Department of Health and Human Services

Division of Welfare and Supportive Services

Child Care Policy Manual

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Child Care
Program Overview

100 CHILD CARE PROGRAM OVERVIEW

101 Introduction

The Child Care Development Fund (CCDF) is the primary federal program devoted to providing families with child care subsidies. The CCDF enables low-income parents and parents receiving Temporary Assistance for Needy Families (TANF) to work or participate in education or training programs.

The Department of Health and Human Services (DHHS), Division of Welfare and Supportive Services (DWSS) acts as the Lead Agency for the Child Care and Development Program (CCDP). Program activities are accomplished through state staff and sub-grantees that are responsible for administration, management, and daily operations for the program.

102 General Provisions

The CCDP pays up to 100% of the state maximum rate for child care costs. Payments may be made to a provider of the parent's choice, when the provider is registered with the CCDP. Refer to manual section (MS) 600, for additional provider details.

Nevada provides child care assistance in the following funding categories:

- **New Employees of Nevada (NEON)** – Subsidy benefits provided to households that are participating in the TANF NEON program.
- **At-Risk** – Subsidy benefits provided to households that have income below 130% of the Federal Poverty Level for their household size.
- **Discretionary** – Subsidy benefits provided to households that have countable income exceeding 130% of the Federal Poverty Level but are below 85% of the State Median Income for their household size.

Within the Child Care funding categories, there are three (3) types of programs:

- **Certificate** – Provides a Certificate to an eligible household to use only for payment of child care services to an eligible provider. Reimbursements are based upon the authorized schedule and actual attendance of the eligible child. The Certificate Program *cannot* be used in conjunction with the Contracted Slot or Wraparound Programs for the same child.
- **Contracted Slots** – A Delegate Agency which has an agreement, e.g., a contract or Memorandum of Agreement (MOA), to serve an approved number of slots for low income families. These agencies are mainly before and after school programs such as Boys & Girls Clubs. Reimbursement for the month of service is authorized when a child is eligible for the entire month and attends at least one (1) day during the service month; however the reimbursement is based upon a

maximum of five (5) days per week. The Contracted Slots Program *cannot* be used in conjunction with the Certificate Program for the same child.

- **Wraparound Services** – Head Start agencies that have an agreement, e.g., a contract or MOA to serve an approved number of slots for child care services before or after the Head Start program. Reimbursement for the month of services is authorized when a child is eligible for the entire service month and attends at least 1 day during the service month; reimbursement for services is based upon a maximum of 5 days per week. Wraparound Services *cannot* be used in conjunction with the Certificate Program for the same child.

Child Care funds *cannot* be used for children enrolled in grades 1 through 12 for the following purposes:

- Any service provided during the regular school day; or
- Any service for which children receive academic credit toward graduation; or
- Any instructional services that supplant or duplicate the academic program of any public or private school (e.g., virtual school).

103 Availability of Child Care Subsidy Benefits

No person will be discriminated against for any reason such as race, age, color, religion, sex, disability (including AIDS and AIDS related conditions), handicap, political belief, sexual orientation, or national origin in any program funded by DWSS.

In the event of identified program funding shortfalls, otherwise eligible households will be prioritized in the following order:

1. NEON
2. CPS/Foster
3. Special Needs At-Risk
4. Homeless At-Risk
5. At Risk
6. Special Needs Discretionary
7. Homeless Discretionary
8. Discretionary

103.1 Wait List

If sufficient funds are not available, the Child Care & Development Program Chief may implement a waiting list.

To be placed on the waiting list, the parent/caretaker must complete an Application for Child Care Assistance, Form 2151-WC, and be prescreened for eligibility. For purposes of placement on the waiting list, the case manager must use client self-declaration and will not pursue independent verification of information.

Households placed on the waiting list must be categorized by potential funding category and subsidy level. Families within a common funding category and subsidy level must be served based upon the date of application. The oldest application must always be served first and prioritized as determined by the CCDP Chief.

Once funding is available, households, according to the prioritization listed above, must be contacted to submit a new application and required verifications.

Requests for wait listed households to provide changes/current information must be sent out a minimum of every 3 months after initial application is placed on the wait list.

> **Exception:** Adult relatives who have assumed care and control of a child(ren) prior to any action taken by a child protective agency will not be subject to wait list placement. The child(ren) will be included as a household member of the relative adult's household. Refer to MS 200 regarding traditional group set.

104 Special Consideration Requests

Requests for consideration to waive specific criteria of the CCDP policy may be submitted in writing to the CCDP Chief for review. Documentation, which supports the request, is required. A written decision will be issued to the requestor who will then notify the client of the CCDP Chief's decision.

