



# FAMILY INDEPENDENCE ADMINISTRATION

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## POLICY DIRECTIVE #12-01-EMP

*(Obsoletes PB #07-05-EMP)*

### NEEDED AT HOME

<b>Date:</b> January 27, 2012	<b>Subtopic(s):</b> Employment/Eligibility
<b>AUDIENCE</b>	The instructions in this policy directive are for JOS/Workers at Job Centers and informational for all other staff.
<b>POLICY</b>	Cash Assistance (CA) applicants/participants who are otherwise work rules required and claim to be Needed At Home (NAH) in order to care for a disabled household member may be considered exempt from compliance with work rules. Supporting documentation from a medical, clinical or other qualified professional confirming required care and proof of joint residence must be submitted before NAH status can be determined.
<b>BACKGROUND</b>	<p>In order for a CA applicant/participant to be eligible for NAH status, a disabled individual requiring care <b>must reside</b> with the CA applicant/participant making the NAH claim. When joint residence cannot be confirmed systemically because the disabled individual being cared for is not in receipt of CA, Food Stamps (FS), Medical Assistance (MA), or Supplemental Security Income (SSI), documentation must be submitted confirming that the individual is living in the same household as the CA applicant/participant. The applicant/participant must also submit medical documentation to confirm that his/her presence in the home is required to care for the disabled individual.</p> <p>The choices listed under the NAH category in the Employment Plan (EP) to identify the disabled household member are separated by child and adult. The choices to identify the NAH household member providing care are separated by parent and nonparent.</p>

HAVE QUESTIONS ABOUT THIS PROCEDURE?  
Call 718-557-1313 then press 3 at the prompt followed by 1 or  
send an e-mail to *FIA Call Center Fax* or fax to: (917) 639-0298

After the NAH determination is made, the following codes are autoposted to record information about the disabled person being cared for. These codes are for informational purposes only.

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

An applicant/participant may be granted a twelve (12) month NAH exemption if he/she is providing care for a disabled household member who is:

- confirmed as living in the same household (in receipt of CA, FS, MA, or SSI); and
- documented as long term disabled (i.e., a disability lasting 12 months or longer).

An applicant/participant may be granted a six (6) month NAH exemption if he/she is providing care for a disabled household member who is:

- documented as temporarily disabled and in receipt of CA, FS, MA or SSI;
- documented as temporarily disabled and not in receipt of CA, FS, MA, or SSI; or
- documented as long term disabled and not in receipt of CA, FS, MA, or SSI (these individuals have to reconfirm joint residence every six (6) months, but only needs to reconfirm the disabled household member's medical documentation every 12 months).

CA applicants/participants who are needed at home part time or are needed at home to care for a disabled child in school full time, are still granted a full time needed at home exemption using the process outlined in this policy directive.

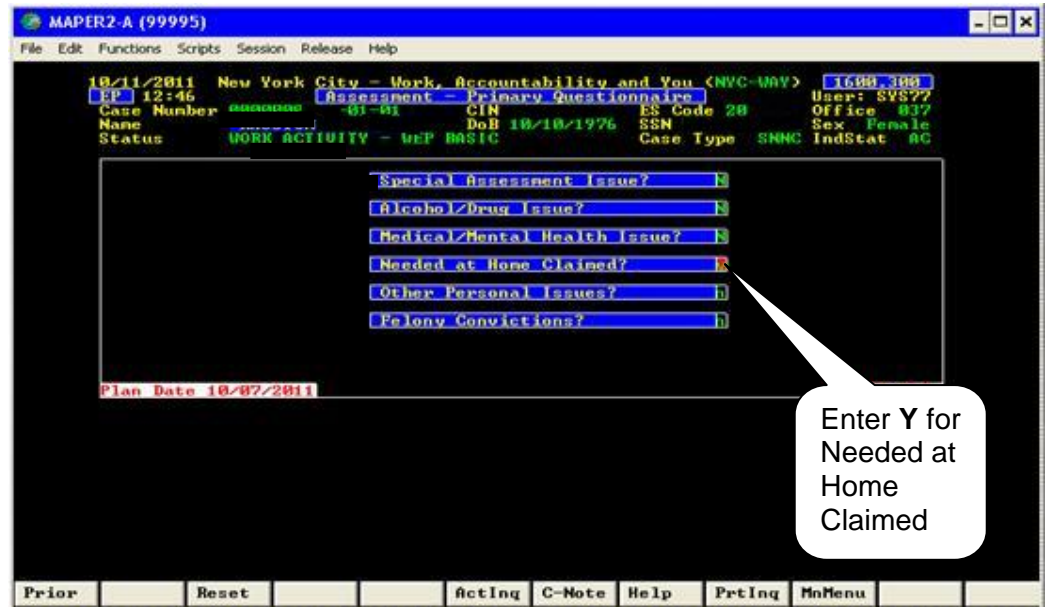
## **REQUIRED ACTION**

Refer to the Needed At Home Desk Guide form (**FIA-1058**) attached to this procedure for an overview of the NAH Process and action codes

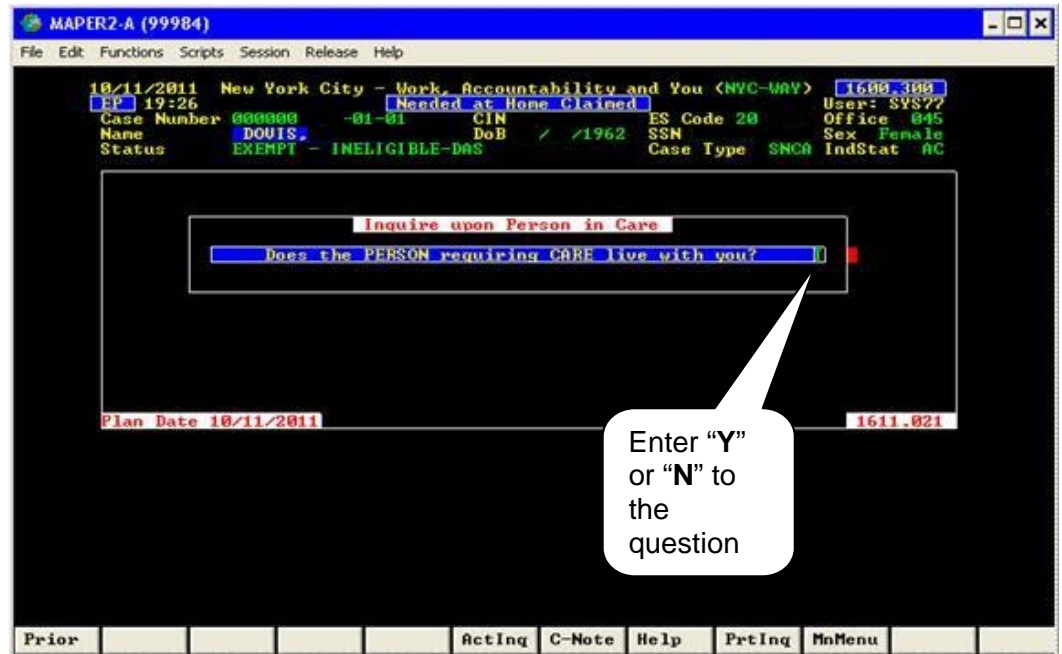
When a CA applicant/participant claims to be needed at home to care for a disabled household member, prior to considering a Needed At Home (NAH) exemption, the JOS/Worker must:

- initiate an Employment Plan (EP) in NYCWAY;
- determine if the applicant/participant is work rules required (between 18 and 59 years of age); and
- screen for other barriers to employment to determine if there is another reason for exemption.

If the applicant/participant is work rules required and there are no other barriers to employment but he/she claims to be needed at home to care for a disabled individual, the JOS/Worker must enter “Y” to select the “Needed At Home Claimed?” box on the **Primary Questionnaire** screen below.



