ADC and ADC-U recipients, who are being recategorized as Family Assistance recipients under the WRA, may now be eligible for CAP.

2. Required Action

CAP SSDs must modify their outreach procedures to include the above-identified households. In addition, these SSDs must modify their certification procedures to allow custodial parents who meet any of the exceptions above to enroll in CAP if otherwise eligible. FA recipients requesting to transfer to CAP within thirty days of the release date of this directive, who meet any of the exceptions (see A.1, a. b. c. or d above) must be enrolled, if otherwise eligible, in CAP retroactive to November 1, 1997. For current CAP recipients, the SSD must verify at the time of next contact or recertification, whether any of the four exceptions noted above exist for a child in the household not receiving CAP, and, if otherwise eligible, enroll the child in CAP retroactive to November 1, 1997.

3. Examples

- a. Barbara O'Reilly is a Family Assistance recipient who is applying for CAP on November 26, 1997. Barbara does not have a child support order for her three children, since the father, Michael O'Reilly, died in 1993. The CAP caseworker verifies that Barbara is

receiving Social Security Survivor's benefits for the three children, so the family can enroll in CAP, if otherwise eligible retroactive to November 1, 1997.

- b. Emily Ryan and her husband, Tim, are applying for CAP for themselves and their two children on December 24, 1997. Since both children were born in wedlock, the family can enroll in CAP, if otherwise eligible, effective January 1, 1997.
- c. Pat Devries and her son have been receiving Family Assistance since June of 1997. Pat has cooperated with the CSEU and has supplied the name and address of the putative father to the FA examiner in June of 1997. At the time of CAP certification (November 22, 1997), the case manager verifies with CSEU that it has filed a petition of support against the putative father and is pursuing a child support order. Therefore, the family can enroll in CAP, if otherwise eligible, retroactive to November 1, 1997.

B. CAP Filing Unit

1. Program Implications

Previously, CAP filing unit procedures applied to a family when an eligible child was applying for CAP. An eligible child was defined as a child under age 18, or 18 years of age and expected to graduate from high school before the month of the child's 19th birthday. In addition, CAP filing unit procedures required that a sibling without a child support order be considered a filing unit member who was not eligible for CAP. This ineligible child did not pull his/her parents into the CAP filing unit.

The WRA requires two changes in CAP filing unit policy. First, while CAP filing unit policy still applies when an eligible child is applying for CAP, there has been a change in the definition of who is an eligible child. An eligible child is now defined as a child under 18 years of age, or 18 years of age and regularly attending high school or the equivalent. There is no longer the requirement that an 18 year old be expected to graduate before the month of his/her 19th birthday.

The second change to the CAP filing unit involves the modification of the child support prerequisite. Since two-parent families are now potentially CAP eligible, an eligible child will now pull in not only his/her siblings but also the siblings' parent. There will continue to be some siblings/parents who are pulled into the CAP filing unit who turn out to be ineligible for CAP. While the CAP grant will not be increased to reflect these ineligible

individuals, their income will be budgeted to determine eligibility and benefit level. There will also be individuals now pulled into the CAP filing unit who are eligible for CAP. These individuals must be included in determining the amount of the CAP grant. SSDs are reminded that the maximum CAP benefit is based on the number of children eligible for CAP, whereas parents are only used in determining the household size for poverty level purposes.

2. Required Action

At the time of next case action (i.e., quarterly report, recertification etc.), CAP SSDs must apply these new filing unit procedures when determining who must be included in the CAP filing unit. Timely notice must be provided to any CAP family whose benefit decreases. Adequate notice may be used for any family whose benefit increases.

Suggested notice language is:

"State law has changed. (Enter names) must now be included in your CAP case, and any income they have must be budgeted to determine your CAP grant."

The regulation cite is 18 NYCRR 366.4(d).

3. Example

Asil Cromme and her son have been receiving CAP since 1995. Also in the household are Asil's boyfriend, Milton, and their common child, Jacquelyn. Previously, CAP filing unit procedures required the filing unit to be composed of Asil, her son, and Jacquelyn even though only Asil and her son were receiving CAP. Milton was not considered a filing unit member. Now, all four individuals are considered members of the CAP filing unit. If Milton has acknowledged paternity of Jacquelyn, Milton and Jacquelyn must be added to the CAP case if otherwise eligible. All of the household's income will be used in determining eligibility.