The CCDP Chief's decision is final and *cannot* be appealed.

105 Duplicate Benefits

A child may participate in only one household at a time. If a child is receiving subsidy benefits with another household, benefits must not be approved for the child until he/she is removed from the other household's certificate. Refer to MS 200 regarding evaluation of households who share joint custody of a child.

110 APPLICATIONS

111 Applications Causing Conflicts of Interest

Case managers must not process applications that cause a conflict of interest. Conflicts of interest may include employee/employer relationship, dating relationship and/or situations in which the client is the case manager's friend, roommate or relative. The manager/supervisor will determine the best method of application processing.

112 Application Types

Requests for an application for child care subsidy may be made verbally, in writing, in person, or through a representative. Upon request, every person will be mailed or given an Application for Child Care Assistance. Every person must be provided the opportunity to apply for subsidy benefits. Clients will be provided assistance in completing the application if such help is requested.

<u>DISTINCTION BETWEEN AN INQUIRY AND AN APPLICATION</u>

An *inquiry* is when an individual inquires about the program and does not submit a signed application to be evaluated for eligibility. An application not signed by the client or authorized representative is an inquiry only and must be returned for signature. The inquiry must not be entered in the computer system.
An *application* for subsidy benefits is made when an individual completes, signs, and submits an Application for Child Care Assistance to a Child Care office.

112.1 Signature Validation

An application (electronic, faxed, or paper) with the original signature of the applicant or authorized representative is required. The following signatures are considered an original signature for applications and all required forms:

- Original signature on a paper application or form submitted directly to the Child Care office either in person, through the mail or in a local office drop box; or
- A signature on a faxed or scanned application or form.

The individual signing the application must be able to be held legally responsible for the statements made on the application. A minor *cannot* sign the application since they *cannot* be held legally responsible.

> **Exception:** A minor who has been emancipated (refer to MS 200); or a minor receiving NEON services.

By signing the application, the client is confirming they have provided accurate and truthful information. If it is discovered the client has provided misleading or inaccurate information, the case manager must evaluate the case for an Intentional Program Violation (IPV). Refer to MS 700 for further information on IPVs.

All signed applications and associated verification must be kept in the eligibility case file and documented in the computer system.

113 New Applications

A new application is defined as an application filed by the household when subsidy benefits are not currently being received. The application date is the day the office receives the Child Care Application for Assistance, which contains the client's name, address, and appropriate signature. If a two-parent household is applying and only one of the adults has signed the application, a Request for Information form must be given/sent to the household requesting the other parent sign copies of the Application, Parent Service Agreement, and Program Penalties forms. The original forms must stay in the case file. If all other eligibility requirements are met, subsidy may begin effective the application date once the requested information is submitted.

Individuals who are applying for NEON funded subsidy, and not currently receiving child care assistance, are required to complete an application. Once an application for NEON funded subsidy is on file, a new application is not necessary as long as there has not been a break in TANF eligibility. NEON child care eligibility is based on a DWSS NEON Referral; see MS 116.1 for more information.

> **Note:** The following new applications must be processed as a reapplication or a reinstatement depending on the circumstances:
>
> - A NEON household who applies within 30 days of their NEON/TANF grant ending (due to no fault of their own).

- A minor parent who transitions from a minor group set on a major parent's case to their own case due to no longer being considered a minor (emancipation or turning 18 years of age). Refer to MS 200 for additional information on minor parents.

114 Reapplications

Reapplications for subsidy benefits are made in the same manner as initial applications. Previous records and eligibility factors must be thoroughly reviewed/verified. Refer to MS 500 for reapplication processing.

115 Reinstatements

Reinstatements are cases restored for service so there is not a lapse in coverage. A denied application may also be reinstated to a pending status or reinstated for approval within 30 days of the application received date stamp.

Exceptions:

- Benefits restored due to a decision by the DWSS Hearing Officer; refer to MS 700 for additional information.
- Benefits continued from a request for a hearing; refer to MS 700 for additional information.

Reinstatement of a denied application or terminated case will be evaluated on a case by case basis. Staff has the flexibility to reinstate an application in lieu of having the client reapply if there are extenuating circumstances or good cause for reinstatement. Case managers should determine if reinstatement is appropriate and provide all applicable verification to supervisory staff for review and decision. The supervisor's decision as well as any information/verification used to make the decision will be documented and maintained in the case file as well as a case note in the computer system.

116 Referrals

Subsidy benefits may be requested based on a written referral from another agency; however, a completed Application for Child Care Assistance is required prior to the issuance of benefits. The referral must be kept in the eligibility case file and documented in the computer system.