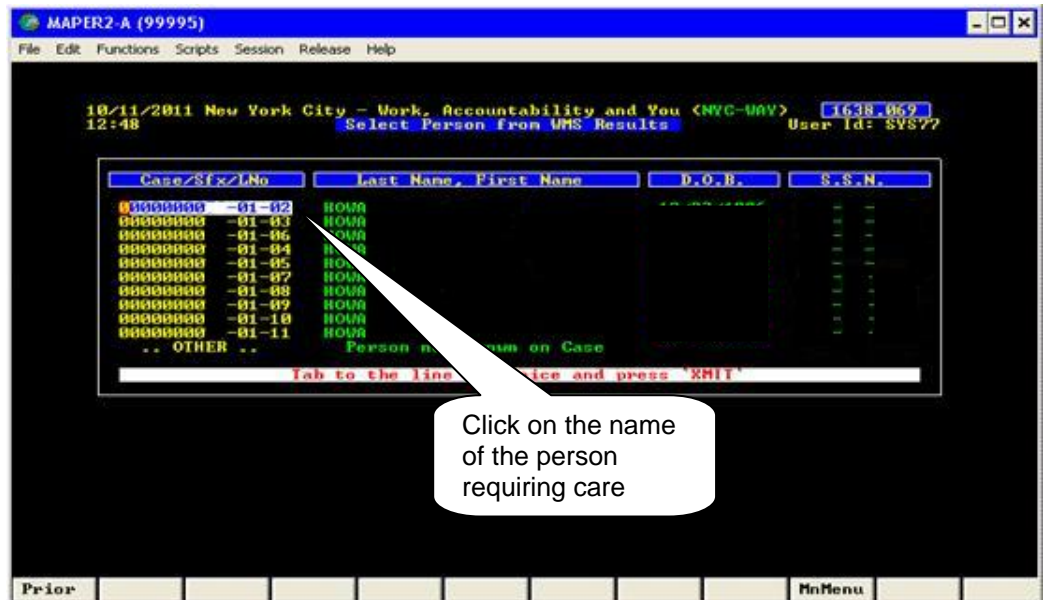
The below **Inquire about Person in Care** screen will open to confirm joint residence.



Confirming Joint Residence

The NAH individual’s joint residence with the disabled household member is a requirement for the NAH status and must be verified. The JOS/Worker must:

- Ask the individual “Does the person requiring care live with you?”
  - If the answer is no, enter “N” for the above question. If the disabled individual requiring care and the NAH individual do not live together then the individual is ineligible for the NAH status. The system will go back to the **Primary Questionnaire** screen to either choose a different barrier at the beginning or begin the engagement process.
  - If the answer is yes, enter “Y” for the above question. Once you press enter, the **Household Composition** screen will open (see below) and all members listed in the WMS household will appear.
- If the name of the person needing care is listed, highlight and click on the name (See below);

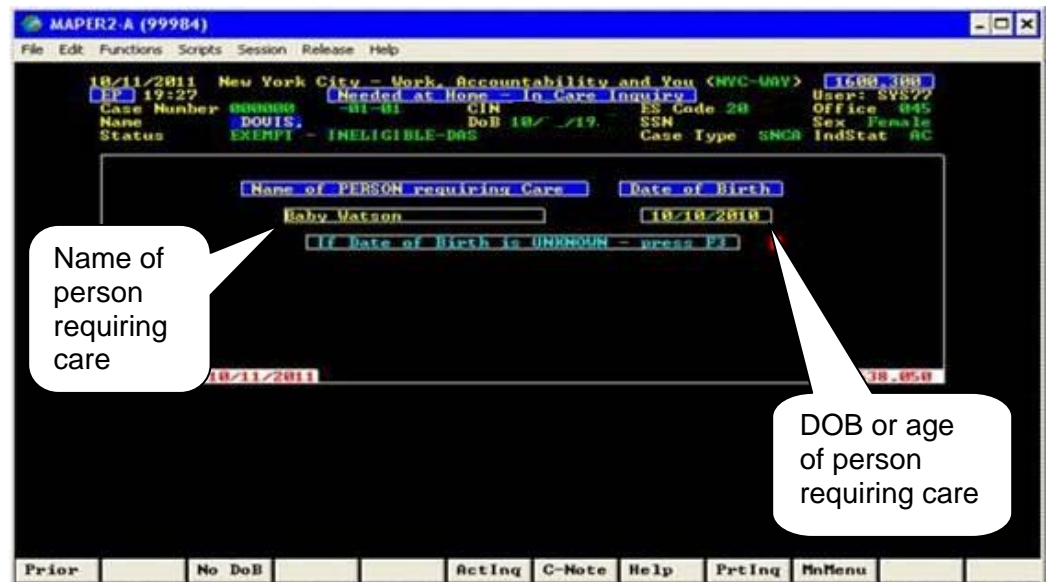


- If the name of the person needing care does not appear on the **Household Composition** screen, select “Other”. (See screen below).



- The **In Care Inquiry** screen will be displayed asking for the name and date of birth or age (if date of birth is unknown) of the person needing care. (See screen below).

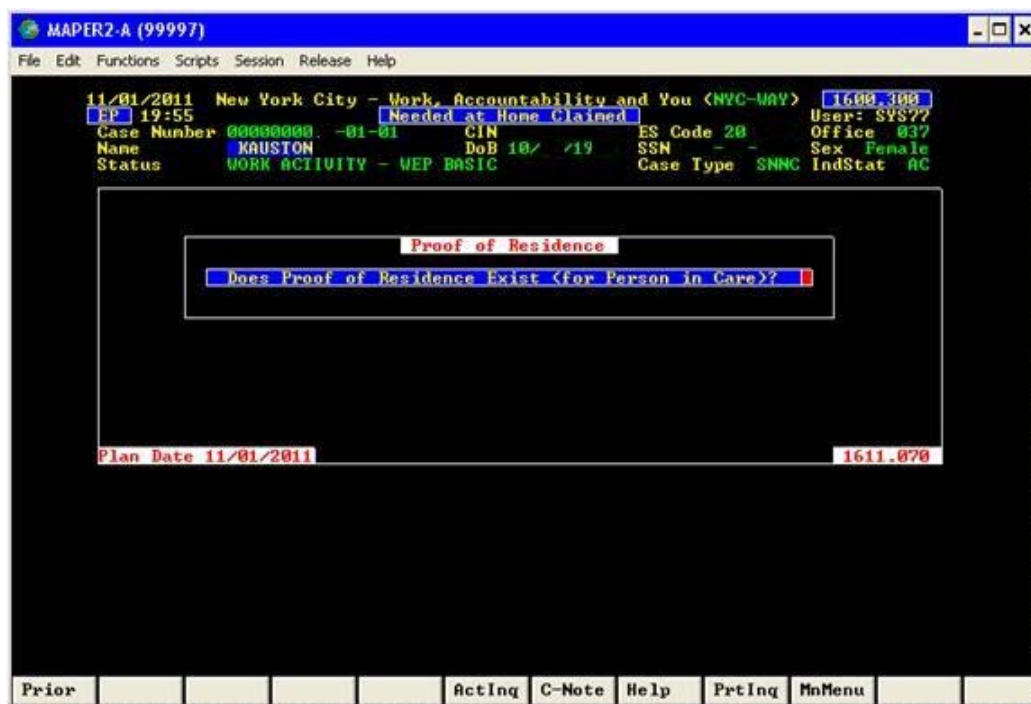
**Note:** If no names are presented because the WMS information is not yet available, the **In Care Inquiry** screen will automatically appear.



If the disabled individual is verified as being in receipt of CA, FS, or MA, no other documentation is required to prove joint residence if the address is confirmed in WMS.

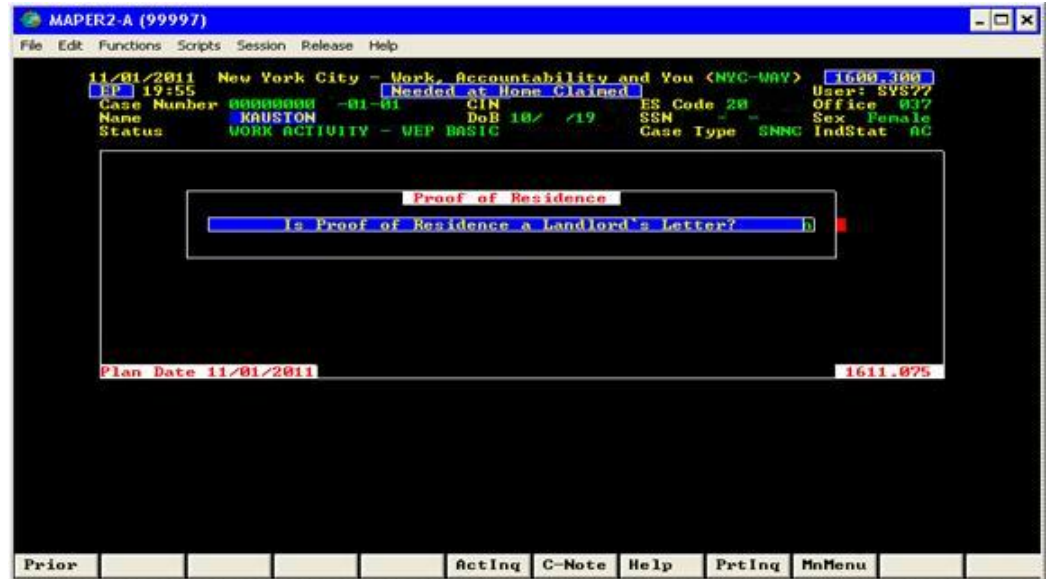
If the person needing care is not in receipt of CA, FS, or MA, the JOS/Worker must access the State Data Exchange (SDX) system in WMS to determine if the disabled individual is in receipt of SSI and to confirm the SDX address.

