FAMILY INDEPENDENCE ADMINISTRATION

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POLICY DIRECTIVE #07-05-EMP

ENGAGEMENT INITIATIVE FOR PARTICIPANTS NEEDED AT HOME PART TIME TO CARE FOR A DISABLED HOUSEHOLD MEMBER

Date:	**Subtopic(s):**
February 20, 2007	Employment Eligibility

AUDIENCE

The instructions provided in this policy directive are for Job Center staff, and are informational for all others.

POLICY

Effective October 2006, caring for a disabled family/household member does not meet the Federal definition of participation in community service and therefore the hours during which an otherwise nonexempt participant provides care for a disabled family household member cannot be counted as hours of participation in work activity.

BACKGROUND

Prior to October 2006, the Family Independence Administration (FIA) was able to include participants, who were otherwise employable but had been exempted from compliance with work rules in order to care for a disabled family/household member on a full or part time basis, in the participation rates. In an effort to prepare these participants for financial independence, an initiative was implemented by FIA in April 2006 at select Job Centers to facilitate the engagement of public assistance (PA) participants who are Needed at Home Part-Time (NAHPT) because the disabled person they are caring for is a child who attends school full time.

To be considered for NAH, the disabled family member **must reside** with the participant making the NAH claim.

As a result of the changes to the Federal rules, the engagement initiative for NAHPT will be expanded to all Job Centers citywide. The Needed at Home (NAH) claim/status for applicants/participants in general will be more closely examined.

Note: For the purposes of this policy directive, the following terms have been defined:

- Disabled − temporary or permanent incapacity that is medically documented and requires full-time care;
- Family member − any individual who is related by blood, marriage, adoption, guardianship or other established relationship;
- Full-time school attendance – attending school 30 or more hours per week.

All applicants/participants who have current NAH status or make a new claim of caring for a disabled household member on a full or part-time basis and have no other barriers to employment must be evaluated for participation in any of the available activities that will facilitate the process of them becoming self-sufficient before limiting the engagement status to NAH full or part-time.

Able to participate on a full-time basis

Individuals who are NAH, but are able to participate in an activity on a full-time basis, must be assigned to the following activities:

Assignment is not limited to these activities

- Training Assessment Group (TAG) for training and education
- Back to Work (BTW)
- Begin Employment Gain Independence Now (BEGIN)
- Parks Opportunity Program (POP)
- Work Experience Program (WEP)

Able to participate on a part-time basis only

Individuals with school-age children must be evaluated for assignment on a part-time basis. If they claim no barrier to employment, they can only be referred to TAG or a modified WEP assignment. The NAHPT modified WEP assignments are with Food Stamp Offices. These offices have been selected because they:

- are located in close proximity to the child's school;
- offer telephone access during work hours;
- release the participant in the event of an emergency with the child during school hours;
- provide participation schedule at the work site that does not exceed 21 hours per week; and
- de-assigns/furloughs the participant from the WEP assignment during the summer months.

If the individual claims a medical or other barrier to employment, the appropriate referral (e.g. WeCARE) should be made on his/her behalf to validate their claim, as per current procedure.

Family Assessment form **(W-582A)**

The Family Assessment Form (**W-582A**), which must be completed and signed by a physician and submitted by all applicants/participants making a claim of NAH, has been revised to clearly indicate the circumstances that require the applicant/participant's care.

School Verification Letter (**W-700E**) is used to determine if an applicant/participant is NAH on a full or part-time basis

To facilitate the determination of an applicant/participant's eligibility for the NAH status and his/her availability for engagement, the School Attendance Verification Letter (**W-700E**) has been developed. The **W-700E** details the child's school program, attendance record and other issues that may impact the engagement of an applicant/participant.