Possible agencies that may refer clients are (not all inclusive):

- Division of Welfare and Supportive Services (DWSS)
- Washoe County Social Services (WCSS)
- Clark County Social Services (CCSS)
- Employment Security Division (ESD)
- Division of Child and Family Services (DCFS)
- Child Protective Services (CPS)
- Tribal Social Services (e.g. court or victim services)
- Non-profit social service agencies (e.g., homeless shelters)

116.1 DWSS NEON Referrals

NEON Child Care referrals from DWSS staff must be submitted on NEON Child Care Referral, Form 2728-WA.

Within 1 business day of receiving a complete NEON Child Care Referral, the case manager must initiate contact with the client to make arrangements for issuing a Certificate.

The referral is considered complete when it includes the following:

- The date of issuance; and
- Clients name, Unique Person Identifier (UPI), and/or DWSS case number; and
- The reason child care services are being requested (NEON pre-eligibility work activities, NEON work activities or Temporary Program activities); and
- Household details (one or two parent household); and
- The start and end dates when services are needed; and
- The schedule for the assigned NEON activity; and
- If applicable, the type of income DWSS has on file for the client and/or other household members; and
- The DWSS case manager's name, phone number, and email address.

If a referral lacks the information necessary to complete a certificate, child care staff must contact the DWSS case manager for completion.

A NEON referral may be rejected as listed below. Notification of the rejection will be sent to the household and the appropriate DWSS case manager. A copy of the rejection notification will be maintained in the case file and the reason the referral was rejected documented in the computer system.

For a household not receiving child care assistance:

- A request to submit an Application for Child Care Assistance, form is sent and the form is not received within 10 days of the request.
  Note: This is only required if there is not already a completed child care application on file
- A request to child care case manager is issued or an appointment has been scheduled and the household fails to contact the case manager/office within time frame of the request.

For households receiving child care assistance:

- A review of NOMADS determines the household is not eligible for NEON/TANF

A NEON referral will be denied if the household submits an Application for Child Care Assistance but fails to provide required verification. Identification for the client (if identification has not previously been verified) and the provider selected are the only required verifications for a NEON/TANF household. A copy of the Notice of Action

(NOA), Form 2158 – WC will be sent to the household and the appropriate DWSS case manager.

Within 30 days of the NEON referral issuance, if all other criteria is met a rejected or denied referral may be approved/reinstated.

If a NEON referral is received for only one parent/caretaker of a two parent/caretaker household (e.g., 2nd parent is disabled or an ineligible non-citizen), the case manager will contact DWSS staff to ensure child care services are needed for the two parent household. If the second parent/caretaker has a purpose or care, contact the household to obtain the second parent/caretaker's schedule. Do not delay or deny child care services while trying to obtain the clarification/verification. If/when clarification/verification is received, update the cases appropriately and case note.

> **Note:** A stepparent is a required household member for child care and therefore must have a purpose of care or be physically or mentally unable to care for the child(ren) in order for the household to be eligible for child care services.
>
> If a physical or mental disability does prevent the stepparent from caring for the child(ren), this must be verified by the DWSS case manager and documented in the Household Details section of the NEON Child Care Referral 2728-WA.

A NEON referral received for a minor parent which does not include a referral for the major parent(s) must be served without obtaining additional information on the major parent(s). This includes requiring the major parent to sign required forms (e.g., child care application, rights and responsibilities or service agreement). The minor parent can complete all required forms.

NEON child care services are provided from the referral issuance date forward. The issuance date of a NEON referral is the day that it was generated by the DWSS case manager and services can begin that day. If a referral is received by Child Care staff after the issuance date, NEON subsidy benefits can be authorized back to the referral issuance date if care was used for that time period. If the child care start date is *prior* to the referral issuance date, DWSS staff must explain the reason for this on the NEON Child Care Referral form. Child Care staff must request approval from their supervisor to authorize benefits for any time period *before* the issuance date.

If the referral issuance date is greater than 14 calendar days from the date of the interview/contact with the case manager, the case manager must contact the DWSS case manager to ensure the referral information is valid prior to approving the benefits.

Once a completed NEON referral is received, the case manager must not re-verify the non-financial and income elements of eligibility. If the client provides additional information which does not match the NEON referral, the case manager must refer the client to their DWSS case manager to report the changes and contact the DWSS case manager regarding the conflicting information. However the referral must still be acted on and the certificate issued within the appropriate time frames.

Child Care staff will not be held responsible if benefits are provided based upon a valid referral from DWSS staff and it is discovered that the household does not meet the program eligibility criteria. Refer to MS 400 for additional criteria for NEON cases.