When the disabled individual is not in receipt of CA, FS, MA, or SSI, the JOS/Worker must request that the applicant/participant provide proof of joint residence and answer the question “Does Proof of Residence Exist (for Person in Care)?”

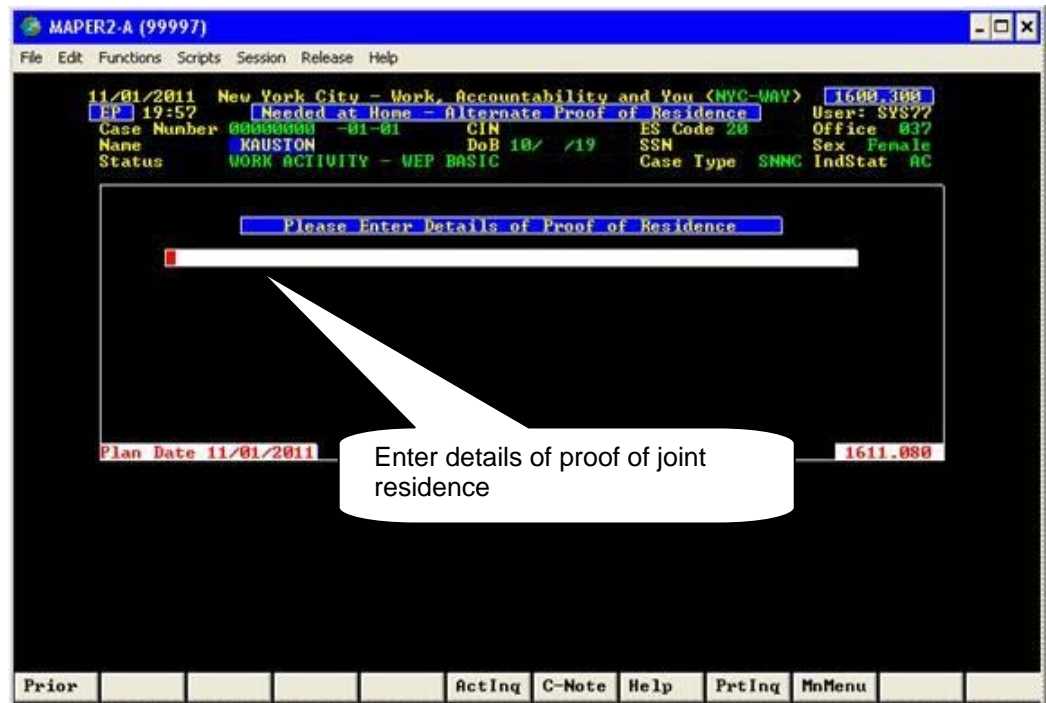


If the answer to the above question is yes, the JOS/Worker must review the documentation and answer the question on the next screen “Is Proof of Residence a Landlord’s Letter?”





If the applicant/participant has no Landlord’s Letter to confirm joint residence, the JOS/Worker must answer no by entering “N”. A screen will open up to enter alternate proof of residence provided by the applicant/participant, if any.



If no documentation of joint residence is provided, the JOS/Worker must schedule a return appointment for the applicant/participant to provide any outstanding NAH documentation, following the process on page nine (9).

### Medical Documentation to Support NAH Status

In addition to proof of joint residence, the JOS/Worker must request a Family Care Assessment Form (**W-582A**), confirming that the applicant/participant is needed at home to care for the disabled household member. The JOS/Worker should collect any medical documentation provided for the disabled household member and scan and index it into the electronic case record.

If the applicant/participant has a completed **W-582A**, the JOS/Worker must enter “Y” to the question in the EP “Family Care Assessment Form Completed?” If the applicant/participant does not have a completed **W-582A** the JOS/Worker must enter “N” to the question in the EP “Family Care Assessment Form Completed?”

**Note:** For long term disabled individuals, the JOS/Worker should check the case record, to see if there is a **W-582A** that is less than 12 months old.

The screenshot shows a terminal window titled "MAPER2-A (99991)". The main display area contains the following text:

```

11/01/2011 New York City - Work, Accountability and You (NYC-WAY) 1600 300
EP 16:59 Needed at Home Claimed User: SVS77
Case Number 00000000 -01-01 CIN ES Code 20 Office 037
Name KAUSTON DoB 10/ /19 SSN Sex Female
Status WORK ACTIVITY - WEP BASIC Case Type SNNC IndStat AC

```

In the center, there is a box titled "Family Care Assessment" containing the question "Family Care Assessment Form Completed?". A blue cursor bar is positioned over this question.

At the bottom of the terminal window, there is a status bar with the text "Plan Date 10/12/2011" and "1611.065".

If the applicant/participant does not have a completed **W-582A**, the JOS/Worker must:

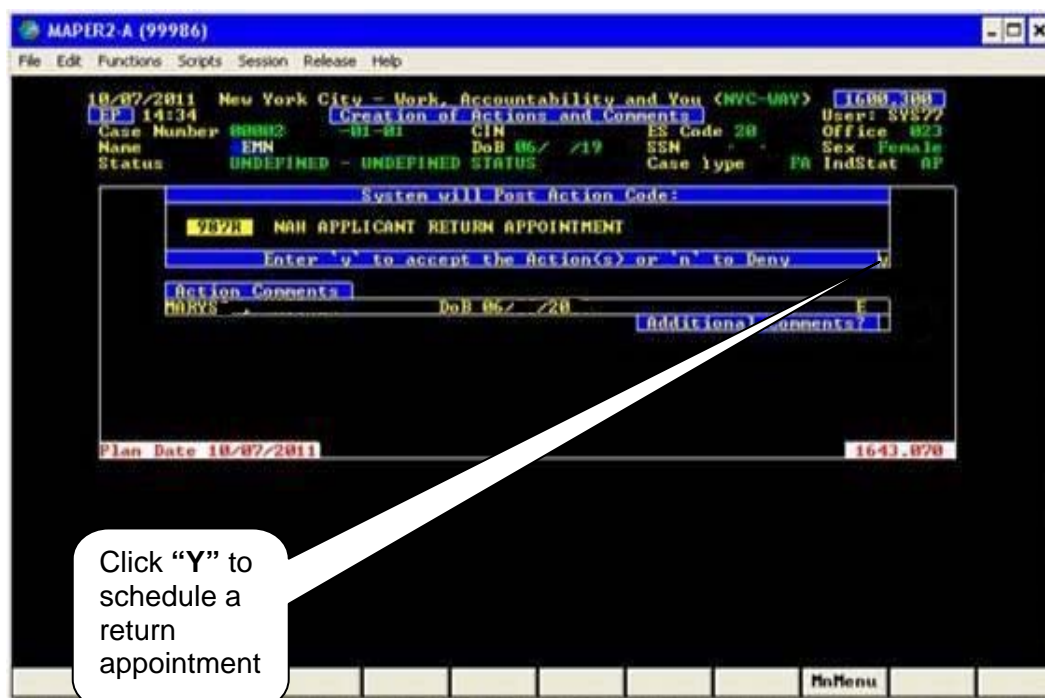
- give the applicant/participant form **W-582A** and explain that the form must be completed and signed by the disabled individual’s medical provider in order to establish NAH status; and
- complete the Documentation Requirements and/or Assessment Follow-Up form (**W-113K**) listing of all documents to be provided at the return appointment, including proof of joint residence, if appropriate, and provide the Eligibility Factors and Suggested Documentation Guide form (**W-119D**); and
- schedule a return appointment following the process on page nine (9).