C. Employability Requirements

1. Program Implications

Previously, the only employment requirement for CAP was that the custodial parent be working at least 20 hours per week. This has changed with the termination of CAP's demonstration status. Now, CAP families are no longer automatically exempt from employment requirements. This impacts CAP in two areas. First, since CAP families are now required to comply with employment requirements, the 20 hour rule has been eliminated. Second, now that CAP participants are subject to employment requirements, the sanction period imposed for voluntary quit situations is

the same as that required for FA under Part 385 of Department regulations. The impact of these two changes is detailed below.

a. Employability Requirements

A CAP participant is subject to employment requirements, unless the participant is:

- o 60 years of age or older
- o under age 16
- o under age 19 and attending school full-time
- o needed in home because of illness or incapacity of another household member
- o a pregnant woman beginning 30 days prior to the medically verified expected date of confinement
- o a parent or other relative providing care for a child under one year of age. Maximum time for this exemption is 12 months for the total period on assistance and only three months per child unless the SSD extends this period for up to 12 months.

Please note that the exemption for a parent providing care for a child under one year of age is the only State exemption from employment requirements which also is an exemption from the federal (TANF) participation requirements.

CAP participants meet TANF participation requirements if they are working the following number of hours per week:

<u>Year</u>	<u>Number of Hours Weekly</u>
1997	20
1998	20
1999	25
2000 (and after)	30

In two parent families, the parents must be working 35 hours or more to meet TANF participation requirements. Districts may choose whether or not to assign CAP participants who are working at least the minimum number of hours to additional employment activities.

b. Voluntary Quit Sanctions

Previously, CAP participants were subject to a 90 day sanction when the CAP participant voluntarily reduced his/her employment in order to receive increased CAP benefits. Since there are no individual sanctionable

program violations for CAP, the entire CAP case was discontinued and a 90 day sanction imposed. Non-sanctioned family members could apply for ADC, and if otherwise eligible, receive ADC benefits.

Now that CAP participants are subject to employability requirements, CAP SSDs must continue to terminate CAP to the entire CAP case when a CAP participant is sanctioned for voluntarily reducing earning capacity to qualify for increased CAP benefits. However, the sanction periods imposed must now mirror those required under Department regulations for FA. Department regulation 385.19(e) imposes different sanction periods when a FA recipient, who is subject to employment rules, is sanctioned. The sanction periods are:

- o until compliance for the first instance of non-compliance within three years,
- o a period of three months and until compliance for the second instance of non-compliance within three years,
- o a period of six months and until compliance for the third instance of non-compliance within three years.

For FA applicants, and FA recipients who are not subject to employment requirements, 385.20(a) imposes a sanction of 75 days for voluntarily reducing earning capacity.

CAP SSDs must follow these two regulations when determining the sanction period to impose for voluntary quit/reduction situations.

2. Required Action

SSDs have discretion in deciding what level of employment activities non-exempt CAP participants will be assigned. SSDs must weigh such factors as the participation rate and self-sufficiency in determining whether to assign CAP participants to additional employment activities.

SSDs must determine CAP voluntary quit/reduction sanction periods in accordance with Department regulations 385.19 and 385.20. These sanction periods must be imposed for any voluntary quit/reduction sanctions imposed after November 1, 1997. The entire CAP case continues to lose eligibility for CAP when any CAP participant is sanctioned.

D. Termination of Experimental Design

1. Program Implications

Previously, 10 of the 14 districts participating in the CAP demonstration were restricted in determining which

Family Assistance cases could be enrolled in CAP. To meet federal demonstration requirements, potential CAP eligibility was not extended to Family Assistance cases whose case number ended with a toe digit of 1. In addition, some CAP SSDs (Monroe, Niagara and Suffolk) were instructed for research and evaluation purposes to use a special program code of "B" rather than "C" on screen 1 of the DSS-3209 when enrolling treatment group cases in CAP. Now that CAP's demonstration status has been terminated, all cases regardless of the toe digit of the case number may now participate in CAP, if otherwise eligible. Also, now that the research component of CAP has ended, entry of a special program code "B" will no longer be allowed.