120 INTERVIEW PROCESS

121 Interview Sites

Eligibility can be determined by either a face-to-face interview with the client/representative, through the mail, or by telephone. If an interview is done through the mail or over the phone, necessary documents must be sent to the client for their signature.

121.1 Interpreter Services

DWSS can assist in providing interpretive services for both foreign and sign languages. If it is identified or if the staff have any reason to believe that a person or companion is deaf or hard of hearing, they must be advised that appropriate auxiliary aids and services, such as sign language and oral interpreters, TTYs, note takers, written materials, assistive listening devices and systems, and telephones compatible with hearing aids, will be provided free of charge. The case manager must ensure that such aids and services are provided when appropriate.

DWSS interpretative services policy is located in section 1460 of the DWSS Eligibility and Payments Manual; https://dwss.nv.gov/pdf/EP_Man_B-1400.pdf.

122 Authorized Representatives

The use of an authorized representative (AR) is allowable when:

- The head of household's participation is limited because of their incapacity, incompetence or when they request someone act on their behalf; or
- The child attends a before and/or after school program and a parent/caretaker may be unavailable to sign the child in/out.

There are two (2) types of ARs called primary and secondary representatives.

- A primary AR receives all requests for information along with any attachments plus all notices. They hold the same responsibility as the client in securing information for determining eligibility, reporting responsibilities and they are the only one authorized to sign on behalf of the client. Primary representatives have the same access to case information as the client. There can only be one active primary AR on the case at any given time.
- A secondary AR is for before/after school providers and they have limited responsibilities which are designated by the client. The secondary AR is not responsible for securing or reporting information, however, if they choose, they may secure and report information to the Child Care office. The secondary AR does not have the same access to case information as the client. A before/after

school provider can be designated as a secondary AR to sign and date an attendance record.

To designate an AR, the client and AR must complete the Designation of Authorized Representative, Form 2163-WC. The form must include the name, address and phone number of the person chosen as the AR and both the client and the AR must sign and date the form before the request can be processed. With each subsequent application, the designation of the AR is required. The original signed document must be kept in the eligibility case file and a copy provided to the client and AR. If the household member is physically or mentally incapable of signing their name, someone other than the AR must witness their mark.

To qualify as an AR, the individual must be:

- 18 years of age or older, and
- Designated by the client; and
- Not providing child care services to the household with the exception of a before/after school provider. Refer to secondary AR section above.

  Note: If the individual is a DWSS or Child Care employee, they must be related by blood or marriage to the client/participant to be the AR. In addition, if the AR is a Child Care employee, the AR must declare the relationship to management staff immediately and the individual must not be allowed access to the client/participant's files (e.g., case file locked up, etc.).

122.1 Abuse by an Authorized Representative

Authorized representatives may be disqualified from representing a household in the program if evidence is obtained that the AR has misrepresented a household's circumstances and/or has knowingly provided false information pertaining to the household. In addition, the client and/or AR may be liable for any overpayment resulting from inaccurate information provided by the AR.

123 Required Forms at Application

The following forms are required to be completed at each application unless the household has received a NEON funded subsidy. The original forms, signed and dated by the client, must be received prior to the authorization of subsidy benefits. Electronically transmitted (fax or email) signed forms are acceptable. Refer to MS 500 for additional information regarding NEON funded subsidy reapplications.

123.1 Rights and Responsibilities/Service Agreement

The Service Agreement outlines the rights and responsibilities of the client/AR, the provider, and child care staff in reference to the Child Care Program.
Clients and/or ARs must sign and date the Service Agreement prior to subsidy benefits being approved. A new form must be reviewed and signed/dated at each application. The original signed document must be kept in the eligibility case file and a copy provided to the client/representative.

123.2 Program Penalties

Program Penalties, Form 2165-WC, gives detailed information about changes the household must report during the certification period and the repercussions for failing to report such changes. It also gives information regarding the penalties for making false or misleading statements or concealing/withholding facts to establish or maintain program eligibility.

Clients and/or authorized representatives must read, initial, sign and date the Program Penalties Form prior to subsidy benefits being approved. A new form must be reviewed and signed/dated at each application. The original signed document must be kept in the eligibility case file and a copy provided to the client/representative.

123.3 Appeal Process

Clients and/or their authorized representatives have the right to a hearing if they are not satisfied with an action taken by the Child Care Program that affects their subsidy benefits; this includes the assessment of an overpayment. Appeal Process, Form 2161-WC, gives information about the procedures for requesting an appeal.

This form must be provided to the client and/or authorized representative at each application. Refer to MS 550 for further information on the appeal process.

