What's Changed on 02/10/2020

Reminder: CAPER Series – Denial for Failure to Verify When Verification Was Provided.
General Information: Forms Update

This page relays to staff and the public of changes to the Cash and Nutrition Assistance Policy (CNAP) Manual regarding policy, procedures, and forms. Reminders and general information may also be displayed on this page. Prior What's Changed pages are listed in FAA6.R01 of the CNAP Manual.

The above list summarizes the information on this page. Within the CNAP Manual, each item listed above links to screens below.

Reminder: CAPER Series – Denial for Failure to Verify When Verification Was Provided.

This notification is the fifth in the CAPER series. It is being issued to inform and educate the field staff of the error rate percentage, the high error elements, and how to avoid having an invalid Case and Procedural Error Rate (CAPER).

Quality Control (QC) has cited 27 invalid CAPER actions for verification issues so far for Federal Fiscal Year (FFY) 2019. Of the 27 errors 14 were cited because the agency denied the application for failure to provide verification when the verification was available in the case file. Staff must complete a thorough review of the case file when searching for verification provided by the budgetary unit (BU). This includes thoroughly searching in OnBase and HEAplus for hard copy documents. HEAplus Notes and Case Documentation (CADO) must be thoroughly examined for potential collateral contact or visual viewed verification. Staff must ensure that verification was requested but was not provided by the participant before taking action to deny an application or terminate the benefits for failure to provide verification.

On 12/20/2018, the client applied for initial Nutrition Assistance (NA) benefits and the application did not meet the expedite criteria. The application was denied for "IN" as the client did not complete the interview. On 02/01/2019, the client was interviewed, the 12/20/2018 application was reverted to open, and the application was prorated to the same day as the interview. On 02/04/2019, the F011 was mailed to the client and it requested, "TERMINATED EMPLOYMENT: Proof that XXXXXXX XXXXXXXX is no longer working at (including last day worked and paid)". The verification was due on 02/14/2019.

A review of the case record shows that the agency received the following information from the client, which was placed in OnBase 01/09/2019:

ARIZONA DEPARTMENT OF ECONOMIC SECURITY (DES)
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

CUSTOMER NAME:	DATE:	HEAPLUS PERSON ID:	APPLICATION ID:

CUSTOMER NAME:	DATE:	HEAPLUS PERSON ID:	APPLICATION ID:
[redacted]	12/20/2018	[redacted]	[redacted]

[redacted] 105 N [redacted] St Apt [redacted] Gilbert, AZ 85234-7676	Call your eligibility worker at 1-855-HEA-PLUS (432-7587) if you have questions or need help.
YOU CAN GIVE THIS FORM TO US: BY MAIL Department of Economic Security P.O. Box 19009 Phoenix, AZ 85005-9000	IN PERSON Call the phone number above to find an eligibility office.

VERIFICATION OF EMPLOYMENT HISTORY

Instructions: Use this form to provide proof of requested information about current or previous employment.
Instrucciones: *Utilice esta forma para proveer comprobante de la información solicitada de su empleo actual o anterior.*

COMPLETED BY CUSTOMER - AUTHORIZATION TO RELEASE INFORMATION/*COMPLETADO POR EL CLIENTE- AUTORIZACIÓN PARA SUMINISTRAR INFORMACIÓN*

I hereby authorize release of any and all information requested below.
Yo doy autorización de suministrar cualquier y toda la información solicitada abajo.

PRINTED NAME OF EMPLOYEE/*NOMBRE DEL EMPLEADO*	SOCIAL SECURITY NUMBER OF EMPLOYEE/*NUMERO DE SEGURO SOCIAL DEL EMPLEADO*
[redacted]	[redacted] - [redacted] - [redacted]

NAME OF EMPLOYER/*NOMBRE DEL EMPLEADOR* [redacted] Cleaners FASHION ONE HOUR CL

SIGNATURE OF EMPLOYEE/*FIRMA DEL EMPLEADO*	DATE/*FECHA*
[redacted]	1/8/2019

Give this form to your current or former employer to provide information from [DATE] to [DATE].
ENTREGUE ESTA FORMA A SU EMPLEADOR ACTUAL O EMPLEADOR ANTERIOR PARA QUE NOS PROVEE LA INFORMACIÓN DE [DATE] A [DATE].

CUSTOMER NAME:	DATE:	HEAPLUS PERSON ID:	APPLICATION ID:
[redacted]	12/20/2018	[redacted]	[redacted]

COMPLETED BY EMPLOYER

New/current employers please complete all questions in Sections A, B, C, AND F. Former employers please complete Sections C, D, E, and F. The person whose name and signature appears above has requested your cooperation in releasing the following information.