Employability Plan (EP)

The Employability Plan (EP) has been modified to assist the user in ensuring that all required procedural and documentation requirements have been met. These modifications include the following:

- Exemptions for an applicant/participant with a child under the age of three months from code **195** (Caretaker of Child under 13 Weeks on PA Case) will be assigned employment status (ES) code **31** (Exempted Parent or Caretaker of Child Under Age 1 on Same PA Case) and Code **196** (Caretaker of NPA Child under 13 Weeks), which updates to ES NYCWAY Action Code **34** (Exempted Parent or Caretaker of Child Under Age 1 on Same PA Case), have been moved under the NAH option of the Primary Questionnaire module.
- The user will have to manually enter the name and date of birth of the person in care whenever this information is not systemically provided.
- For foster parents, a contact number to verify the name and date of birth of the person in care is also required.

The following NYCWAY action codes were designed to capture data that will distinguish for whom the applicant/participant is providing care:

- **18AC** NAH Care for Adult
- **18CC** NAH Care for Child Not in School FT
- **18CS** NAH Care for Child in School FT

These action codes will be posted via the EP and recorded for **informational purposes** only. They **do not** indicate that an exemption has been granted.

The household members listed under the Needed at Home category within the EP are as follows:

- Adult
- Child <13 weeks old
- Disabled Child >13 weeks
- Disabled Foster Child
- Foster Child (not disabled) <13 years old (see note below)

Note: At this time the Agency is unable to provide child care to any employable applicant/participant who is a foster care parent and requires child care for the foster child in order to comply with work requirements. Until this issue can be addressed, these applicants/participants will be deemed exempt. As with any exception, documentation must be provided to verify foster care participation. In situations where the foster child is in school full time and no other barriers exist, the applicant/participant must be assigned according to the NAHPT rules.

REQUIRED ACTION

As per current procedure, Workers must screen all applicants/participants for work barriers and determine whether they are otherwise work eligible prior to consideration of a Needed at Home exemption status.

For an applicant who appears to meet the criteria for or participants who make a claim of or are reassessed for a NAH exemption, the Worker must:

- verify that the disabled family member resides in the same household;

  Note: If the disabled child's presence can be verified via the Welfare Management System (WMS), then no further proof of residence is required.

- verify the name and date of birth of the disabled family household member;
- provide the **W-582A** to the applicant/participant;
- give the applicant/participant the **W-700E** whenever the care provided is for a child (under 19 years of age) who attends school full time. Before providing this form, the Worker must complete the top portion of the form and inform the applicant/participant that s/he must sign the "Parent/Guardian's Authorization to Release Information" section of **W-700E** in order for the authorized school representative to complete the form;
- if care is for a child who is neither the biological nor the adopted child of the applicant/participant, ensure that proof from an authorized agency that the child is under the guardianship/foster care of the applicant/participant is submitted (i.e., Family Court documents, foster care agency letter, Administration for Children's Services [ACS] letter, etc., including contact name and number).

A completed **W-700E** is required only when child is in school full time.

In addition, for applicants the Worker must:

Applicants claiming a NAH status are exempt from job search until the claim is verified.

- advise them that in the event their case is accepted, they must have the **W-582A** and the **W-700E** completed prior to the reassessment call-in that will occur after the case is accepted, and continue to use the **905H** (Applicant is Caretaker of Incapacitated H/H Member) and **905I** (Applicant is Foster Parent) NYCWAY action codes to process the applicant case.

For participants, if they do not have the proper documentation, the Worker must schedule a return appointment to submit the required documentation. Once the appointment is scheduled via the EP, Action Code **187R** (Return Appt−Needed at Home) will post and the Notice to Report to Center (**M-3g**) will be generated.

