Work First Family Assistance (WFFA)
Documentation Workbook

____________________________ County Department of Social Services

This is not an application. This is a workbook that will be used to collect the information needed to determine your eligibility for Work First Family Assistance.

PROGRAM SCREENING (ALL ANSWERS MUST BE YES TO BE POTENTIALLY ELIGIBLE.)	
❑ Yes ❑ No	Is there a child in the home under age 18 or age 18 and will graduate from high school by age 19?
❑ Yes ❑ No	Is the applicant an adult who lives with the child(ren) and who meets the kinship rule? (See WFFA Manual Section 112.)
❑ Yes ❑ No	Does the family reside in North Carolina and intend to remain?

Applicant: ________________________ Mailing Address if Different:

Address: ________________________ ________________________

________________________ ________________________

Phone: _______________ If not your phone, whose? ________________________

Directions to home: ____

HOUSEHOLD MEMBERS:

1	Name (Last, First, MI)		Relationship to applicant:		Date of Birth
Individual ID No.		Race/Ethnicity	Sex	Marital Status	Social Security Number
Grade	School		Citizenship: ☐ U.S. CITIZEN ☐ LEGAL PERMANENT RESIDENT ☐ OTHER		
Father's Name			Mother's Name		

2	Name (Last, First, MI)		Relationship to applicant:		Date of Birth
Individual ID No.		Race/Ethnicity	Sex	Marital Status	Social Security Number
Grade	School		Citizenship: ☐ U.S. CITIZEN ☐ LEGAL PERMANENT RESIDENT ☐ OTHER		
Father's Name			Mother's Name		

3	Name (Last, First, MI)		Relationship to applicant:		Date of Birth
Individual ID No.		Race/Ethnicity	Sex	Marital Status	Social Security Number
Grade	School		Citizenship: ☐ U.S. CITIZEN ☐ LEGAL PERMANENT RESIDENT ☐ OTHER		
Father's Name			Mother's Name		

4	Name (Last, First, MI)		Relationship to applicant:		Date of Birth
Individual ID No.		Race/Ethnicity	Sex	Marital Status	Social Security Number
Grade	School		Citizenship: ☐ U.S. CITIZEN ☐ LEGAL PERMANENT RESIDENT ☐ OTHER		
Father's Name			Mother's Name		

Check here: ☐ if more people are listed on the back of this page

5	Name (Last, First, MI)		Relationship to applicant:	Date of Birth
Individual ID No.	Race/Ethnicity	Sex	Marital Status	Social Security Number
Grade	School		Citizenship: ☐ U.S. Citizen ☐ Legal Permanent Resident ☐ Other	
Father's Name			Mother's Name	

6	Name (Last, First, MI)		Relationship to applicant:	Date of Birth
Individual ID No.	Race/Ethnicity	Sex	Marital Status	Social Security Number
Grade	School		Citizenship: ☐ U.S. Citizen ☐ Legal Permanent Resident ☐ Other	
Father's Name			Mother's Name	

7	Name (Last, First, MI)		Relationship to applicant:	Date of Birth
Individual ID No.	Race/Ethnicity	Sex	Marital Status	Social Security Number
Grade	School		Citizenship: ☐ U.S. Citizen ☐ Legal Permanent Resident ☐ Other	
Father's Name			Mother's Name	

8	Name (Last, First, MI)		Relationship to applicant:	Date of Birth
Individual ID No.	Race/Ethnicity	Sex	Marital Status	Social Security Number
Grade	School		Citizenship: ☐ U.S. Citizen ☐ Legal Permanent Resident ☐ Other	
Father's Name			Mother's Name	

9	Name (Last, First, MI)		Relationship to applicant:	Date of Birth
Individual ID No.	Race/Ethnicity	Sex	Marital Status	Social Security Number
Grade	School		Citizenship: ☐ U.S. Citizen ☐ Legal Permanent Resident ☐ Other	
Father's Name			Mother's Name	

10	Name (Last, First, MI)		Relationship to applicant:	Date of Birth
Individual ID No.	Race/Ethnicity	Sex	Marital Status	Social Security Number
Grade	School		Citizenship: ☐ U.S. Citizen ☐ Legal Permanent Resident ☐ Other	
Father's Name			Mother's Name	