A. NEW/CURRENT EMPLOYER

DATE HIRED	ANTICIPATED DATE OF FIRST CHECK	RATE OF PAY	ANTICIPATED GROSS INCOME PER PAY PERIOD
		$ Per	$

HOURS WORKED PER WEEK *(If hours per week vary, indicate the average)*	HOURS WORKED PER DAY *(If hours vary, indicate the range possible)*

DOES THE EMPLOYEE RECEIVE ANY OF THE FOLLOWING?
- ☐ TIPS How Often: _____ Anticipated Amount: _____
- ☐ BONUSES How Often: _____ Anticipated Amount: _____
- ☐ COMMISSIONS How Often: _____ Anticipated Amount: _____

IS EMPLOYEE REIMBURSED FOR ANY OF THE FOLLOWING?
- ☐ Travel How Often: _____ Amount: _____
- ☐ Lodging How Often: _____ Amount: _____
- ☐ Uniforms How Often: _____ Amount: _____

EMPLOYEE IS PAID	IS PAY DIRECT DEPOSITED?
☐ Weekly ☐ Bi-weekly ☐ Twice monthly ☒ Monthly	☒ Yes ☐ No If yes, name of bank

DAY OF WEEK OR DATE(S) PAID	OVERTIME RATE	OVERTIME HOURS PER WEEK	WILL OVERTIME CONTINUE?

$ | WEEK | CONTINUE? ☐ Yes ☐ No

ARE WAGES RECEIVED UNDER THE WORKFORCE INVESTMENT ACT (WIA) PROGRAM?
☐ Yes ☐ No

CONTRACT *(attach a copy of the contract)*
☐ Yes ☐ No ☐ Per Job (Rate) $ _____ ☐ Hourly (Rate) $ _____ ☐ Other

CHILD SUPPORT WITHHOLDING
☐ Yes ☐ No Amount $ _____ How often? _____

EXPECTED CHANGES IN INCOME
☐ Yes ☐ No When _____ Type: ☐ Increase ☐ Decrease ☐ Other Reason:

HAS THIS EMPLOYEE TEMPORARILY STOPPED WORKING FOR ANY OF THE FOLLOWING REASONS?
☐ MATERNITY LEAVE
☒ INJURY
☐ CONTRACT/SEASONAL
☐ FAMILY MEDICAL LEAVE (FMLA)
☒ OTHER: mentally/physically unable

LAST DATE WORKED: 10/1/2018

LEAVE IS: ☐ PAID ☒ UNPAID

DATE EMPLOYEE EXPECTED TO RETURN TO WORK: never

WORKERS COMPENSATION *(Claim pending, or claim being paid)*
☐ Yes ☒ No Carrier's Name:

B. HEALTH INSURANCE INFORMATION (NEW/CURRENT EMPLOYER)

DOES YOUR COMPANY OFFER HEALTH INSURANCE? *(If yes, continue section B. If no, go to section C.)*
☐ Yes ☒ No

DOES THE EMPLOYEE CURRENTLY HAVE (OR HAS HAD) HEALTH INSURANCE WITH YOUR COMPANY?
☐ Yes ☒ No If no, did employee decline health insurance? ☐ Yes ☒ No

NAME OF INSURANCE COMPANY	ADDRESS
N/A	
POLICY NUMBER	POLICY DATE From: To:
CUSTOMER ID NUMBER/GROUP NUMBER	NAME OF THE INSURED

CUSTOMER NAME:	DATE:	HEAPLUS PERSON ID:	APPLICATION ID:
[redacted]	12/20/2018	[redacted]	[redacted]

C. PAYCHECKS ISSUED (ALL EMPLOYERS)

Indicate each paycheck issued to the employee. From: To:

MONTH / YEAR	PAY PERIOD ENDING	ACTUAL PAY DATE	GROSS AMOUNT	# OF HRS.	TIPS	MONTH / YEAR	PAY PERIOD ENDING	ACTUAL PAY DATE	GROSS AMOUNT	# OF HRS.	TIPS
8/1/18	7/22/18	8/4/18	$ 1709.30		$				$		$
			$		$				$		$
			$		$				$		$
			$		$				$		$
			$		$				$		$
9/7/18	8/19	9/1/18	$ 1709.30		$				$		$
			$		$				$		$
			$		$				$		$
			$		$				$		$
			$		$				$		$
2015	9/16/18	9/29/18	$ 1709.30		$				$		$
			$		$				$		$
			$		$				$		$
			$		$				$		$
			$		$				$		$

D. FORMER EMPLOYER

EMPLOYEE TERMINATION
Last date worked: 10/1/18 Date final check was/will be issued: 10/1/18

Gross amount of final wages: $ _____

REASON FOR TERMINATION

☐ Laid off ☐ Fired ☐ Quit *(specify reason)*: _____

☐ Retired *(Monthly benefit)* $ _____ ☒ Other: medically unable

E. BENEFITS RECEIVED (FORMER EMPLOYER)

HAS OR WILL THIS FORMER EMPLOYEE RECEIVE PAYMENT FOR VACATION LEAVE, SICK LEAVE, OR DISABILITY?