123.4 Voter Registration Application

Ensure the client has been informed that by completing the voter registration section of the application or declining to register:

- Will not affect eligibility or benefit amounts
- The decision is confidential and used only for voter registration purposes;
- A complaint can be filed with the Secretary of State, Capitol Complex, Carson City, Nevada 89710, if they believe someone interfered with their right to:
    - Register or decline to register to vote; or
    - Privacy in deciding whether to register or apply to register to vote

If the household answers “Yes”, provide a Voter Registration Application and explain:

- Assistance, on request, will be provided in completing the voter registration application form;
- The registration application may be completed in private and mailed at their convenience;
- Information regarding the office where the form originated will remain confidential and will not be used for voter registration purposes.

If the household member answers “No”, request they sign and date the form indicating their declination. If there is no response on the form, it is not treated as a declination. A voter registration application must be provided to the applicant.

If the individual completing the interview is an AR, request the AR give the head of household the Voter Registration Application form. Document the form was provided to the AR.

Do not pend the case or delay benefits for completion of the voter registration section. This section is not an eligibility requirement.

Note: See MS 800 for voter registration requirements for Delegate Agencies.

130 ELIGIBILITY FACTORS

At each application, the following eligibility factors must be evaluated and, as applicable, verified prior to the approval of subsidy benefits. For detailed information regarding these elements, refer to MS 200 and 300.

- Identification
- Age
- SSN
- Citizenship
- Relationship
- Custody
- Special Needs
- Purpose of Care
- Household Composition
- Homeless Status
- Residency
- Income & Assets

Note: Households must report all changes that have occurred from the date of application through the date of approval.

131 Verification

Verification is the actual proof of certain eligibility or case management factors, such as the age of the child or income and is required to approve initial or continue ongoing benefits. When verification is not available to the case manager through an electronic source or collateral contact, households are responsible for furnishing verification. Case managers must provide the household with a Request for Information Form giving them at least 10 calendar days to provide the needed verification. Refer to MS 133 for more information regarding pending information.

Verification of all eligibility requirements must be done prior to authorization and issuance of benefits.

Exception: Households who meet the definition of “homeless” will be allowed up to 90 days to provide verifications that are not readily available or easily obtainable.

For the verification to be acceptable, it must be “current” which is defined as being issued within the previous 30 calendar days from application date stamp. The 30-day period begins the day prior to the application date extending back 30 calendar days.

Exception: For income verification it may be necessary to evaluate income received more than 30 days prior to the application date. See MS 390 for more information on income budgeting procedures.

131.1 Types of Verification

- Primary Source – Hard Copy
  This type of verification occurs when the case manager actually makes copies or receives copies of the document(s) the client provides. This includes, but is not limited to, pay check stubs, rent receipt, utility bills, birth certificates, Social Security cards, driver's license, NOMADS printouts, etc. The primary source of verification is able to stand solely on its own. This also includes forms (i.e., 2186-WC, Employment Verification, etc.) which verify any eligibility factor.
- Secondary Source – Collateral Contacts
  These contacts are made by telephone to landlords, employers, utility companies, Social Security Administration, etc., to verify information necessary to make an eligibility determination. The case manager should try to make these types of telephone calls when the client is present, if possible, although it is not necessary.

  Note: The results of all collateral contacts and other verifications must be documented and must always contain the name and telephone number of the person the case manager spoke to and the date the contact was made. Any other identifying information such as company, agency, person's title, etc. should also be included.
- Visually Viewed
  Any document that cannot be copied (i.e., naturalization document) must be documented in the computer system. In addition, if a NOMADS screen is viewed to verify any eligibility factor, it must be documented in the computer system which screen was used to verify that eligibility factor.

  Note: Verification of income, if in NOMADS, *cannot* just be viewed. It must be copied and included in the case file.

Documentation requirements must include the following pertinent information, as applicable:

- Name(s)
- Document type(s)
- Date(s)
- Document/Certificate and/or registration number (if applicable)
- Dollar amount(s) (if applicable)
- Date the verification was viewed
- The worker's signature and title

- Other Verification – Client Statement/Self-Declaration
  This type of verification can only be used when all avenues of hardcopy or collateral contacts have been exhausted or there is undue hardship to the client if they are required to pursue obtaining certain verifications. Acceptance of this type of verification must be fully justified and the case manager must document in the computer system the reason why they have accepted a client's statement.

  A client statement or the signed application may be used for proof of income when the client does odd jobs from various sources and cannot obtain verification or if the third party who is required to complete a form or statement on

behalf of the client refuses to do so (this is known as third party non-coop). If the application is used, it must be signed within the previous thirty (30) days and give enough information to accurately project the household's ongoing countable income.