2. Required Action

The 10 CAP districts (Broome, Erie, Monroe, New York City, Niagara, Oneida, Onondaga, Rockland, St. Lawrence and Suffolk) in which FA cases with a toe digit 1 were prohibited from CAP must now revise their outreach activities to include potentially eligible FA cases with a toe digit 1. In addition, after December 1, 1997, an entry of "B" in the special program code field on the DSS-3209 will no longer be allowed. Monroe, Niagara and Suffolk counties must change these "B's" to "C's" at the time of next recertification.

E. District Withdrawal From CAP

1. Program Implications

The following procedures must be adhered to if a district opts to terminate CAP as a component of its FA program:

- a. The district must notify the Department at least 90 days prior to the planned termination of CAP.
- b. All CAP outreach and enrollment activities must cease immediately.
- c. Within 30 days of the Department being notified of the district's intent to terminate CAP, all participating CAP families must receive timely notice of the district's intent to terminate CAP, and the last day through which CAP benefits will be issued on their behalf. CAP benefits to a participating family must be continued through each family's current payment quarter; however, each family must be provided with at least one full calendar month's benefits prior to program termination.
- d. CAP discontinuance notices must specify a date and time for the district to conduct an interview so that each family's eligibility can be redetermined for Family Assistance, Food Stamps, Medicaid and Child

Care. The interview must be scheduled so as to avoid any interruption of benefits for otherwise eligible families.

2. Required Action

Districts must review and familiarize themselves with these procedures so that, in the event a district opts to terminate its CAP program, adequate provisions are made for program shut-down.

F. CAP/MA Delinkage

1. Program Implications

Up until now, CAP participants have been categorically eligible for Medicaid. This meant that anyone participating in CAP was automatically entitled to Medicaid. This included CAP custodial parents and their dependents.

Under the WRA, CAP participants are no longer categorically eligible for Medicaid. This means that CAP participants must have their eligibility for Medicaid determined separately. Most CAP participants will continue to be eligible for Medicaid while in receipt of CAP. There are limited instances, however, in which CAP participants will not be eligible for Medicaid. For example:

- o Resource Limit - To be eligible for Medicaid under the low income families with children group, a family must have countable assets at or below \$3,000. In addition, the resource exclusions of the Family Assistance program are applied in determining a family's countable resources. It must be noted, however, that the provisions of section 352.23(b)(6) of Department regulations regarding the sale of non-exempt real property do not apply. For purposes of Medicaid eligibility, the equity value of non-exempt real property is a countable resource.
- o FA Income Eligibility - Generally, eligibility for Medicaid is determined according to the financial eligibility requirements of the Family Assistance program. The financial eligibility requirements of FA are found at sections 352.18, 352.19 and 352.20 of Department regulations and are addressed in 97 ADM-23. While this means that eligibility for Medicaid must be determined using the new 42% earned income disregard, the following exceptions to the FA budget must be noted:
 - o Lump sum payments are counted as income only in the month received. Any portion of such payments remaining in subsequent months is counted as a resource.

- o Child/adult care costs continue to be disregarded from earnings. This means that any child/adult care costs (up to \$200 per month for a child under age 2, or \$175 per month for a child age 2 or over) actually paid by the CAP custodial parent must be allowed as a disregard. This does not apply to child care expenses paid by the SSD, only to any care costs in excess of that paid by the SSD. For example, if the SSD is providing \$400 in child care costs, but the CAP family is being charged \$500 for child care, the difference (\$100) must be disregarded.

2. Required Action

Effective November 1, 1997 a separate determination of Medicaid eligibility must be completed for all new CAP cases. Authorization of Medicaid for all current CAP recipients will continue until the next recertification for CAP or next client contact after November 1, 1997. The procedures CAP SSDs must follow are:

- o Resources - There are not expected to be many CAP families who will lose eligibility for Medicaid because of the resource limit. CAP case managers will need to begin addressing the issue of resources with CAP custodial parents when the next quarterly report is received or at the next recertification so that MA eligibility can be monitored.