If the Worker determines that the participant has the proper documentation and has satisfied the requirements for exemption, the participant will be granted a 90-day exemption via the system-posting of one of the following NYCWAY action codes:

NYCWAY exemption action codes

187V Determined Exempt− Caretaker for Household Member
195 Caretaker of Child <3 Months Old − On PA
196 Caretaker of Child <3 Months Old − Not on PA
183B Foster Parent of Disabled Child − Exempt
174V Foster Parent of Child Not in School Full Time

All the NYCWAY exemption action codes will generate the Notification of Temporary Assistance Work Requirements Determination (Exempt) form (**LDSS-4005 NYC**), which the participant must sign. The participant must receive a copy of the signed **LDSS-4005 NYC** for their records.

Note: For participants whose only reason for the exemption claim is the care of a disabled child in school full time, the **W-700E** must be completed by authorized school personnel and must indicate that the parent or guardian is required to be immediately available and regularly needed to address the needs of the child, in order for the participant to be deemed exempt.

Only caretakers of disabled children or foster children (not disabled) who attend school full time are eligible for the NAHPT status and can participate in the NAHPT Special Assignment. All other claims of NAH status will be determined exempt or nonexempt.

The Worker assessing/reassessing the employability of a participant who has made a claim of exempt status based on his/her need to be at home to care for a disabled child who attends school full time, will code the participant as NAHPT when:

NAHPT eligibility factors

- no other barriers to employment exist;
- participant is not in training or employed full time;
- the Worker verifies the child resides in the home of the participant;
- the child is in school full time (minimum of 30 hours per week);
- the **W-700E** does not indicate the need for the parent/guardian to be immediately available or regularly needed at school to address the needs of the child;
- the participant is unable to participate in traditional full-time work activities due to the needs of the child;
- the participant is not providing care concurrently for a disabled adult.

If the participant is determined eligible for NAHPT status, and based on the data elements indicated within the EP, the system will post Action Code **18CS** (NAH Child in School Full-Time) and one of the following action codes to indicate the NAHPT status:

- **174P** Needed at Home Part Time (Foster Child)
- **187P** Needed at Home Part Time

ES code **16** will be used until the availability of the new ES code **40** (Needed in the Home Part Time to Care for a Disabled Family Member − Nonexempt), created specifically for the NAHPT status.

Once Action Codes **174P** and **187P** are posted, the participant's ES code will automatically change to **16** (Work Limited) and the Notification of Temporary Assistance Work Requirements Determination (Non−Exempt) (**LDSS-4005[a] NYC**) will be generated.

Note: The above action codes were designed to technically assist with NYCWAY system edits required to create a process within the EP subsystem to guide the Worker through the system to the appropriate NAHPT assignment.

The Worker must refer to TAG any participant deemed to be NAHPT who wishes to participate in a training program.

For NAHPT participants who are assigned to a specialized WEP assignment the Worker must inform them that they will be:

- required to participate in part-time work activities, up to a maximum of 21 hours per week;
- assigned to a Non-Public Assistance Food Stamp (NPA FS) Office location close to the child's school;

- attending a general orientation that will be at 109 East 16th Street, NY, NY, where a specific WEP assignment location will be determined;
- released from the work assignment as necessary (must be documented) should an emergency arise at the school; and
- de-assigned/furloughed from the Special WEP assignment during the summer school break.

If the participant documents that s/he is in full-time or part-time training, refer him/her to TAG and budget income.

In addition, the Worker must:

- obtain additional details of the participant's educational background and employment goals;
- determine if child care is needed for any preschool-age children in the household so that the participant can be engaged in Special WEP, and see that needed child care is in place according to the protocol at the local Center (ACS/non-ACS);
- record additional details of the participant's employment history, experience and preferences;
- make the Special WEP assignment by selecting one of the NPA sites according to the participant's borough;
- ensure the participant is assigned to the appropriate number of biweekly hours.The maximum hours for these part-time, limited Special WEP assignment sites will be 42 per cycle and must be reduced if the budget does not support the maximum of 42 hours biweekly.

Participants will be monitored for active participation through the normal WEP roster process.

If the participant states that s/he refuses to accept the limited work assignment, the Worker will emphasize the necessity of a mandatory work assignment according to Federal regulation requirements. Participants who do not report to the work assignment will be subject to conciliation and possible loss of benefits.