11	Name (Last, First, MI)		Relationship to applicant:	Date of Birth
Individual ID No.	Race/Ethnicity	Sex	Marital Status	Social Security Number
Grade	School		Citizenship: ☐ U.S. Citizen ☐ Legal Permanent Resident ☐ Other	
Father's Name			Mother's Name	

Benefits From Other States

Has anyone on the application lived outside of North Carolina? ❑ Yes ❑ No

If yes, who? ________________________ When? _________ Where? _______________

Did he/she receive any assistance in the other state? (Check all that apply.)
❑ TANF (Federal) ❑ Food Stamps ❑ Medicaid (Verify months of TANF assistance received.)
Agency's phone number: ______________________.

Temporary Absence

Is anyone temporarily absent from the home? ❑ Yes (Complete the questions below.) ❑ No

Who?	When Did He/She Leave?	Why?	When Will He/She Return?

If the family member is expected to be absent for **fewer than** 90 consecutive days, **include** him/her in the application, unless he/she is receiving WFFA or TANF assistance in another case. If absent for more than 90 days, see Section 112, V.

Individual Criminal Violations

Is anyone in your home:

❑Yes ❑ No Trying to avoid a felony prosecution? Name: ____________________________

❑Yes ❑ No Fleeing from law enforcement? Name: ____________________________

❑Yes ❑ No Trying to avoid jail after conviction of a felony? Name: ____________________________

❑Yes ❑ No In violation of the conditions of probation or parole? Name: ____________________________

❑Yes ❑ No Convicted of a drug-related felony committed on or after August 23, 1996? Name: ______________________

These individuals may not be eligible for WFFA. (See Work First Manual Section 104A.)

Child Support Enforcement

☐ (check ✓) Discuss the Child Support Requirement, as stated in Attachment I (page 13).
(Optional) Offer to complete the Affidavit of Parentage (DSS-1809) if appropriate.

Absent Parents:

Absent Parent Name:	Child(ren):	
Address:	AP Phone Number:	AP SSN
	AP's Employer:	
Absent Parent Name:	Child(ren):	
Address:	AP Phone Number:	AP SSN
	AP's Employer:	
Absent Parent Name:	Child(ren):	
Address:	AP Phone Number:	AP SSN
	AP's Employer:	

INCOME

Does anyone in your household have income from working? (This includes work study, sick pay, severance pay, vacation pay, working for a temporary agency, sheltered workshop, JTPA, or VISTA.) ❑ **Yes** ❑ **No** If yes, complete the following:

1. Name: ______________________ Date Started: ______________

Employer: ______________________ Hrs. per Week: ______________

Employer Address: ______________________ Rate of Pay: ______________

____

Pay Received This Month (month of app.)		Pay Received Last Month	
Date	**Amount (gross)**	**Date**	**Amount (gross)**

2. Name: ______________________ Date Started: ______________

Employer: ______________________ Hrs. per Week: ______________

Employer Address: ______________________ Rate of Pay: ______________

____

Pay Received This Month (month of app.)		Pay Received Last Month	
Date	**Amount (gross)**	**Date**	**Amount (gross)**

List all jobs for the last 6 months for anyone in your household who currently is **not** working.

Person Who Worked	Employer	Dates Worked	Date Of Final Pay

If anyone in your household has **self-employment income, rental income, roomer income, or boarder income,** complete the following:

Who? ____________________Type of Business/income ________________________________

Collect at least two months' information. Additional months may be needed to make a representative projection of expected income.

Month	Income	Expenses*	Adjusted Gross
1.			
2.			
3.			

* See Section 114 XV. for discussion of expenses.

Unearned Income. Does anyone in your household receive any of the following?

Yes	No	Source Of Income	Who Receives the Income?	Freq.	Date Received	Average Monthly Amount
❑	❑	*Work First Family Assistance*				
❑	❑	Financial Contributions given on a regular basis. Contributor:				
❑	❑	Child Support/Alimony/Work Release Direct - Clerk of Court – IV-D (County:)				
❑	❑	Social Security Claim #				
❑	❑	Social Security Claim #				
❑	❑	Supplemental Security Income (SSI) Claim #				
❑	❑	Supplemental Security Income (SSI) Claim #				
❑	❑	Military Allotment				
❑	❑	Veteran's Benefits: Compensation/Pension/ A & A Portion VA File #				
❑	❑	Unemployment Compensation				
❑	❑	Worker's Compensation				
❑	❑	Pension/Retirement/Civil Service Annuity				
❑	❑	Railroad Retirement				
❑	❑	Private Disability (May be earned. See 114, III.)				
❑	❑	Interest/Dividends				
❑	❑	Educational Grants, Scholarships				
❑	❑	Income From Trust Fund/Promissory Note				
❑	❑	Foster Care Payment/County Supplement				
❑	❑	Other				

Key the above income into the automated budget in EIS.