A letter(see Attachment I) requesting the custodial parent to provide resource and health insurance coverage information must be sent to each CAP family when processing the quarterly report forms received in November and December of 1997 and January of 1998. Participants must respond to this letter requesting information as a condition of Medicaid eligibility. Failure to comply will result in a loss of Medicaid eligibility, not the termination of the CAP case.

Also, the quarterly report form is being modified to address the issue of resources and health insurance coverage. SSDs will be informed via an informational letter (INF) as soon as these changes are made.

If CAP participants become ineligible for Medicaid due to resources, the case must have a separate eligibility review made by the SSD's Medicaid unit or a CAP case manager trained in Medicaid eligibility guidelines.

- o FA Income Eligibility - ABEL is being reprogrammed to automatically perform a FA eligibility test when the CAP budget is done. However, in the interim, until SSDs are notified that ABEL has been reprogrammed, SSDs may need

to complete (but not store) FA budgets for Medicaid eligibility purposes when rebudgeting cases for quarterly reporting or at recertification.

Attachment II to this ADM lists FA earned income thresholds to be used as a guideline as to when a FA budget must be calculated for a CAP case for Medicaid eligibility. Attachment II indicates by SSD and household size the earned income level at which a family receiving a maximum shelter allowance would lose eligibility for FA. For CAP cases that would receive a maximum shelter allowance on FA, the CAP case manager may use this as a guide as to when a FA budget needs to be done for Medicaid eligibility. CAP cases whose earnings are less than the threshold amount are eligible for Medicaid and do not need an FA budget completed. All other CAP cases including those with any unearned income must have a separate FA budget calculated for Medicaid.

For CAP families who meet FA eligibility standards, Medicaid must continue to be authorized. If a CAP family's income exceeds the FA eligibility standards, the CAP case manager must first determine if the family is paying any child care costs. If the family has child care costs which exceed the amount the SSD is providing as a child care allowance, the expenses (up to \$200 per month for a child under age 2, or \$175 per month for a child age 2 or over) must be deducted from the family's net income. The remaining net income must then be compared to the FA eligibility standards. This calculation must be done off-line, since ABEL will not deduct child care costs. (An alternative would be to run a budget on MBL.)

If a family's income, after deducting any child care costs, exceeds the FA eligibility standards due to increased earnings, and the family has been receiving Medicaid during three of the last six months prior to the loss of Medicaid eligibility, Medicaid coverage must be continued in accordance with the Transitional Medical Assistance (TMA) guidelines (see 90 ADM-30). All CAP participants whose Medicaid coverage is continued under TMA must be sent timely notice. The DSS-4014: "Action Taken on Your Recertification: PA, FS, MA Coverage and Services" or the DSS-4015: "Notice of Intent to Change Benefits: Public Assistance, Food Stamps, Medical Assistance Coverage and Services (Timely and Adequate)" together with the Medical Assistance Fact Sheet (see Attachment III) must be used, and the CAP case manager must check the first box of the Medicaid section of the notice indicating continued Medicaid coverage. The

following language must also be added to this section of the notice:

"Medical Assistance coverage will continue under Transitional Medical Assistance (see attached Medical Assistance fact sheet)."

A copy of the ABEL budget must accompany the DSS-4014 or DSS-4015.

When an eligibility determination is made in the middle of the month, and the family's income exceeds the FA eligibility standards, Medicaid is extended to the end of the month and, if the family is entitled to TMA, the first six month extension period begins the first of the month following ineligibility. If ineligibility occurs at the end of the month, and timely notice cannot be provided by the first day of the following month, Medicaid coverage must be continued throughout the month following the month of ineligibility. The first six-month period begins the first of the month following the effective date of the timely and adequate notice.

The CAP case manager will be responsible for ensuring that Medicaid eligibility is determined for periods beyond the initial six months of TMA coverage. While families receiving a TMA extension normally receive a quarterly mailer from Medicaid, this will not be the case for CAP families; they will only receive the CAP quarterly report while on CAP. Up until the quarterly report is revised, CAP SSDs will be required to send a notice requesting health insurance information to each CAP family receiving TMA when a quarterly report is returned. In determining Medicaid eligibility for months beyond the initial six months of TMA coverage, health insurance premiums must be deducted in determining the family's net available income. Please note that in no instance may TMA be provided for more than 12 months.