PROGRAM IMPLICATIONS

Model Center Implications	There are no Model Center implications.
Paperless Office System (POS) Implications	Any and all documents, with the exception of domestic violence-related documents, submitted and/or signed by a participant must be scanned and indexed into the electronic case file and be available for future reference.

Food Stamp Implications	Participants who fail to comply with a work assignment will be sanctioned as per current procedure, if all children on the case are six years of age or older. For participants who have children less than six years of age, a separate FS determination must be made. Under the simplified Food Stamp rules, Temporary Assistance to Needy Families (TANF) participants with children under the age of six, who fail to comply with a WEP assignment are subject to a FS sanction.
Medicaid Implications	There are no Medicaid implications.

LIMITED ENGLISH SPEAKING ABILITY (LESA) AND HEARING IMPAIRED IMPLICATIONS

For Limited English Speaking Ability (LESA) applicants/participants, make sure to obtain appropriate interpreter services in accordance with PD #06-12-OPE. For hearing-impaired applicants/participants, make sure to obtain appropriate interpreter services in accordance with PD #06-13-OPE.

FAIR HEARING IMPLICATIONS

Avoidance/ Resolution	Ensure that all case actions are processed in accordance with current procedures and that electronic case files are kept up to date. Remember that applicants/participants must receive either adequate or timely and adequate notification of all actions taken on their case.
Conferences	An applicant/participant can request and receive a conference with a Fair Hearing and Conference (FH&C) AJOS/Supervisor I at any time. If an applicant/participant comes to the Job Center requesting a conference, the Receptionist must alert the FH&C Unit that the individual is waiting to be seen. The FH&C AJOS/Supervisor I will listen to and evaluate any material presented by the applicant/participant, review the case file and discuss the issue(s) with the JOS/Worker responsible for the case and/or the JOS/Worker's Supervisor. The AJOS/Supervisor I will explain to the applicant/participant the reason for the Agency's action(s). If it is determined that the applicant/participant has presented good cause for the infraction or that the outstanding Notice of Intent needs to be withdrawn for other reasons, the FH&C AJOS/Supervisor I will: • settle in conference (SIC);

- enter the action code for Good Cause Granted **820** (NOI Conference) into NYCWAY and indicate the reason for the good cause in the comment field of the action code;
- post Action Code **10FH** for a Referral from FH&C for Employability Assessment to the Job Center as per PD #03-25-SYS. Forward all verifying documentation submitted by the applicant/participant to the appropriate JOS/Worker and any instruction regarding corrective action to be taken, if applicable;
- complete a Conference Report (**M-186a**).

In addition, if the adverse case action still shows on the "Pending" (**08**) screen in WMS, the AJOS/Supervisor I must:

- prepare and submit a Fair Hearing/Case Update Data Entry Form (**LDSS-3722**), change the **02** to an **01** if the case has been granted aid continuing (ATC); or
- prepare and submit a PA Recoupment Data Entry Form (**LDSS-3573**) to delete a recoupment.

If it is determined that the applicant/participant has not shown good cause for the infraction or that the Agency's action(s) should be sustained, the AJOS/Supervisor I will:

- explain to the applicant/participant why s/he cannot settle the issue(s) in conference (SIC);
- enter the action code for Good Cause Not Granted (**830**) into NYCWAY if the infraction was generated by the NYCWAY system;
- complete the (**M-186a**).

Evidence Packets

All complete and relevant evidence packets prepared by the FH&C AJOS/Supervisor I should include documents specific to the issue, such as copies of relevant case entries, and copies of the NYCWAY screen indicating the action codes.