The client's statement must not be used to verify identity, citizenship, disability, age if under 19, SSN (when there is a discrepancy) or any information which is questionable.

131.2 Verification Responsibilities

131.2.1 Household

Clients are responsible for furnishing verification or collateral evidence needed for proof of their circumstances. If verification is not available or not sufficient, the household must designate an alternate source for the information. The case manager must assist in obtaining verification when a household is cooperating but is unable to provide required information.

131.2.2 Case Manager

Case managers are responsible for verifying information required for child care subsidy. When verifying information, follow these guidelines:

- Verify elements of eligibility and other household circumstances that impact eligibility and benefit amount/level which are unverified and required;
- Do not re-verify eligibility factors that were previously verified and are not subject to change if previous verification is available in the local office. (Example: relationship, birth proof/citizenship, and deprivation due to death, or any other verification which is maintained in the permanent section);
- Do not ask a client to provide additional proof if verification is available through inquiry systems or interfaces (e.g., NOMADS, CSEP, ESD, DMV&PS Internet), or the client indicates the information is readily available in the local office files (active, denied or closed cases including other program areas), and the information is sufficient to establish current eligibility;
- Determine what types of verifications are readily available to the household and request them first if you anticipate them to be sufficient proof. If preferred sources of verification are not readily available, alternate sources of verification must be accepted if they are reliable and provide sufficient proof;
- Evaluate the verification the household provides and determine if it is reliable and sufficient to decide eligibility and benefit amount/level. If a source of verification is unreliable, suggest a reasonable alternative or request the client to designate another collateral source;
- Do not deny, terminate or delay benefits if the household has tried all avenues to provide the requested verification or if a third party collateral source refuses to provide verification and there is no reasonable alternate verification available. The clients statement can be accepted in this type of circumstances, however all efforts made by the client or the third party non- cooperation must be documented in the computer system.

131.3 Evaluating Verification

As the case manager obtains verification, they must evaluate it to ensure it:

- Meets the verification requirements for the program element; and
- Does not conflict with other verification, or that the conflicts are resolved and documented; and
- Proves (either by itself or in combination with other verification) the facts being verified; and
- Establishes the program element for the appropriate benefits and corresponding budget month.

131.4 Questionable Information

When information is received that is questionable or conflicts with information already in the file or information from another source contradicts statements made by the household, the case manager must attempt to resolve the issue prior to approving eligibility. The household must be provided an opportunity to resolve any discrepancy by providing proof or designating a suitable collateral source. The case manager must include case notes in the computer system regarding the clarification received.

132 Incoming Information

All information signed and/or received from the client or third-party must be date-stamped with the date the Child Care office received the documentation.

133 Pending Information

Benefits must not be approved if information required for the eligibility determination has not been received. Therefore, if all required proof cannot be furnished during the interview, the case manager must give the client a Request for Information (RFI) explaining what is needed, the date the information is due and the date the application will be denied/terminated if the information is not received. A copy of this form must be kept in the client's eligibility case file even after the return of the requested information.

The household must be allowed at least 10 calendar days to provide requested information. The day after the request date is the first day of the 10-day period. When the due date falls on a weekend or holiday, the due date is the next working day. When a household or individual is attempting, but is unable to provide the information by the date specified in writing, the due date can be extended to allow time for the additional information as long as the contact is made prior to the expiration date of the RFI. The case manager must document the new due date and the reason for the extension in the case notes.

Exceptions:

- Victims of Domestic Violence approved for a fictitious address through the Secretary of State's CAP program must be allowed 20 calendar days to

provide verifications due to mail forwarding. Refer to MS 200 for additional information on CAP.

- Homeless households who are attempting but unable to provide verification to establish eligibility will be allowed one 90 day period to comply with verification requirements.

If all required information is provided, the client is notified in writing of the eligibility results. Refer to MS 140 for additional information on the disposition of application.)
If all required information is not provided or postmarked within the requested time period, the case manager must deny the application immediately (additional notice is not required). Refer to MS 500 for information on pending verifications on reported changes after the case is approved.

Note: Third party non-cooperation *cannot* cause the household to be ineligible.

140 DISPOSITION OF APPLICATION

An eligibility decision must be made as quickly as possible but no later than 30 calendar days after a completed and signed application is received in the Child Care office. The day after the date the application is received in the office is the first day of the 30-day period.

Exception: The case manager determines there are extenuating circumstances which necessitate the eligibility decision exceeding the 30 calendar day period. The reason must be documented in the computer system.

Example: Client reschedules an interview and at the interview additional verification is required which when allowing the 10 days would take the decision date past the 30 day calendar period.