Since TMA is limited to a maximum of 12 months, the case must be tracked for a separate determination of Medicaid eligibility at the end of the twelve months of TMA coverage. Eligibility will need to be determined by the SSD's Medicaid unit or a CAP case manager trained in Medicaid eligibility guidelines. While custodial parents may lose their Medicaid eligibility at this time, it is very possible that children will continue to be Medicaid eligible under the expanded Medicaid guidelines for children. Following a redetermination of eligibility, the CAP family must be provided timely and adequate notice before any changes to the family's Medicaid coverage are effective. The appropriate manual Medicaid notice must be used in situations in which there is a change in Medicaid coverage.

Please note that if a CAP family's income exceeds the FA eligibility standard due to increased child support payments, Medicaid coverage must be provided for four months following the month in which the income exceeded the FA eligibility standard. After four months of this extended Medicaid coverage, a separate determination must be made by the district's Medicaid unit or a CAP case manager trained in Medicaid guideline. Timely and adequate notice must be provided advising the family of the change in Medicaid coverage.

- o Medicaid Eligibility For CAP Participants Until March 31, 1998 - CAP participants losing Medicaid eligibility due to increased earnings or child support collection continue to be eligible for Medicaid through TMA and child support extensions. Continued Medicaid eligibility through the application of these will provide the required Medicaid coverage through March 31, 1998 for most CAP participants.

If a CAP recipient is found to be ineligible for Medicaid under any program of Medicaid coverage or under the TMA or child support extensions such that Medicaid coverage would end before March 31, 1998, SSDs must contact the Office of Medicaid Management to find out how to extend Medicaid coverage. Upstate, Sharon Burgess must be contacted at (518)473-5536 and for New York City, the New York City Representative must be contacted at (212)613-4330.

3. Systems Implications

Since there may now be CAP participants who are eligible for CAP but ineligible for Medicaid, CAP districts must enter Medicaid coverage code "04" on screen 5 of the DSS-3209 when a CAP participant is no longer eligible for Medicaid.

SSDs have the option of referring CAP participants to their local Medicaid unit or having a CAP case manager trained in Medicaid guidelines determine continuing Medicaid eligibility when a separate determination for Medicaid is required. SSDs may either opt to open a new MA case when some CAP case members are no longer eligible for Medicaid or TMA, or they may continue to provide Medicaid for those eligible on the CAP case (only one DSS-3209).

G. CAP Administrative Expenditures

All local social services districts operating CAP programs will use the following instructions to claim reimbursement for their administrative expenditures. However, these instructions represent a change for the original seven districts which began operating CAP in 1988-89. These seven districts (Albany,

Allegany, Chautauqua, Monroe, Niagara, Suffolk and Ulster) should begin using these instructions for the original claim submission of expenditures incurred during January 1998 and thereafter. Also, please understand that during their initial start up period, the funding for districts just starting CAP is different. New CAP expansion districts will have this period defined as part of their approval process. ^{**}(Districts implementing CAP in 1998 should see the section below entitled "Special Start Up Considerations".)

Please note that CAP program costs are eligible for federal TANF reimbursement and are shared on a 50% Federal, 25% State and 25% local basis. The Enacted Budget for SFY 1997-98 continues to fund administrative costs incurred for CAP at 50% Federal and 50% State shares. However, beginning with April 1998 expenditures, there will be a gradual reduction in the State share funding of 10% of the non federal reimbursement (or 5% of the total funding) for each of the next five fiscal years. This means that the Local share of administrative costs will increase from the current 0% to 25% for SFY 2002 and thereafter.

Local districts will use the Schedule RF-2A and the DSS-3922 Financial Summary for Special Projects form to claim the administrative expenditures for the CAP project. There is available 50 percent Federal, 50 percent State funding for administrative costs (with the exception of A-87 costs for which there are no State funds available) for the new resources approved by the Department that are necessary to operate the CAP program. These expenditures are not brought forward to the D-17.