All complete and relevant evidence packets must include copies of :

- a WMS budget printout;
- Client Notice System (CNS) notices;
- mandatory call-in or appointment letter given or sent to the participant;
- a clear and concise History Sheet (**W-25**) or case notes in NYCWAY detailing the action taken;
- **W-700E**;
- **W-582A**;
- **LDSS-4005 NYC** or **LDSS-4005(a) NYC**;
- conciliation Notice (**W-532A** or **W-532B**);
- relevant documentation to support the applicant/participant's residence status in the same household as the care provider.

RELATED ITEMS

PD #03-25-SYS

REFERENCES

06-LCM-10
06-ADM-17

ATTACHMENTS

W-582A	Family Care Assessment (Rev. 2/20/07)
W-582A (S)	Family Care Assessment (Spanish) (Rev. 2/20/07)
W-700E	School Attendance Verification Letter

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Date: _____

Case Number: _____

Case Name: _____

Center: _____

Family Care Assessment

Dear Physician/Treatment Facilitator:

Mr./Ms. _____ has declared that s/he is not able to participate in an employment program activity at this time because of the need to care for a disabled/sick household member. The sick/disabled individual is your patient.

The name of the patient is _____.

Please complete page 2 of this form so that this Agency will be able to better assess the participant's availability to engage in an employment program.

Thank you for your cooperation.

Sincerely,

_____
Interviewer's Signature

I hereby authorize the release of this information to the Human Resources Administration's Family Independence Administration.

_____ _____
Patient's Signature Date

Human Resources Administration
Family Independence Administration

Care Required for Sick/Disabled Household Member

To be completed by physician

Patient's Name: _____ Age: _____ SS Number: _____

Patient's Address: _____

_____

Date last evaluated: _____

Diagnosis: _____

_____

_____

Is this a permanent disability ☐ or a temporary disability ☐

If temporary, length of disability: _____ to: _____

Patient Limitations (If the information pertains to a child under 19 years of age, please indicate only those items which you consider to be age-appropriate functions/abilities).

Can this patient…	CAN DO	CANNOT DO WITHOUT ASSISTANCE
1. Ambulate inside house?		
2. Ambulate outside house?		
3. Get up from bed?		
4. Get up from seated position?		
5. Go to the toilet?		
6. Dress?		
7. Wash?		
8. Bathe?		
9. Prepare meals?		
10. Feed him/herself?		

Please note any major physical or mental impairments which limit this patient's ability to care for him/herself (e.g., blindness, deafness, memory impairment, etc.):

_____

_____

Can patient manage without home care services during the day (between 9:00 AM and 5:00 PM)?

☐ Yes

☐ No, part-time home care is needed from _____ AM/PM to _____ AM/PM (Mon Tues Wed Thu Fri Sat Sun)

☐ No, full-time home care is needed. If this is indicated: Name and telephone number of person or agency currently providing home care service to patient: _____

Telephone Number: _____

Physician's Name (please print): _____

Physician's License Number: _____ Telephone Number: _____

Business Address: _____

_____

Physician's Signature: _____ Date: _____

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Centro: _____

Evaluación de Cuidado Familiar

Estimado Médico/Proveedor de Tratamiento:

El/La Señor(a) _____ ha declarado que actualmente no puede participar en una actividad del programa de empleo porque necesita cuidar a un miembro del hogar incapacitado/enfermo. La persona enferma/incapacitada es paciente de usted.

El nombre del paciente es _____.

Favor de llenar la página 2 de este formulario para que esta Agencia pueda evaluar mejor la disponibilidad del participante para un programa de empleo.

Gracias por su cooperación.

Atentamente,

_____
Firma del Entrevistador

Por la presente, autorizo que se revele esta información a la Administración de Independencia Familiar (Family Independence Administration) de la Administración de Recursos Humanos (Human Resources Administration).

_____ _____
Firma del Paciente Fecha

Care Required for Sick/Disabled Household Member

To be completed by physician

Patient's Name: _____ Age: _____ SS Number: _____

Patient's Address: _____

_____

Date last evaluated: _____

Diagnosis: _____

_____

_____

Is this a permanent disability ☐ or a temporary disability ☐

If temporary, length of disability: _____ to: _____

Patient Limitations (If the information pertains to a child under 19 years of age, please indicate only those items which you consider to be age-appropriate functions/abilities).