141 Notice of Action to the Client

At the end of the interview/evaluation, the case status is pending, denied, or approved. Any time benefits are approved, denied, increased, or reduced, a Notice of Action/Notice of Appeal, Form 2158-WC, must be provided to the household. The Notice of Action explains their eligibility status and the reason for the decision and the Notice of Appeal allows the household the opportunity to appeal any negative decision made by the Child Care office. Refer to MS 550 for details regarding the appeal.

142 Denied Application

Benefits are denied immediately when:

- Ineligibility is established; or
- The client/representative fails to provide information essential to determine eligibility within the requested time period; or
- The client/representative voluntarily withdraws their request for assistance.

If the household is denied, the client must receive a Notice of Action/Notice of Appeal explaining the reason for denial.

143 Approved Application

Benefits are approved when all eligibility requirements are met. At the time the client is determined to be eligible for subsidy benefits, they must be issued a separate Certificate for each eligible child and a Notice of Action/Notice of Appeal. Refer to MS 162 for information on approved applications.

The Certificate must include the following:

- The date subsidy benefits begin and end; and
- The subsidy percentage the Child Care Program will pay; and
- The daily reimbursement rate the Child Care Program will pay; and
- The name of the eligible child; and
- The name and physical address of the provider who will care for the child; and
- The authorized schedule of attendance for the child; and
- The amount of time the child is authorized to attend on a daily basis (i.e., FT, PT).

143.1 Certificate Distribution

The original signed Certificate(s) must be kept in the eligibility case file. Copies must be provided to:

- The client/representative, and
- The provider.

144 Selection of a Child Care Provider

It is the parent's/caretaker's responsibility to select a child care provider. Child care staff may assist in providing the parent/caretaker with information about local child care providers; however, they must not recommend or endorse any program or service. Families are encouraged to visit and interview several programs prior to making a final decision. Refer to MS 600 for additional provider information.

144.1 NEON Clients Unable to Find Suitable Child Care

45 Code of Federal Regulations (CFR) Part 98.33 (b) requires the Child Care Program to inform parents who receive NEON/TANF that if a single custodial parent of a child less than 6 years of age cannot find suitable child care, based on the definitions provided in the DWSS TANF State Plan, DWSS staff may make an exception to the work requirements. The parent must provide proof to substantiate the claim of unsuitable child care. The Child Care case manager must complete Work Requirement Exception, Form 2153-WC, and send it along with the verification provided by the parent to the appropriate NEON staff for a decision.

DEFINITIONS from the DWSS TANF State Plan

- Appropriate Child Care - Child care chosen by the parent offering developmentally appropriate practices which meet the needs of the parent and child.
- Reasonable Distance - A parent should not have to travel more than sixty (60) minutes to drop off their child at the care provider location and sixty (60) minutes to pick up their child.
- Unsuitability of Informal Care - Informal child care is unsuitable if it is not being provided legally, or does not meet basic health and safety standards as outlined in the Child Care State Plan.

  Note: Legal child care is defined as licensed care, if required by state/county/city law. If licensing is not required by law, the provider must be registered with the Child Care Program.

  Informal child care is unsuitable if circumstances exist that may cause possible abuse, neglect or harm to children as outlined in city, county and/or state statutes.

  Informal child care is unsuitable if the arrangements do not support the working schedule of a parent, are not affordable, are not easily accessible, or do not meet quality standards as defined by the parent.
- Affordable Child Care Arrangements - Affordable child care is child care that does not exceed 10 to 15% of the parent's gross income.

150 COOPERATION

151 Cooperation with Child Care Program Requirements

The household is required to cooperate with the CCDP in securing all information needed to determine initial or continuing eligibility. Failure to do so results in ineligibility for the entire child care household. The case manager may assist in obtaining verification when a household is cooperating but is unable to provide the required verification.

If a third party refuses to supply information without an individual's permission, the signature page of the most recent application may be used as an authorization to release information. To protect the household's privacy, the case manager must not copy the top portion of the application where the client reports income, education or provider information.

152 Cooperation with DWSS and/or CCDP

A case may be selected to review the accuracy of subsidy benefits paid or authorized. Clients are required to cooperate with the review process. Failure to cooperate may result in ineligibility until compliance. If the client fails to cooperate with DWSS, DWSS will notify the appropriate Child Care office in writing of non-cooperation and child care staff will terminate assistance immediately, allowing for advance notice of the adverse action. Refer to MS 502 regarding advance notice of adverse action. If the household contacts the Child Care office during the ineligible period wishing to cooperate, the child

care staff must advise the client to contact the applicable DWSS Unit responsible for reviewing the case (e.g., I&R or Quality Control).