To properly claim reimbursement for CAP administrative costs, each employee position established for the CAP program must be separately coded so that the salaries and fringe benefits can be readily identified for reimbursement of the local share.

Also, any non-salary costs associated with the CAP program must be similarly coded for reimbursement.

The CAP administrative costs will be claimed initially in the normal manner on the Schedule D in the F1 column. The CAP employees will be included in the RMS for the calculation of the shift of eligibility costs from E/IM to Food Stamps and Medicaid.

Each local district will receive the usual 50% federal share through the RF-2A claim package submission. Since all districts are in excess of their administrative cost cap, State reimbursement on the RF-2A is not considered in these claiming procedures. The additional state reimbursement to make the district whole (with the exception of A-87 costs) will be reported and claimed on the DSS-3922. (The Schedule D-17 is not used to support the DSS-3922 in this instance.) General instructions for the DSS-3922 are found in the Fiscal Reference Manual, Volume II, Chapter 3.

To calculate the local share of the CAP program you should prepare a worksheet which will remain in your fiscal office available for audit.

Step 1 - Add up all the salaries for those employees assigned to the CAP program.

Employee #1	\$1100
Employee #2	1050
Employee #3	<u>1100</u>
Total Salaries	\$3250

Enter the total salaries on Line A1 of the form DSS-3922-Financial Summary for Special Projects in the Total Expenditures Column.

Step 2 - Multiply the total salaries obtained in Step 1 by the Fringe Benefit rate used on the current month's Schedule D and enter the result on Line A2 of the form DSS-3922 in the Total Expenditures Column.

\$3,250	Total Salaries
<u>x.25%</u>	Fringe Benefit Rate
\$ 813	Total Fringe Benefits

Step 3 - Add the totals obtained in Step 1 and Step 2 and enter the result on Line A3 of the form DSS-3922 in the Total Expenditures Column.

\$4,063 Total Salaries and Fringe Benefits

Step 4 - Add up all non-salary expenditures for travel, equipment, supplies and other non-salary expenses (e.g. telephone service, postage, rent, etc.) which are directly attributed to the CAP program and enter these totals on Lines B5, B6, B7 and B9 respectively on the form DSS-3922 in the Total Expenditures Column. (NOTE: There will be no expenditures for consultants or Contractual Services).

\$150	Travel
500	Equipment
200	Supplies
<u>300</u>	Other Non-Salary Expenses
\$1150	

Step 5 - Take the total obtained in Step 4 (\$1150) and enter the results on Line B10 of the form DSS-3922 in the Total Expenditures Column.

Step 6 - Multiply the total salaries and fringe benefits amount on Line A3 in the Total Expenditures Column by 50% and enter the result on Line A3 of the form DSS-3922 in the State Share Column.

Step 7 - Multiply the total non-salary costs amount on Line B10 in the Total Expenditures Column by 50% and enter the result on Line B10 of the form DSS-3922 in the State Share Column.

Note: There will be no enhanced reimbursement for other expenditures or Indirect charges for this program.

Step 8 - (**For districts implementing CAP in 1998 there is an additional step to be performed at this point. Please see the section below entitled "Special Start Up Considerations".) Add the amounts on Lines A3 and B10 (and D if a new CAP district) together and enter the results on Line E - Project Total for both the State Share and the Total Expenditures Column. Please note that with these revised instructions the local districts no longer need to submit informational claim schedules.

Also, please remember that beginning with SFY 1998-99 there will be an annual increase in the Local share of 5% of the total funds for each of the next five State fiscal years. Therefore, starting with the original claim submission of expenditures incurred during SFY 1998-99 (April 1998 through March 1999), your agency should multiply the amounts in the Total column by 45% and enter the result in the State Share Column. For each succeeding SFY (April through March), this percentage should be decreased by 5%, e.g., for SFY 1999-00, the State Share percentage would be 40%.

This increase in Local share applies to both the existing districts as well as the new ones that have exhausted their initial start-up 100% TANF funds.