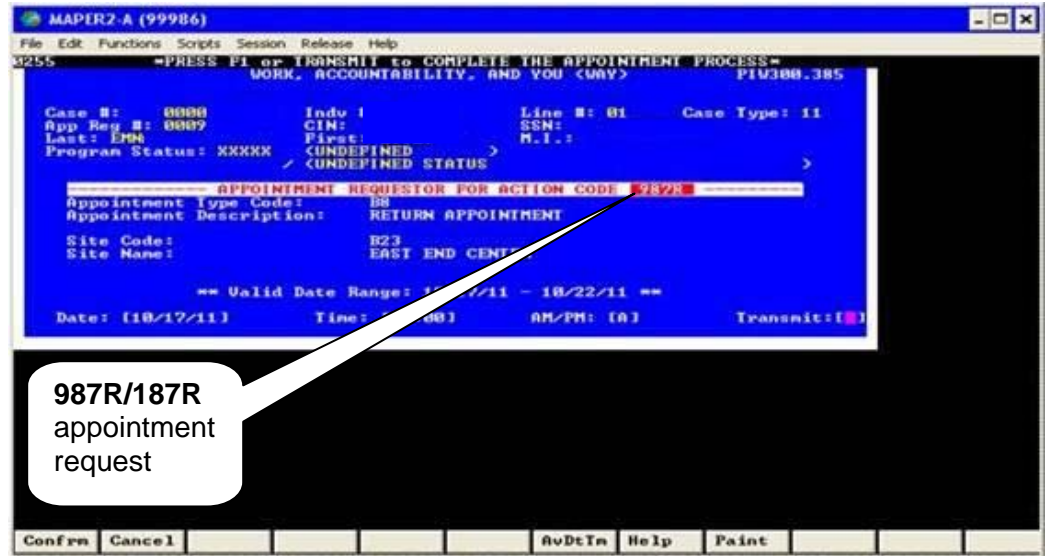
Scheduling A Return Appointment

The JOS/Worker must schedule a return appointment when form **W-582A** has not been completed and/or when verification of joint residence with the applicant/participant is required.

If the JOS/Worker answers “**N**” to either the joint residence or the family care assessment question in the EP, a screen will appear and offer either Action Code **987R** (NAH Return Appointment – Applicant) or **187R** (NAH Return Appointment – Participant). The JOS/Worker must enter “**Y**” to accept the action.

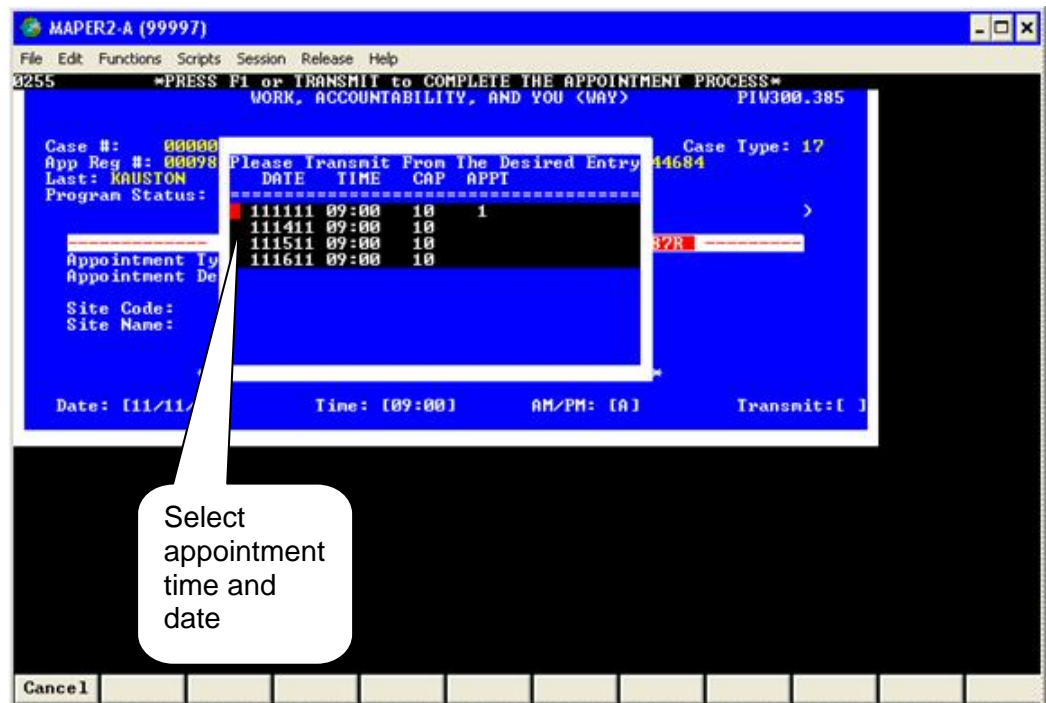


An **Appointment Requestor** screen will appear offering an appointment date range for **987R/187R** return appointments, which is at least ten (10) calendar days from the date of the present appointment. NYCWAY will display the first available appointment in the date range. The JOS/Worker must select the return appointment date and time and the system will generate the Notice to Report to Center form (**M-3g**) with the selected time and date of the appointment and the documents that must be completed and brought back.



987R/187R  
appointment  
request

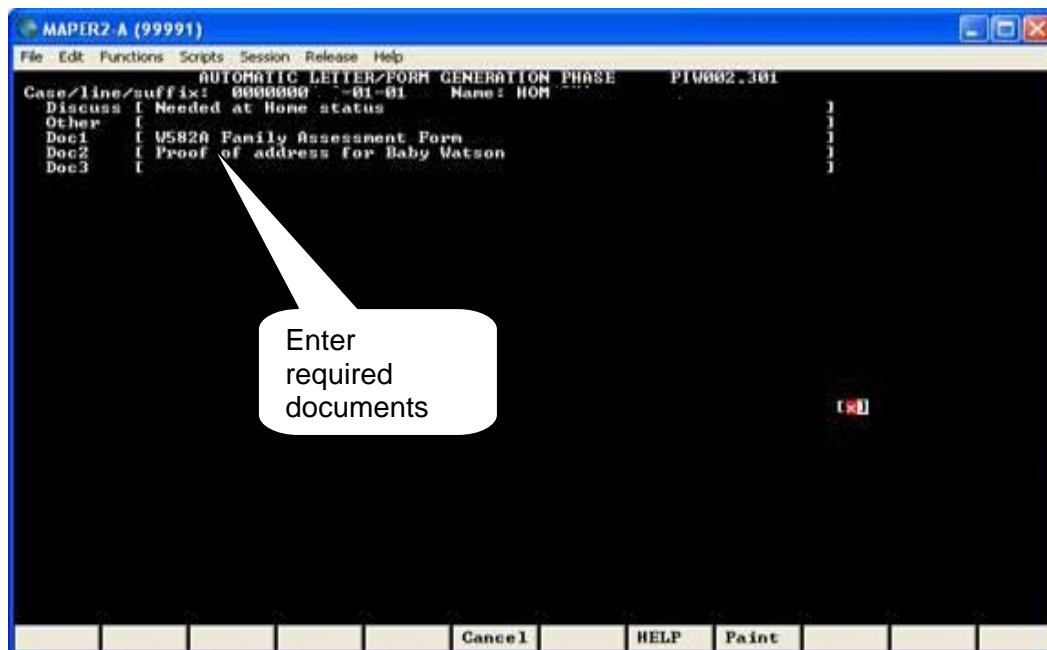
If an alternate day/time is needed, the Worker should select the appropriate return appointment date and time using the Av (available) Dt (date) Tm (Time) function key (F7) and Transmit.



Select  
appointment  
time and  
date

Once a return appointment is selected, the system displays the **Form Review** screen where the user will indicate how many copies of the appointment letter to generate before going to the **Automatic Letter/Forms Generation** screen.

On the **Automatic Letter/Forms Generation** screen, the JOS/Worker must enter the specific document(s) the applicant/participant needs to bring to the return appointment and the items listed will be filled in when the **M-3G** is printed.



### Applicant/Participant Reports to the Return Appointment

When the applicant/participant reports to the return appointment with the completed **W-582A** signed by a medical provider that supports the NAH claim (and proof of joint residence, if required), the JOS/Worker must:

- scan and index the documentation into the electronic case record;
- re-access the NAH option of the EP and the initial screens will be displayed again. The system will initially prompt for another return appointment:
  - If the required documents are returned, enter “**N**” and transmit.
  - If another appointment is needed, enter “**Y**”.