RESOURCES:

Does anyone you are applying for have any of the following? Check (✓) all that apply.

Yes ✓	Resource	Who Owns the Resource? (List all owners.)	STATED VALUE				Access (Circle all that apply.)	Verified Value
			Retro 3	Retro 2	Retro 1	Mo. Of App.		
	Cash/						A J RT I	
	Checking Account #: Bank: #: Bank:						A J RT I A J RT I	
	Savings Account/ Safe Deposit Box #: Bank: #: Bank						A J RT I A J RT I	
	IRA's, CD's, Money Market, Mutual Funds #: Bank: #: Bank:						A J RT I A J RT I	
	Stocks Broker: Stock Name: # Shares: **Bonds** Issuer: **U.S. Savings Bonds** Face Value: Series #:						A J RT I	
	Other						A J RT I	

A = Accessible to Owner **J = Jointly Owned**
RT = Resulting Trust (List actual owner in 4th column.) **I = Inaccessible (Document reason.)**

TOTAL:

Life Insurance: Does anyone you are applying for have **life insurance?** ❑ Yes ❑ No

If yes, complete the following:

1. Owner	Name of Insured	Policy No.	Date issued
Insurance Company	Face value	Cash value	Verified
2. Owner	Name of Insured	Policy No.	Date issued
Insurance Company	Face value	Cash value	Verified

Are there any loans outstanding against any policy? ❑ Yes ❑ No
If Yes, amount: ______________

Vehicles: Does anyone you are applying for own any **cars, trucks, motorcycles, or other motor vehicles?** ❑ Yes ❑ No If yes, complete the following:

1. Owner		Year	Make	Model			EXC?
Amt. Owed	To Whom?			VEH2 Value	Rebut Value	Equity Value	
2. Owner		Year	Make	Model			EXC?
Amt. Owed	To Whom?			VEH2 Value	Rebut Value	Equity Value	
3. Owner		Year	Make	Model			EXC?
Amt. Owed	To Whom?			VEH2 Value	Rebut Value	Equity Value	
4. Owner		Year	Make	Model			EXC?
Amt. Owed	To Whom?			VEH2 Value	Rebut Value	Equity Value	

EXC? = Is the vehicle excluded?

Total Countable Value Of Vehicles ________________

If the applicant has excess resources, you must inform him he can rebut/reduce the value of the resource. Does the applicant wish to rebut/reduce the value of a resource? ❑ Yes ❑ No

Total Resources: ________________ (Limit: $3,000)

MEDICARE

Is anyone you are applying for covered by **Medicare**? ❑ Yes ❑ No If yes, complete the data below.

Who?	RSDI Claim Number	Med. A	Med. B
		❑ Yes ❑ No	❑ Yes ❑ No
		❑ Yes ❑ No	❑ Yes ❑ No
		❑ Yes ❑ No	❑ Yes ❑ No
Verification:			

PRIVATE HEALTH INSURANCE *

Complete the following for anyone who is covered by private health insurance:

Insured / Owner (Sponsor)	Type	Insurance Company Name and Address	Insurance Eff. Date	Policy Number/Group Number (Sponsor SSN)	Premium Amt./Frequency / Who Pays?
			/ /		/
			/ /		/
			/ /		/

Verification:

* **Complete a DMA-2041 for private health insurance.**

NOTE: If a Medicaid individual has private health insurance and a catastrophic illness, evaluate with DMA for coverage under the Health Insurance Premium Payment (HIPP) Program.