****SPECIAL START UP CONSIDERATIONS:**

The SFY 1997-98 State Budget funds start up administrative costs incurred by districts implementing CAP in calendar year 1998 at 100% Federal share. The funding for these start up costs is limited to \$1.5 million. Those local social services districts implementing CAP will make some special adjustments during the start up period when claiming expenditures up to their allocation of the \$1.5 million:

There is available 100 percent Federal funding for administrative costs including A-87 costs associated with the resources approved by the Department that are necessary to operate the CAP program. To accomplish this, when claiming expenditures during the start up period districts should use the Federal Share Column in the last three steps (Steps 6, 7, & 8) above rather than the State Share Column. There is also an additional step required in the the process prior to Step 8:

Step 8A - Enter a pro rata share of A-87 costs for CAP employees on Line D in the Total Expenditures Column. (Pro rata share would be determined by dividing the number of CAP employees by all employees in the F1 function and multiplying the resulting percentage times the total F1 A-87 amount on Section 2, Line 1 of the DSS-2347A "Schedule D-1 Claiming of Eligibility/Income Maintenance (E/IM) Expenditures.") Multiply this amount by 50% and enter the amount in the Federal Share Column of the DSS-3922. Remember to add the amount on Line D into the calculation in "Step 8" above.

Once the start-up funding has been exhausted, the district should use the instructions detailed above on pages 14 - 17, without application of the special start up modifications.

If you have any questions on the above please contact the Bureau of Local Financial Operations (Regions I-IV) Roland Levie at 1-800-343-8859, extension 4-7549 (User ID FMS001) and (Region V) Marvin Gold at (212) 383-1733, (User ID OFM270).

V. EFFECTIVE DATE

This Administrative Directive is effective December 1, 1997, retroactive to November 1, 1997.

Patricia A. Stevens
Deputy Commissioner
Division of Temporary Assistance

Case Name: _____

Case Number: _____

Date: _____

Dear CAP Participant:

There has been a change in State Law (SSL section 131-z) regarding the Child Assistance Program (CAP). In the past, CAP participants had automatically been eligible for Medicaid. As of November 1, 1997 this has changed. CAP participants must now meet Medicaid eligibility guidelines to continue to qualify for Medicaid.

Because of this change, we need information from you which we may not have asked for in the past. The information we need is in two different areas. First, we now need information on your resources. Resources include things like savings and checking accounts, automobiles, life insurance, mutual funds, etc. They do not include things you own and use for day-to-day living like clothes, furniture, refrigerators, etc. The back of this letter contains a list of the resources which normally count towards Medicaid. Please complete the back of this form and estimate the value of each resource you own. For automobiles, you need to indicate the fair market value of your automobile. We can estimate this if you give us the type (make and model) of automobile you own and the model year.

Second, we need current information on any health insurance you have and any premiums which you pay. Please provide us with the following information below:

Name of Insurance Company: _____

Policy and Group Number: _____

Who Policy Covers: _____

What Is the Cost of the Policy: _____

Who Is Paying the Premium: _____

If you do not have health insurance, write in "None" under Name of Insurance Company.

We need this form completed and returned to us within ten days from the date this letter is postmarked, or you may lose your Medicaid or CAP benefits. Please mail this completed form back to your CAP case manager before then. If you have any questions, please call your CAP case manager.

Thank you.

MAKE SURE TO COMPLETE BOTH THE FRONT AND BACK OF THIS FORM

Resource Declaration

RESOURCE	VALUE
1. Savings Accounts	\$ _____
2. Checking Accounts	\$ _____
3. Cash on Hand	\$ _____
4. Certificate of Deposits	\$ _____
5. Mutual Funds	\$ _____
6. Automobiles	
Make: _____	
Model: _____	
Year: _____	\$ _____
7. Life Insurance (cash value)	\$ _____
8. IRA, KEOGH, 401-K or Deferred Compensation	\$ _____
9. Other (fill in) _____	\$ _____

Please sign and date this side below:

Signature: _____ Date: _____

MAKE SURE TO SEND THIS BACK TO US WITHIN TEN DAYS

Family Assistance Earned Income Thresholds

DISTRICT	HOUSEHOLD SIZE						
	2	3	4	5	6	7	8
Albany	\$799	\$ 992	\$1,190	\$1,387	\$1,528	\$1,673	\$1,851
Allegany	\$812	\$1,007	\$1,206	\$1,405	\$1,546	\$1,691	\$1,870
Broome	\$864	\$1,075	\$1,280	\$1,478	\$1,623	\$1,772	\$1,958
Chautauqua	\$764	\$ 951	\$1,145	\$1,345	\$1,494	\$1,626	\$1,798
Erie	\$777	\$ 937	\$1,128	\$1,328	\$1,475	\$1,630	\$1,812
Monroe	\$864	\$1,082	\$1,301	\$1,519	\$1,734	\$1,890	\$2,085
NYC	\$864	\$1,068	\$1,273	\$1,470	\$1,636	\$1,832	\$1,990
Niagara	\$778	\$ 968	\$1,164	\$1,365	\$1,514	\$1,671	\$1,855
Oneida	\$788	\$ 979	\$1,175	\$1,378	\$1,527	\$1,683	\$1,871
Onondaga	\$839	\$1,082	\$1,239	\$1,439	\$1,599	\$1,759	\$1,953
Rockland	\$864	\$1,082	\$1,301	\$1,519	\$1,737	\$1,956	\$2,174
St. Lawrence	\$795	\$ 987	\$1,184	\$1,382	\$1,536	\$1,693	\$1,842
Suffolk	\$864	\$1,082	\$1,301	\$1,519	\$1,737	\$1,956	\$2,174
Ulster	\$864	\$1,082	\$1,301	\$1,519	\$1,737	\$1,904	\$2,101

TRANSITIONAL MEDICAL ASSISTANCE FACT SHEET

Your Medical Assistance coverage will continue under Transitional Medical Assistance for 6 months as long as you are a caretaker relative of a dependent child under age 21 who is living with you.

This is because your income is over the Low Income Family income limit due to increased earnings, new employment or loss of earned income disregards.

You may be eligible to receive Transitional Medical Assistance for up to 6 more months after the first 6 months of your extended Medical Assistance has ended if:

- o your earned income remains below certain levels; and
- o you remain employed; and
- o a dependent child under age 21 continues to live with you.

If you want Transitional Medical Assistance to continue for the full 12 months, you must complete the information on the reports we send you every 3 months. You must return the reports, along with copies of your paystubs, to us by the due date which will be shown on the first page of the report. You will receive your next report within 4 months. Remember to save your paystubs so that you can send copies to us with the reports.

It is important that you return these reports to us because the information you give in the reports will be used to determine your eligibility for the additional 6 months of Transitional Medical Assistance coverage.

HOJA DE DATOS DE LA ASISTENCIA MEDICA TRANSITORIA

Su cobertura de Asistencia Médica continuara bajo la Asistencia Médica Transitoria por 6 meses siempre y cuando usted tenga un familiar que provea cuidado a un(a) niño(a) dependiente menor de los 21 años de edad que este viviendo con usted.

Esto se debe a que su ingreso excede el límite de ingresos para Familias de Bajos Ingresos debido a un aumento en ganancias, un nuevo empleo o perdida de ingresos ganados que no se toman en cuenta.

Puede ser que usted sea elegible para recibir beneficios de la Asistencia Médica Transitoria por un máximo de 6 meses mas despues de que hayan terminado los primeros 6 meses de la Asistencia Médica Transitoria si:

- o su ingreso ganado permanece por debajo de ciertos niveles; y
- o usted permanece empleado(a); y
- o un niño(a) dependiente menor de 21 años de edad continua viviendo con usted.

Si usted desea que continúe la Asistencia Médica Transitoria por los 12 meses completos, usted debe completar la información en los informes o reportes que nosotros le enviamos cada 3 meses. Usted debe devolvernos los informes, junto con copias de sus talones salariales, antes de la fecha indicada en la primera pagina del informe. Usted recibira su proximo informe dentro de 4 meses. Recuerde de guardar sus talones salariales de manera que usted pueda enviarnos copias a nosotros con los informes.

Es importante de que usted nos devuelva estos informes debido a que la información que usted proporciona en los informes será utilizada para determinar su elegibilidad para los 6 meses adicionales de cobertura de la Asistencia Médica Transitoria.