MAPER2-A (99997)

File Edit Functions Scripts Session Release Help

11/01/2011 New York City - Work, Accountability and You <NYC-WAY> 1600.300  
 EP 19:50 Needed at Home Claimed User: SVS??  
 Case Number 00000000 -01-01 CIN ES Code 20 Office 037  
 Name KAUSTON, DoB 10/ /19 SSN - Sex Female  
 Status WORK ACTIVITY - WEP BASIC Case Type SNMC IndStat AC

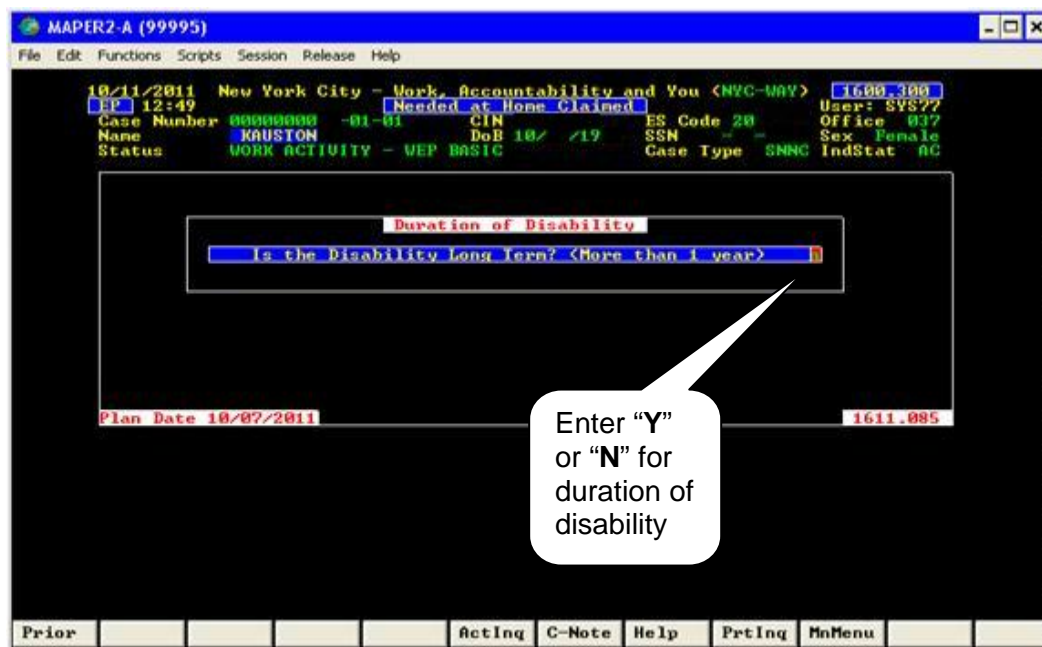
Needed at Home - Return Appointment

Re-schedule another Return Appointment?

Plan Date 11/01/2011 1611.010

Prior ActIng C-Note Help PrtIng MnMenu

- if proof of joint residence is provided, change “N” to “Y” for the question “Does the person requiring care live with you?” on the **Person In Care Inquiry** screen;
- if the **W-582A** has been completed, change “N” to “Y” to the question “Family Care Assessment Completed?” on the **Family Care Assessment** screen;
- enter “Y” or “N” to the appropriate answer to the question “Is the Disability Long Term (More than 1 year)?” on the **Duration of Disability** screen.



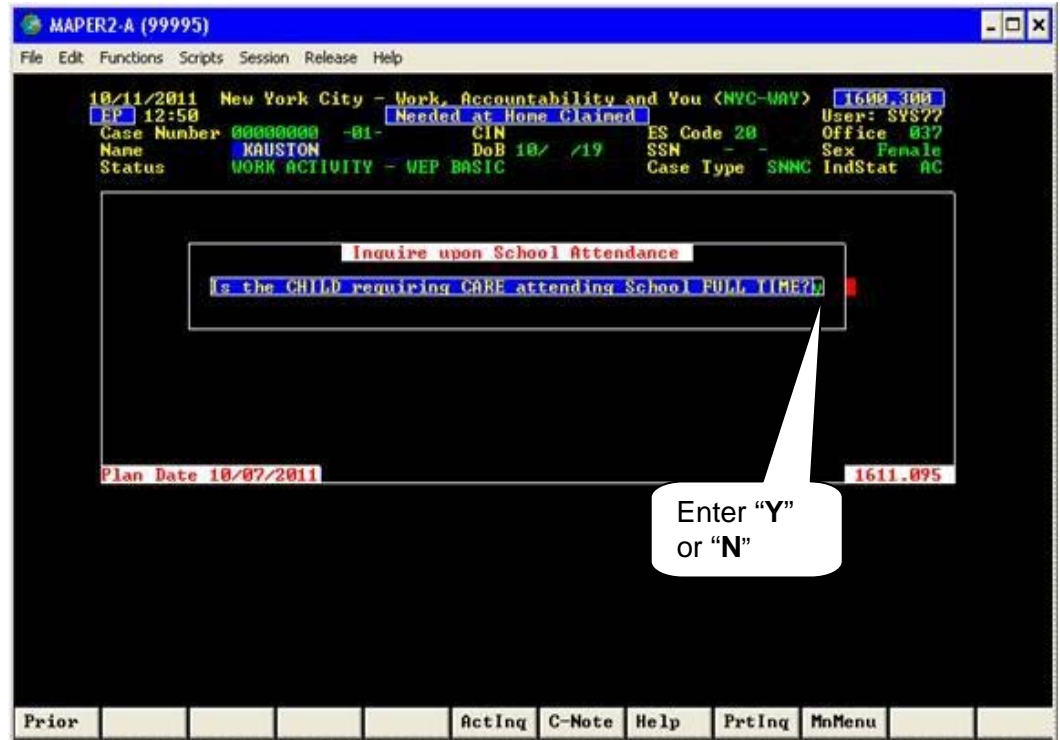
The system will then ask a series of questions. The first question is: "Is the caretaker a parent?"



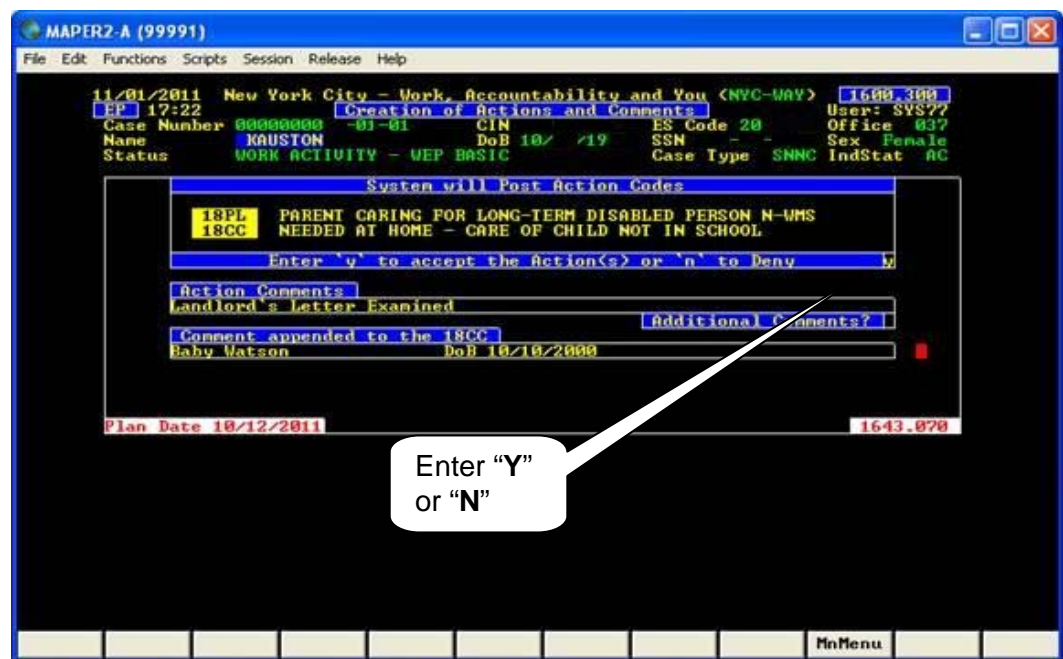
**Note:** This is asking if the caretaker is a parent in general, not if the caretaker is the parent of the disabled individual. The caretaker need only be a parent of a minor under the age of 18 regardless if the minor currently resides with him/her or not. These questions are for informational/reporting purposes only and do not affect the NAH status.



The next screen will ask: "Is the child in school full-time?" Enter "Y" or "N"



- the EP will then display the **Creations of Actions and Comments** screen which will display the action codes offered and allow additional comments to be entered. The JOS/Worker must enter "Y" to accept the action codes offered for posting.





Once all items have been completed within the EP, the system will display the appropriate Exemption Code and Auxiliary Code which contains details of the disabled person in care.

- One of the codes listed below will post and update the Employability Status (ES) code.