1. **Has anyone you are applying for been in an accident in the last 12 months?** ❑ Yes ❑ No
   If yes, complete Form DMA-2043.
2. **Does everyone on your application receive Medicaid?** ❑ Yes ❑ No
   If no, have you already applied? ❑ Yes ❑ No **If so, when?** ______________________
3. **Does anyone you are applying for owe any medical bills?** ❑ Yes ❑ No
4. **Does anyone you are applying for have any current medical expenses?** ❑ Yes ❑ No

If Question 3 or 4 above is answered Yes or if there is a retroactive medical need, complete the chart below.

Family Member	Provider / Phone #	Date Of Service	Date Of Last Payment	Amount Charged	Type / Freq.	TPR/ Medicare Payment	Family Member Portion	Amount Usable	Verification
		/ /	/ /						
		/ /	/ /						
		/ /	/ /						
		/ /	/ /						
		/ /	/ /						

COLLATERAL CONTACT

We need the name, address, and phone number of a person who does not live with you and is not related to you or anyone in your household. I need to contact this person to verify your household situation.

Name: ________________________________

Address: ________________________________

____

Phone: ________________________________

Did this collateral verify household size, composition, and residence?
❑ Yes ❑ No - obtain a second collateral.

Discrepancies:

ADDITIONAL INFORMATION

Do you pay rent? ❑ Yes ❑ No

Do you receive any Section 8 assistance or a rent subsidy? ❑ Yes ❑ No

If yes, how much are you responsible for each month? $ ________________

Is anyone in your household pregnant? ❑ Yes ❑ No

Name: ____________________________ **Due Date:** ______________

Is anyone on your application a member of a federally recognized tribe? ❑ Yes ❑ No

If yes, complete the following:

Name of Tribal Member:	Tribe:	Have an enrollment card?
		❑Yes ❑ No
		❑Yes ❑ No
		❑Yes ❑ No
		❑Yes ❑ No

Additional Services

Our agency also offers other services and referrals to other community programs. Please tell me if anyone you are applying for would be interested in the following.

Service Explained	Service Offered	Referred Yes	Referred No
❑	**Family Planning Services** - These services include counseling, education, and medical services for males and females regarding birth control. **Who?** ___________________________	❑	❑
❑	**Medical Transportation** - If approved for Medicaid, you can get help from the county DSS in arranging and/or paying for medical transportation for visits to the doctor's office or hospital. **For whom?** __________________________ **(Complete DMA-5046.)**	❑	❑
❑	**Health Check** – This program provides medical and dental health care screenings for *Work First Family Assistance* and Medicaid recipients from birth through age 21 and assistance in arranging transportation to appointments. **For whom?** ____	❑	❑
❑	**Adult Health Screening** - This program provides for 1 annual health screening for adults over age 21 so that serious illnesses can be detected early and treated. **For Whom?**______________________	❑	❑
❑	**Carolina ACCESS** (for applicable counties)	❑	❑
❑	**Carolina Alternative** (for applicable counties) **Provider Chosen:** ____________________________	❑	❑
❑	**WIC** (Women's Infants and Children) - WIC is a program to help you buy food if you are pregnant or have a child under age 5 in the home. ❑ **Currently receives WIC**	❑	❑
❑	**Maternity Care Services** - The Baby Love Program will provide a maternal care coordinator (MCC) to assist pregnant women during their pregnancy. If you want this service, do you agree to let DSS give the MCC information about your eligibility? ❑ Yes ❑ No	❑	❑
❑	**Day Care** – Assistance in arranging and/or paying for day care for children under age 13 or disabled children age 13 and over. **Do you need dependent care assistance?**	❑	❑
❑	**Life Line** - Anyone in your home who gets *Work First Family Assistance* or SSI and has a phone bill in his name can get a deduction on his phone bill. **For whom?** ____________________	❑	❑
❑	**Vocational Rehabilitation** - Assistance for individuals with minor disabilities for medical treatment, rehabilitation, training, education, and job placement. **For whom?** ______________________	❑	❑
❑	**Voter Registration** – Are you registered to vote at your current address? ☐ Yes ☐ No **If no, would you like to register while you are here today?**	❑	❑

Benefit Diversion

Is Benefit Diversion appropriate for this applicant?

❑ Benefit Diversion is not appropriate.