Can this patient…	CAN DO	CANNOT DO WITHOUT ASSISTANCE
1. Ambulate inside house?		
2. Ambulate outside house?		
3. Get up from bed?		
4. Get up from seated position?		
5. Go to the toilet?		
6. Dress?		
7. Wash?		
8. Bathe?		
9. Prepare meals?		
10. Feed him/herself?		

Please note any major physical or mental impairments which limit this patient's ability to care for him/herself (e.g., blindness, deafness, memory impairment, etc.):

_____

_____

Can patient manage without home care services during the day (between 9:00 AM and 5:00 PM)?

☐ Yes

☐ No, part-time home care is needed from _____ AM/PM to _____ AM/PM (Mon Tues Wed Thu Fri Sat Sun)

☐ No, full-time home care is needed. If this is indicated: Name and telephone number of person or agency currently providing home care service to patient: _____

Telephone Number: _____

Physician's Name (please print): _____

Physician's License Number: _____ Telephone Number: _____

Business Address: _____

_____

Physician's Signature: _____ Date: _____

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

SCHOOL ATTENDANCE VERIFICATION LETTER

Job Center:	**NAH Liaison:**
Participant's Name:	**PA Case Number:**
Child/Student's Name:	**Date:**

Parent/Guardian's Authorization to Release Information

I authorize the school to release the information requested below regarding my child/student's school attendance and activities.

Parent/Guardian's Signature: _____ Date: _____

Autorización del Padre/Madre/Tutor para Proporcionar Información

Autorizo a la escuela a proporcionar la información solicitada más abajo respecto a la asistencia y actividades escolares de mi hijo(a)/estudiante.

Firma del Padre/Madre/Tutor: _____ Fecha: _____

For Completion by Authorized School Representative

School: _____ Grade: _____

Schoool Address: _____

School Telephone: ( ) _____ School Fax: ( ) _____

School Type: ☐ Public ☐ Private ☐ Parochial ☐ Other (describe below)

Example of "other": home school, special education, etc. Attach additional documentation if necessary:

_____

School Attendance Schedule

List child/student's school attendance:

Day	From	To
Monday	AM/PM	AM/PM
Tuesday	AM/PM	AM/PM
Wednesday	AM/PM	AM/PM
Thursday	AM/PM	AM/PM
Friday	AM/PM	AM/PM

Total school hours per week: _____

Is transportation provided to and from school for child/student? ☐ Yes ☐ No
If yes, please fill in the date and time:

Day	To	From
Monday	AM/PM	AM/PM
Tuesday	AM/PM	AM/PM
Wednesday	AM/PM	AM/PM
Thursday	AM/PM	AM/PM
Friday	AM/PM	AM/PM

Does child/student participate in an after-school program? ☐ Yes ☐ No
If yes, please fill in the date and time:

Day	From	To
Monday	AM/PM	AM/PM
Tuesday	AM/PM	AM/PM
Wednesday	AM/PM	AM/PM
Thursday	AM/PM	AM/PM
Friday	AM/PM	AM/PM

Does the child/student have disciplinary/behavioral/medical problems/conditions for which the parent/guardian is required to be immediately available and is regularly needed during school hours to address the needs of the child/student?
☐ Yes ☐ No

Does the child/student take medication during the school day?
☐ Yes ☐ No

Is there an authorized person available to administer medication at school? ☐ Yes ☐ No

Name of authorized person: _____

Is the child frequently absent? ☐ Yes ☐ No

If yes, please explain: _____

Authorized School Representative's Signature: _____

Print Name: _____ Date: _____

Phone: ( ) _____ Fax: ( ) _____

Official School Stamp