**Note:** All individuals granted NAH status will be granted a full exemption from the work requirements even if they are caretakers of disabled children who are in school full-time.

#### Parent NAH Exemption Codes (Updates ES code to **38**)

Refer to the NAH Desk Guide for a list and description of codes associated with the NAH process

- Action Code **18PP** (12 month exemption) – the caretaker is a parent and cares for a disabled household member with a **long-term disability** who is on CA, FS, MA, or SSI.
- Action Code **18PT** (6 month exemption) – the caretaker is a parent and cares for a **temporarily disabled** household member who is on CA, FS, MA, or SSI.
- Action Code **18PL** (6 month exemption) – the caretaker is a parent and cares for a disabled household member with a **long-term disability** who is not on CA, FS, MA or SSI.
- Action Code **18PS** (6 month exemption) – the caretaker is a parent and cares for a **temporarily disabled** household member who is not on CA, FS, MA or SSI.

#### Non-Parent NAH Exemption Codes (Updates ES Code to **58**)

- Action Code **18NP** (12 month exemption) – the caretaker is a non-parent and cares for a household member with a **long-term disability** who is on CA, FS, MA or SSI.
- Action Code **18NT** (6 month exemption) – the caretaker is a non-parent and cares for a **temporarily disabled** household member who is on CA, FS, MA or SSI.
- Action Code **18NL** (6 month exemption) – the caretaker is a non-parent and cares for a household member with a **long-term disability** who is not on CA, FS, MA or SSI.
- Action Code **18NS** (6 month exemption) – the caretaker is a non-parent and cares for a **temporarily disabled** household member who is not on CA, FS, MA or SSI.

#### NAH Exemption Notification

When the applicant/participant is determined to be exempt from participation in employment activities, the JOS/Worker must:

- select the appropriate NAH exemption code to be posted in NYCWAY. The Notification of Temporary Assistance Work Requirements Determination (EXEMPT) (**LDSS- 4005 NYC**) with Part 2 (Other than Medical) will be generated;
- give form **LDSS-4005 NYC** to the applicant/participant to sign (no negative action can be taken if an individual refuses to sign the form); and
- scan and index the form into the electronic case record.

#### NAH Non-Exempt Process and Notification

When a CA applicant/participant is not granted a NAH exemption because the **W-582A** does not support NAH status (i.e., the **W-582A** does not indicate that the applicant/participant is providing care for the disabled individual, the disabled individual does not require home-care, or joint residence is not confirmed), the JOS/Worker must:

- reassess and address any unresolved barriers to employment, if appropriate; and
- If there are no other barriers to employment, provide the applicant/participant with Part 3 (nonexempt– Other than Medical) of the Notification of Temporary Assistance Work Requirements Determination (NONEXEMPT) – (**LDSS-4005A NYC**).

#### Assignment to Work Activities

If there are no barriers to employment, the JOS/Worker must open an EP, provide **LDSS-4005A** (NONEXEMPT) and assign the applicant/participant to one or a combination of the following work activities:

- Training Assessment Group (TAG)
- Back to Work (BTW)
- Begin Employment Gain Independence Now (BEGIN)
- Work Experience Program (WEP)

#### Applicant/Participant Fails to Report (FTR) to the Return Appointment

Applicant FTR to the  
NAH return appointment

When a CA applicant FTR to the NAH return appointment without good cause, Action Code **987F** will autopost and the case will go on a worklist to be denied CA. If the CA applicant is not legally responsible for any other CA case members, the FTR is processed as a line denial.

Participant FTR to the NAH return appointment

When a CA participant who is a legally responsible adult for other CA case members FTR to the NAH return appointment without good cause, Action Code **487F** will autopost to begin the Notice of Intent (NOI) process to close the case using WMS Closing Code **N17** (Failure to keep an Eligibility Related Appointment). Adults who are not legally-responsible for any other CA case members and FTR to a return NAH appointment will be processed as a line closing.

Expiration of NAH Exemption

When the NAH FAD (6 month or 12 month) expires, a batch appointment for reassessment of NAH status will automatically be sent to the participant via form **W-584M**.

If the participant reports to the reassessment appointment, the JOS/Worker must:

- review the prior exemption code and the date of the current **W-582A** to determine whether an updated **W-582A** is needed, or only proof of continued joint residence;
  - If an updated **W-582A** is required, provide the individual requesting an extension of NAH status with a new **W-582A** and explain that the form must be completed and signed by the disabled individual’s medical provider; or
  - If proof of joint residence is required, provide the individual with forms **W-113K** and **W-119D** listing that proof of joint residence is required at the return appointment;
- schedule a return appointment using the process on pages nine (9) and ten (10) or
- If provided, collect any updated medical documentation or joint residence confirmation and scan and index it into the electronic case record.

Documentation required for 6 month reevaluation of long term disabled individuals not on CA, FS, MA or SSI

When reevaluating participants who were granted a six (6) month exemption to care for a long-term disabled household member who is not on CA, FS, MA or SSI , a new **W-582A** is not required as long as the document on file is less than one year old.

Confirm joint residence

However, the JOS/Worker must reconfirm joint residence using the process on pages four (4) through seven (7). At the **W-584M** call-in appointment, the JOS/Worker must schedule a return appointment if the individual reports for the appointment, but does not bring proof of joint residence.

New **W-582A** A new **W-582A** is required for individuals with all other temporary (6 month) NAH exemptions if the individual requests an extension of the NAH exemption.

See the FTR process on page eleven (11) If the applicant/participant FTR to the return appointment and is the legally responsible adult, the case must be closed. If the applicant/participant is not a legally responsible adult, a line closing must be processed.

**PROGRAM IMPLICATIONS**

Paperless Office System (POS) Implications

Any and all documents, with the exception of domestic violence-related documents, submitted and/or signed by an applicant/participant must be scanned and indexed into the electronic case file and be available for future reference.

Other POS instructions are in the body of this policy directive.

Food Stamp Implications

Eligibility for exemption from FS work rules due to being needed at home does not require that the disabled individual being cared for reside in the same household.

Medicaid Implications

There are no Medicaid implications.

**LIMITED ENGLISH PROFICIENCY (LEP) AND HEARING - IMPAIRED IMPLICATIONS**

For Limited English Proficiency (LEP) and hearing-impaired participants, make sure to obtain appropriate interpreter services in accordance with [PD #11-33-OPE](#) and [PD #08-20-OPE](#).

**FAIR HEARING IMPLICATIONS**

Avoidance/ Resolution

Ensure that all case actions are processed in accordance with current procedures and that the electronic case files are kept up to date.

The participant must receive either adequate or timely and adequate notification of all actions taken, depending upon the circumstances of his/her case. Remember to make every reasonable attempt to resolve the issue

**Conferences**

A participant can request and receive a conference with a Fair Hearing & Conference (FH&C) AJOS I/Supervisor I at any time. If the applicant/participant comes to the Job Center and requests a conference, the Receptionist must notify the FH&C AJOS/Supervisor I. In Model Offices, the Receptionist at Main Reception will issue an FH&C ticket to the participant to route him/her to the FH&C Unit and does not need to verbally alert the FH&C staff.

The FH&C AJOS/Supervisor I will listen to and evaluate any material presented by the 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 the reason for the Agency's action(s) to the participant.

If the participant has in fact presented good cause for the infraction or shown that the outstanding NOI needs to be withdrawn for other reasons, the FH&C AJOS/Supervisor I will Settle in Conference (SIC), enter detailed case notes in NYCWAY, and forward all verifying documentation submitted by the participant to the appropriate JOS/Worker for corrective action to be taken.

In addition, if the adverse case action still shows on the "Pending" (08) screen in the Welfare management System (WMS), the AJOS/Supervisor I must prepare and submit a Fair Hearing/Case Update Data Entry Form ([LDSS-3722](#)), change the 02 to 01 if the case has been granted Aid to Continue (ATC). The AJOS/Supervisor I must complete a Conference Report ([M-186a](#)).

**Evidence Packets**

Should the participant elect to continue his/her appeal by requesting or proceeding to a Fair Hearing, which has already been requested, the FH&C AJOS/Supervisor I is responsible for ensuring that further appeal is properly controlled and that appropriate follow-up action is taken in all phases of the Fair Hearing process.


**REFERENCES**

08-ADM-07  
 18 NYCRR §§ 385.2(b)-(c)  
 Social Services Law § 332(1)(c)

**RELATED ITEMS**

[Employment Process Manual](#)  
[PB #11-48-OPE](#)

**ATTACHMENTS**

 Please use Print on Demand to obtain copies of forms.