☐ Yes ☒ No

IF YES, HOW PAID				
☐ Included in final wages	Date: _____ Gross Amount (separate from wages): $ _____			
☐ Received in one payment	Date: _____ Gross Amount: $ _____			
	IF PAID IN INSTALLMENTS, HOW OFTEN? _____			
☐ Paid in installments *(Include future payments)*	Date:	Gross Amount: $	Date:	Gross Amount: $

CUSTOMER NAME: [redacted]	DATE: 12/20/2018	HEAPLUS PERSON ID: [redacted]	APPLICATION ID: [redacted]

	Date:	Gross Amount: $	Date:	Gross Amount: $

HAS OR WILL THIS FORMER EMPLOYEE RECEIVE PAYMENT FOR SEVERANCE?

☐ Yes ☒ No

IF YES, HOW PAID?				
☐ Included in final wages	Date: _____ Gross Amount (separate from wages): $ _____			
☐ Received in one payment	Date: _____ Gross Amount: $ _____			
	IF PAID IN INSTALLMENTS, HOW OFTEN? _____			
	Date:	Gross Amount: $	Date:	Gross Amount: $
☐ Paid in installments *(Include future payments)*	Date:	Gross Amount: $	Date:	Gross Amount: $

WAS THIS FORMER EMPLOYEE COVERED BY HEALTH INSURANCE THROUGH YOUR COMPANY?	HAVE BENEFITS STOPPED?
☐ Yes ☒ No	☐ Yes ☐ No If No, complete Section B.

F. COMPANY INFORMAT (ALL EMPLOYERS)

PRINTED NAME OF PERSON COMPLETING FORM [redacted]	SIGNATURE OF PERSON COMPLETING FORM [redacted]	TITLE manager	
NAME OF COMPANY [redacted] Cleaners	COMPANY PHONE NUMBER [redacted]	COMPANY FAX NUMBER Ø	DATE 1/9/19

The employment verification reported that the client's last day worked and last day paid occurred on 10/01/2018. On 03/04/2019, the agency took action to deny the application with the "VI" code and the following notes were placed in HEAplus and in CADO:

Date	Time	Entered By	Description	Person
03/04/2019	02:51:39 PM	[redacted]	(Eligibility Worker, DES)	

V&E - REVIEWED HEA/ONBASE. PI DID NOT PROVIDE REQUESTED INFORMATION. TERM EMPLOYMENT FORM DID NOT PROVIDE GROSS AMOUNT OF LAST CHECK IN ONBASE-NOT COMPLETE-UNABLE TO VERIFY @ [redacted]/NEED VP VERIFICATION/EXNS VERIFICATION/AR FORM.

TD 3/4/19 AZTEC [redacted]

The NA Denial/Closure (F200) notice was mailed to the client on 03/05/2019. The notice listed, “YOU DID NOT GIVE US PROOF OF ALL INCOME OR PROOF THAT INCOME HAS STOPPED FOR REQUESTED HOUSEHOLD MEMBER(S) FROM ALL REQUESTED SOURCE(S)/EMPLOYER(S) “and” TERMINATED EMPLOYMENT: Proof that XXXXXX XXXXXXX is no longer working at (including last day worked and paid)XXXXXXX XXXXXXX CLEANERS”

The case record contained the verification and it was available at the time of the NA interview on 02/01/2019. Since the verification of termination was in the case recorded at the time of the interview, the agency should not have requested this information. The client provided verification of the last day worked and the last day paid from their former employer. QC cited this action as invalid because the verification of termination was in the case record.

QC also noted that the denial notice was not clear and understandable as it listed information that the client had previously provided.

For more information see FAA2.A03 in the Cash and Nutrition Assistance Policy (CNAP) Manual (Index: Verification-information verification) and FAA2.A02 (Index: Verification-use of verification codes).

General Information: Forms Update

Changes to Forms – 02/01/2020 through 02/07/2020

As a reminder, it is important not to save documents on your desktop or a folder. It is better to use the form you need directly from the Document Center. Forms are frequently updated and sometimes the current form must be used for programming purposes.

Revised forms:

- Claim of Sexual Assault or Incest (FAA-0260A-S) Form (Spanish)
- Unwed Minor Parent Abuse/Neglect Claim (FAA-0259A-S) Form (Spanish)
- Pre-Hearing Conference Information (FAA-1654A-S Form (Spanish)
- Appeal Decision (FAA-1655A-S) Form (Spanish)
- Appeal of Appeal Decision (FAA-1655B-S) Form (Spanish)
- Appeal Information Needed (FAA-1657A-S) Form (Spanish)

Newly created forms:

- No forms were created during the specified period

Revised Marketing Materials (Posters, Pamphlets, Flyers):

- No revisions to marketing materials were made during the specified period