❑ Benefit Diversion Offered ❑ Approved in the amount of $________________

❑ Declined/Denied (Reason: ____)

❑ Benefit Diversion Agreement (Form DSS-8657) Completed

REQUIRED FORMS AND NOTICES

Check (✓)

- ❑ **Rights and Responsibilities were explained. (Give applicant Attachment I)**
- ❑ **Audit/DAST screening was completed for each adult (DSS-8218)**
- ❑ **Form DMA 2188 (Notice of Privacy Practices) was given to the applicant.**
- ❑ **Form DSS-8227 (Important Information You Need to Know) was given to the applicant.**
- ❑ **MRA Core Requirements (DSS-6963A) was signed by each adult.**
- ❑ **First Stop requirement was explained to each adult.**
- ❑ **Form DSS-6966 (Notification of the Family Violence Option) was given to the applicant.**
- ❑ **Form DSS-8221 (Work Requirements if Child Care Not Available) was given to the applicant.**

CERTIFICATIONS

❑ **The following individuals *can not* be included in your Work First case:**

Name(s):	Reason:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

❑ **It appears you are not eligible for Work First Famiy Assistance because:**

____

____.

Do you still want to apply? ☐ **Yes** ☐ **No**

If no, do you want to apply for Medicaid? ☐ Yes ☐ No

If no, complete DMA-5095 for Medicaid.

By signing this form, I am saying that:

- ✓ I understand the penalties for giving false information, and I have told the truth on this form.
- ✓ Everyone included in my application is a United States citizen or a legally admitted alien.
- ✓ I know my rights and what I must do to get assistance.
- ✓ I agree to give information about what I have said.
- ✓ I agree to report changes to social services.
- ✓ I agree to let social services get proof of what I have said from any person or other agency.
- ✓ I know social services keeps private anything said about my situation.
- ✓ I know if I do not sign this form, I will not get assistance.

Applicant's Signature: ______________________________ *Date:* ______

Signature of Witness: *(if signed with a "X")* ______________________________ *Date:* ______

Interviewer's Signature: ______________________________ *Date:* ______

Decisions on applications must be made within 45 days.

MATCHES

Attach printout if **HIT** is checked.

Individual	Date	SDX	BENDEX	ESC/UIB	TPQ	DOT	IV-D
PAYEE		❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT
2		❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT
3		❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT
4		❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT
5		❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT
6		❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT
7		❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT	❑ HIT ❑ NO HIT

- ✓ Is there a family cap child? ________________________________
- ✓ Is there a minor parent? ________________________________
- ✓ How many months have been used on time limits? _____ (24 month) _____ (60 month)

DISPOSITION

❑ Approved

❑ Retro Auth-from _____________ thru ______________

❑ Ongoing Auth-from _____________ thru ______________

❑ Pending/Reason ____

❑ Denied ❑ Withdrawn REASON: ____

_______________________________________ Processor's Signature

_____________________ Date

NOTICE OF REQUIREMENT TO COOPERATE AND RIGHT TO CLAIM GOOD CAUSE FOR REFUSAL TO COOPERATE IN CHILD SUPPORT ENFORCEMENT

BENEFITS OF CHILD SUPPORT ENFORCEMENT

Your cooperation in the child support enforcement process may be of value to you and your child because it might result in the following benefits.

- Finding the absent parent;
- Legally establishing your child's paternity;
- The possibility that support payments might be secured and might be higher than your welfare grant; **and**
- The possibility that you and your children may obtain rights to future social security, veteran's, or other government benefits.

WHAT IS MEANT BY COOPERATION?

The law requires you to cooperate with the social services and child support agencies to get any support owed to you and any of the children for whom you want *Work First Family Assistance*, unless you have good cause for not cooperating.

In cooperating with the social services or child support agency, you may be asked to do one or more of the following things.

- Name the parent of any child applying for or receiving *Work First Family Assistance* and give information you have to help find the parent;
- Help determine legally who the father is if your child was born out-of-wedlock;
- Give help to obtain money owed to you or the children receiving *Work First Family Assistance*; **and**
- Report to the State any money which is given directly to you by the absent parent and/or absent spouse.

You may be required to come to the social services office, child support office, or court to sign papers or give necessary information.

ASSIGNMENT OF RIGHTS

- Any child support paid or owed to you due to a court order must be paid to Child Support Enforcement.
- The child support paid to Child Support Enforcement will be used to repay the *Work First Family Assistance* benefits you have received.

WHAT IS MEANT BY GOOD CAUSE?