<b>W-582A(e)</b>	Family Care Assessment Form (Rev. 1/27/12)
<b>W-582A(s)</b>	Family Care Assessment Form (Rev. 1/27/12)
<b>W-584M(e)</b>	Mandatory Appointment for Evaluation of Work Activity (Rev. 1-27-12)
<b>W-584M(s)</b>	Mandatory Appointment for Evaluation of Work Activity (Rev.1-27-12)
<b>FIA-1058</b>	Needed At Home Desk Guide and Exemption Codes



Date: \_\_\_\_\_  
Case Number: \_\_\_\_\_  
Case Name: \_\_\_\_\_  
Center: \_\_\_\_\_

### Family Care Assessment

Dear Physician/Treatment Facilitator:

Mr./Ms. \_\_\_\_\_ claims that he/she is not able to participate in an employment program activity because of the need to care for a disabled/sick household member. The disabled/sick 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.

SAMPLE

### Care Required for Sick/Disabled Household Member

To be completed by physician

**Note to Physician: Please make sure each question is filled out in sections A, B and C. If not applicable, write N/A.**

**A. General Information and Diagnosis:**

1. Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_
2. Patient's Address: \_\_\_\_\_
3. Patient's Diagnosis: \_\_\_\_\_

(Please note any major physical or mental impairment that limit the patients ability to care for himself/herself)

4. This is a:  long-term disability  temporary disability
5. If temporary, anticipated length of disability:  Up to six months  Seven months or longer
6. Date of onset of disability: \_\_\_\_\_

**B. Current Care:**

1. Does the patient require home care services or a home attendant?  Yes  No
2. Is a household member/relative currently providing care?  Yes  No  
If Yes, name of household member/relative currently providing care: \_\_\_\_\_
- Does the individual providing care reside with the patient?  Yes  No
- Relationship to patient: \_\_\_\_\_
3. Is the Patient currently receiving home care services/attendant services from a health care provider?  
 Yes  No If Yes, name of Health Care Provider: \_\_\_\_\_
4. Is the patient residing in a health care/assisted living facility?  Yes  No  
If Yes, name of health care/assisted living facility: \_\_\_\_\_

**C. Patient's Ability to Care for Himself/Herself:**

(If patient is under 19 years of age, please only answer items that you consider to be age-appropriate)

	<u>With Assistance</u>	<u>Without Assistance</u>
Can this patient:		
1. Ambulate inside the house?		
2. Ambulate outside the house?		
3. Get up from bed?		
4. Get up from a seated position?		
5. Go to the toilet?		
6. Dress?		
7. Wash?		
8. Bathe?		
9. Prepare meals?		
10. Feed himself/herself?		

11. If patient is under 19 years of age, can patient attend school full-time?  Yes  No
12. Can patient be left alone?  Yes  No If Yes, for how long each day? \_\_\_\_\_

Physician's Name (please print): \_\_\_\_\_

Physician's License Number: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Business Address: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Stamp \_\_\_\_\_ Fax: \_\_\_\_\_

Fecha: \_\_\_\_\_  
Número del Caso: \_\_\_\_\_  
Nombre del Caso: \_\_\_\_\_  
Centro: \_\_\_\_\_

### Evaluación de Cuidado Familiar

Estimado Médico/Administrada de Tratamiento:

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

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.

SAMPLE

### Care Required for Sick/Disabled Household Member

To be completed by physician

**Note to Physician: Please make sure each question is filled out in sections A, B and C. If not applicable, write N/A.**

**A. General Information and Diagnosis:**

1. Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_
2. Patient's Address: \_\_\_\_\_
3. Patient's Diagnosis: \_\_\_\_\_

(Please note any major physical or mental impairment that limit the patients ability to care for himself/herself)

4. This is a:  long-term disability  temporary disability
5. If temporary, anticipated length of disability:  Up to six months  Seven months or longer
6. Date of onset of disability: \_\_\_\_\_

**B. Current Care:**

1. Does the patient require home care services or a home attendant?  Yes  No
2. Is a household member/relative currently providing care?  Yes  No  
If Yes, name of household member/relative currently providing care: \_\_\_\_\_
- Does the individual providing care reside with the patient?  Yes  No
- Relationship to patient: \_\_\_\_\_
3. Is the Patient currently receiving home care services/attendant services from a health care provider?  
 Yes  No If Yes, name of Health Care Provider: \_\_\_\_\_
4. Is the patient residing in a health care/assisted living facility?  Yes  No  
If Yes, name of health care/assisted living facility: \_\_\_\_\_

**C. Patient's Ability to Care for Himself/Herself:**

(If patient is under 19 years of age, please only answer items that you consider to be age-appropriate)

	<u>With Assistance</u>	<u>Without Assistance</u>
Can this patient:		
1. Ambulate inside the house?		
2. Ambulate outside the house?		
3. Get up from bed?		
4. Get up from a seated position?		
5. Go to the toilet?		
6. Dress?		
7. Wash?		
8. Bathe?		
9. Prepare meals?		
10. Feed himself/herself?		

11. If patient is under 19 years of age, can patient attend school full-time?  Yes  No
12. Can patient be left alone?  Yes  No If Yes, for how long each day? \_\_\_\_\_

Physician's Name (please print): \_\_\_\_\_

Physician's License Number: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Business Address: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Stamp \_\_\_\_\_ Fax: \_\_\_\_\_

Date: \_\_\_\_\_  
Case Number: \_\_\_\_\_  
Case Name: \_\_\_\_\_  
Center: \_\_\_\_\_  
Action Code: \_\_\_\_\_

### Reevaluation of Employability Status Appointment

As a condition of eligibility for Cash Assistance, all resources must be verified. An individual's ability to work is a resource. A review of our records indicates that you are currently temporarily exempt from participating in work activities because:

Your employability status (ability to work) needs to be reevaluated and we have therefore scheduled you for a mandatory eligibility appointment. This will include a review of your treatment needs, if you are in a treatment program. If you are a single parent or caretaker relative, you may have an opportunity to participate in a range of work activities, including work experience, job search and education or training programs. Your appointment is indicated below. Please arrive on time.

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Location Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

If you have any questions or are unable to keep this appointment, please call the telephone number above. You must contact us prior to your reporting time to arrange for a new appointment.

**This is a mandatory eligibility appointment. Failure to keep this appointment or cooperate can result in the closing of your Cash Assistance case. Please note that failure to comply with this cash assistance resource requirement has no effect on your Medicaid eligibility.**

If you are working, you must bring in proof of earnings to your appointment. Please bring this letter and your child care provider enrollment form with you. If you cannot participate in work activities, please bring original documents that support your inability to participate. If you are already attending an education or training program, bring documents showing that you are attending. Do not enroll in any new education or training program before your appointment.

If you have a child under age 13, or have a child under the age of 19 with a special need, the City of New York will pay for your child care and, if needed, will help you find a child care provider for the time you are required to be engaged in a work-related activity.

Fecha: \_\_\_\_\_  
Número del Caso: \_\_\_\_\_  
Nombre del Caso: \_\_\_\_\_  
Centro: \_\_\_\_\_  
Código de Acción: \_\_\_\_\_

### Cita para Nueva Evaluación del Estado de Empleabilidad

Como requisito de elegibilidad para Asistencia en Efectivo todos los recursos deben verificarse. La capacidad que tiene una persona de trabajar es de por sí un recurso. Según nuestros archivos usted actualmente está temporalmente exento de participar en actividades de trabajo debido a que:

Su estado de empleabilidad (capacidad para trabajar) debe ser reevaluado y por tal razón le hemos programado una cita obligatoria de elegibilidad. Dicha cita incluye una evaluación de sus necesidades de tratamiento, si asiste a algún programa de tratamiento. Si es tutor pariente o padre o madre soltero(a) usted puede tener la oportunidad de participar en una variedad de actividades laborales que abarcan experiencia de trabajo, búsqueda de empleo, y programas educativos o de capacitación. Los datos de su cita se indican a continuación. Favor de ser puntual.

Fecha de la Cita: \_\_\_\_\_ Hora: \_\_\_\_\_ Teléfono: \_\_\_\_\_  
Nombre del Local: \_\_\_\_\_  
Dirección: \_\_\_\_\_  
Ciudad: \_\_\_\_\_ Estado: \_\_\_\_\_ Código Postal: \_\_\_\_\_

Si tiene alguna pregunta o si no puede cumplir la cita, favor de llamar al número de teléfono más arriba. Para programar una nueva cita, usted tiene que comunicarse con nosotros antes de su hora de cita.

**Esta es una cita obligatoria para elegibilidad. El no acudir a esta cita o cooperar con la misma puede resultar en el cierre de su caso de Asistencia en Efectivo. Por favor tenga presente que el incumplimiento de estos requisitos de recursos de Asistencia en Efectivo no afecta su elegibilidad de Medicaid.**

Si usted trabaja, debe traer pruebas de ingresos cuando venga a la cita. Por favor traiga esta carta y su formulario de inscripción del proveedor de cuidado infantil. Si usted no puede participar en actividades de trabajo, traiga por favor la documentación original que compruebe su incapacidad de participar. Si ya asiste a un programa de capacitación o educativo, traiga documentación que verifique su asistencia. No se inscriba en ningún otro programa de capacitación o educativo antes de esta cita.

Si usted tiene un niño menor de 13 años, o un niño menor de 19 años con necesidades especiales, la Ciudad de Nueva York pagará su cuidado infantil y, si necesario, le ayudará a conseguir un proveedor de cuidado infantil para el período que usted tenga que participar en una actividad relacionada con el trabajo.



### Needed At Home Desk Guide and Exemption Codes

Scenario	JOS/Worker Actions
<p><b>Applicant/participant makes an initial request for Needed at Home (NAH) status</b></p>	<ul style="list-style-type: none"> <li>Initiate the EP</li> <li>Access WMS to determine if the disabled household member is in receipt of CA, FS, MA or SSI (to confirm joint residence).</li> <li>Provide the Family Care Assessment (<b>W-582A</b>) form.</li> <li>Schedule a return appointment (Action Code <b>987R</b> will post for applicants and <b>187R</b> will post for participants).</li> <li>The Notice to Report to Center (<b>M-3g</b>) form will be generated with the time/date of the appointment to return with the completed <b>W-582A</b> and proof of joint residence, if required.</li> </ul>
<p><b>Applicant/participant fails to report (FTR) to M-3g return appointment</b></p>	<ul style="list-style-type: none"> <li>An applicant must be denied Cash Assistance (CA).</li> <li>A participant's case is closed if he/she is the legally responsible adult; or</li> <li>The line is closed if the participant is not a legally responsible adult.</li> </ul>
<p><b>Applicant/participant reports to M-3g return appointment, but has no documents</b></p>	<ul style="list-style-type: none"> <li>Schedule another return appointment (<b>987R/187R</b>).</li> <li>Provide an <b>M-3g</b> form with the time/date of the return appointment.</li> </ul>
<p><b>Applicant/participant reports to the M-3g return appointment with required documents</b></p>	<ul style="list-style-type: none"> <li>Re-access the EP.</li> <li>Evaluate returned documents.</li> <li>Confirm joint residence and make an NAH determination based on information provided on form <b>W-582A</b>.</li> <li>Enter the NAH determination by clicking "Y" when the EP asks "Is Family Care Assessment form completed?"</li> </ul>
<p><b>NAH status is approved</b></p>	<ul style="list-style-type: none"> <li>If NAH status is approved, advise the applicant/participant about the exemption period (<b>6 or 12 months</b>).</li> <li>In the EP, based on the JOS/Worker's responses, the system will offer the appropriate exemption code (see <b>page 2</b> for a list of exemption codes).</li> <li>An Employment Status (ES) code will autopost (<b>ES 38</b> for a parent caretaker of a disabled household member or <b>ES 58</b> for a non-parent caretaker of a disabled household member). An auxiliary code will also autopost with information about the person in care (<b>18AC</b>-Care for an adult, <b>18CC</b>-Care for a child not in school full-time, <b>18CS</b>-Care for a child in school full-time).</li> <li>Give the applicant/participant a Notice of Temporary Assistance Work Requirements Determination (Exempt) <b>LDSS-4005 NYC</b> form.</li> </ul>
<p><b>NAH Denied</b></p>	<ul style="list-style-type: none"> <li>Explain why NAH status is being denied.</li> <li>In the EP, address any unresolved barriers to employment.</li> <li>Provide the applicant/participant with Notice of Temporary Assistance Work Requirements Determination (Non-exempt) Form <b>LDSS-4005a NYC</b>.</li> <li>Make the appropriate work activity assignment.</li> </ul>
<p><b>Applicant/participant FTR to the work activity assignment</b></p>	<ul style="list-style-type: none"> <li>An employment sanction will be imposed.</li> </ul>

SAMPLE

### Needed At Home Desk Guide and Exemption Codes (continued)

Scenario	JOS/Worker Actions
<b>NAH exemption period will expire in 30 days</b>	<ul style="list-style-type: none"> <li>A Reassessment of Employability Status (<b>W-584M</b>) form will be system generated 30 days before the NAH exemption expires with a time and date of the reassessment appointment.</li> </ul>
<b>Applicant/participant FTR to Reassessment of Employability Status (W-584M) appointment</b>	<ul style="list-style-type: none"> <li>Initiate the Notice of Intent (NOI) process to close the case if the applicant/participant is a legally responsible adult (closing code <b>N17</b>); or</li> <li>Initiate a line closing if the applicant/participant is <u>not</u> a legally responsible adult.</li> </ul>
<b>Applicant/participant reports to the W-584M status reassessment appointment and requests an NAH extension</b>	<ul style="list-style-type: none"> <li>Provide a new <b>W-582A</b> form and/or request proof of joint residence.</li> <li>Schedule a return appointment (<b>987R/187R</b>); and</li> <li>Provide Form <b>M-3g</b> with the time/date of the return appointment.</li> </ul> <p><b>Note:</b> A CA applicant/participant who is granted a 6 month exemption because he/she is needed at home to care for a disabled household member, who is not on CA, FS, MA, or SSI, must confirm joint residence every 6 months but only needs to provide a new W-582A form every 12 months.</p>
<b>Applicant/participant reports to the W-584M reassessment appointment and no longer claims NAH</b>	<ul style="list-style-type: none"> <li>Initiate an EP.</li> <li>Address an other unresolved barriers to employment.</li> <li>Provide Form <b>LDSS-4005a NYC</b> (non-exempt)</li> <li>Make a work activity assignment.</li> </ul>
<b>Applicant/participant FTR to the M-3g return appointment for extension of NAH status</b>	<ul style="list-style-type: none"> <li>Initiate the NOI process to close the case if the NAH applicant/participant is the legally responsible adult (<b>N17</b>); or</li> <li>Initiate a line closing if the NAH applicant/participant is a non legally responsible adult is NAH.</li> </ul>
<b>Applicant/participant reports to the M-3g return appointment NAH extension denied</b>	<ul style="list-style-type: none"> <li>Explain why the NAH exemption is being denied.</li> <li>Initiate an EP.</li> <li>Address any unresolved barriers to employment</li> <li>Provide Form <b>LDSS-4005a NYC</b> (non-exempt).</li> <li>Make a work activity assignment.</li> </ul>
<b>Applicant/participant reports to the M-3g return appointment NAH extension approved</b>	<ul style="list-style-type: none"> <li>Initiate the EP.</li> <li>Evaluate the new documentation.</li> <li>Indicate in the EP the appropriate exemption period (an exemption code will autopost).</li> <li>Provide Form <b>LDSS-4005 NYC</b> (exempt) if the NAH extension is granted.</li> </ul>
Exemption Codes	Description
<b>18PP</b>	Parent caretaker of a long term disabled household member on CA, FS, MA, SSI ( <b>12 month exemption</b> )
<b>18PT</b>	Parent caretaker of a temporarily disabled household member on CA, FS, MA, or SSI ( <b>6 month exemption</b> )
<b>18PL</b>	Parent caretaker of a long term disabled household member <u>not</u> on CA, FS, MA or SSI ( <b>6 month exemption</b> )
<b>18PS</b>	Parent caretaker of a temporarily disabled household member <u>not</u> on CA, FS, MA, or SSI ( <b>6 month exemption</b> )
<b>18NP</b>	Non parent caretaker of a long term disabled household member on CA, FS, MA, SSI ( <b>12 month exemption</b> )
<b>18NT</b>	Non parent caretaker of a temporarily disabled household member on CA, FS, MA, or SSI ( <b>6 month exemption</b> )
<b>18NS</b>	Non parent caretaker of a temporarily disabled household member <u>not</u> on CA, FS, MA, or SSI ( <b>6 month exemption</b> )
<b>18NL</b>	Non parent caretaker of a long term disabled household member <u>not</u> CA, FS, MA, or SSI ( <b>6 month exemption</b> )