You may have good cause not to cooperate in the State's efforts to collect child support. You may be excused from cooperating if you believe that cooperation would not be in the best interest of your child and if you can provide evidence to support this claim.

IF YOU DO NOT COOPERATE AND YOU DO NOT HAVE GOOD CAUSE

- Your Work First payment will be reduced or terminated.
- You will be ineligible for Medicaid, unless you are pregnant. (Your children will still receive Medicaid, if eligible.)

HOW AND WHEN YOU MAY CLAIM GOOD CAUSE

- If you want to claim good cause, you must tell a worker that you think you have good cause. You can do this at any time you believe you have good cause not to cooperate.
- If you claim "good cause," you must be given another notice. This second notice will explain the circumstances under which social services may find good cause and the type of evidence or other information social services needs to decide your claim. You may ask for this second notice to help you decide whether or not to claim good cause.

YOUR RIGHTS

You have the right to:

- Apply for help and, if denied, reapply at any time.
- Get help, if you are eligible.
- Have up to 3 people with you in your interview.
- Have anything you tell us kept private.
- Withdraw from any assistance you get at any time.
- Apply to have another person added to your case.
- Get a written notice of any information we need to complete your application.
- Be protected by federal law against discrimination on the basis of race, color, national origin, sex, religion, age, disability, or political beliefs.
- Get a notice telling you why your application is denied.
- Apply for retroactive Medicaid for up to 3 months prior to your date of application.
- Not have a permanent address as long as you plan to stay in North Carolina.
- Use your check however you want, as long as it is in the best interest of your family. If you do not use your check correctly, another person may be appointed to get your check and use it for you and your family.
- Ask for a hearing from the department of social services and the Division of Social Services if:
  - You are denied your right to apply for Work First Family Assistance.
  - Your application was not acted upon timely (within 45 calendar days).
  - Your application was denied, and you think the decision was wrong.
  - You believe your assistance is wrong based on the county's use of State regulations.
  - Your assistance is changed or stopped.
  - You asked for a review of your circumstances, and it has taken longer than 30 days or was not done.

SOCIAL SECURITY NUMBERS

- You must tell the department of social services all of the social security numbers used by everyone in your household.
- The social security numbers will be matched with the Social Security Administration, the Internal Revenue Service, the Employment Security Commission (ESC), out-of-state welfare and ESC agencies, and any other agency that is necessary.
- You have the right to withdraw your application(s) if you do not want this done.

YOUR RESPONSIBILITIES

- You must let your caseworker know of any changes in your situation within 10 days.
- You must let your caseworker know about any changes in your address, employment, property, resources, expenses or needs, or who lives in your home. If you are not sure if you should report a change, the best thing to do is to report it, and let your caseworker decide if it is needed.
- Remember -- you may have more than 1 caseworker, and you must report your changes to each one.
- If you expect a child to be away from home for longer than 90 consecutive days, you must report the child's absence within 5 days of knowing this change. If you do not, your check will be reduced or terminated. This child is no longer eligible for cash assistance unless he has good cause for being absent from the home.
- You must let your caseworker know immediately if you get more Work First Family Assistance than you are supposed to.
- You must tell the truth. It is against the law to make false statements or to willfully withhold information. If you do not tell the truth, you can be taken to court and charged with fraud. Everything you tell the department of social services will be checked by them and, perhaps, by a State or federal reviewer. If anyone in your home is convicted of giving false information about where he lives in order to receive Work First Family Assistance, Medicaid, or SSI benefits in more than one place, he will be ineligible to receive cash assistance for 10 years from the conviction.
- The information you give may be stored in a computer data bank.
- By signing an application for Medicaid, you agree to allow the State to bill any medical insurance anyone included in the application has for any bills Medicaid pays. You also agree that, if you get a payment from an insurance company for a bill that Medicaid paid, you will repay the State for the Medicaid you used. You also agree to report to the department of social services if anyone in your Medicaid case is in an accident.

***WORK FIRST FAMILY ASSISTANCE* REPORTING**

If you get *Work First Family Assistance*, you may have to fill out a report of your family's income and your household situation every 3 months. If you get a *Work First Family Assistance* report, you must fill it out and return it to the department of social services by the deadline date printed on the form. If you get a report and do not turn it in, your *Work First Family Assistance* will stop.