Program eligibility will not be restored until DWSS reports client compliance to the Child Care office.

Note: Refer to MS 600 for provider cooperation requirements with DWSS.

160 APPROVING CHILD CARE SUBSIDY BENEFITS

161 Required Information at Approval

At each approval (new or reapplication), the case manager must ensure the following:

- The original application form is complete and signed by the client (by both parents in a 2-parent household); and
- The client has read and signed the Service Agreement explaining their rights and responsibilities (by both parents in a 2-parent household); and
- The client has read and signed the Program Penalties form, which explains their reporting responsibilities and the penalties for Intentional Program Violations (by both parents in a 2-parent household); and
- All required verification according to policy is in the eligibility case file and date stamped with the date it was received by the Child Care office; and
- The authorized representative has been re-established, if applicable; and
- The client has been issued a copy of the Certificate; and
- The client has been issued the Notice of Action/Notice of Appeal, Form 2158-WC.

162 Authorization of Subsidy Benefits

Before the Certificate is issued, child care staff must ensure funds are available to reimburse the child care provider for services rendered in accordance with the Certificate. Refer to MS 103 for additional information on wait list.

All Certificates must be issued from the computer system; however, in the event it cannot be accomplished at the time of the decision, a handwritten Certificate may be issued for the current month only. Within 5 calendar days after issuing a handwritten Certificate, the information must be entered in the computer system and an automated Certificate must be generated for the certification period and issued to the client and provider.

Exception: If there is a system issue which takes longer than 5 calendar days to resolve, this must be documented in a case note. Once the system issue is resolved, child care staff has 5 calendar days from date of system resolution notification to update the case and issue an automated Certificate.

163 Subsidy Amount

Parents/caretakers are required to participate in the cost of their child care services. The co-payment amount is determined by the household size and countable income as detailed in MS 170. The household must pay a minimum 5% co-payment, unless the:

- Household has applied for or is receiving TANF and a NEON Child Care Referral has been received from DWSS; or
- Household has a child placed with their home by a child protective agency. This is evaluated on a case-by-case basis and applies to both foster and CPS placement; or
- Household is considered homeless. Refer to MS 200 for the definition of homeless; or
- Child is receiving Wraparound Services.

Note: If the household meets one of the above exceptions and they have been found guilty of committing an Intentional Program Violation (IPV), they are subject to the applicable IPV penalty and are required to make the applicable co-payment.

164 Effective Dates of Subsidy Benefits

The effective date of child care benefits is the day the application was received and date stamped in the Child Care office unless:

- The child(ren) is eligible for Contracted Slot or Wraparound Services. Refer to MS 800 for detailed information about Contracted Slots and Wraparound Services.
- The household has a NEON referral. The effective date of the certificate must be the date requested on the NEON referral as long as it is not prior to the NEON referral issuance date. Refer to MS 106.1 for additional information on effective dates for NEON referrals.
- The effective date of the certificate can be back-dated to the date of the placement of the child(ren) in the Foster or CPS household as long as the application is received within 14 calendar days of the placement.

Note: If the application is greater than 14 calendar days of the placement in the Foster/CPS household, a special consideration request must be sent to the CCDP chief for approval.

If the certification period does not begin with the application date, the reason for the discrepancy must be documented in the computer system case notes.

Note: When an appeal or hearing determines benefits were improperly denied or discontinued, corrective measures must be made to ensure the case is reinstated back to the original date of eligibility and the appropriate payments are made to the provider(s) or client.

165 Length of Certification

The certification period for all households must be 365 days unless they meet one of the exceptions listed below:

- The client is receiving subsidy based upon a NEON referral. These clients must be approved for benefits based on the dates listed on the NEON referral. Refer to MS 116.1 and 410 for additional information on NEON cases.

  Note: If the certificate period is less than the recommended period on the NEON referral, the case manager must notify the DWSS case manager of the approved end date. This can be done by providing a copy of the certificate to the DWSS case manager or notifying them by email.
- The only eligible child will be turning 13 (or 19 if verified to have a special need). The day they turn 13 (or 19 if verified to have a special need), they are ineligible for benefits and the certificate must end. Refer to MS 200 for age requirements.
- The household requests a shorter certificate period or they indicate they will no longer qualify for benefits (e.g., only eligible child is in the home for less than 12 months or household is moving to another state). The case manager must document in the case notes the reason for a certification period less than 12 months.
- Wraparound cases can be approved for up to 3 years. Refer to MS 800 for additional information on Wraparound cases.

170 INCOME LIMITS AND SUBSIDY PERCENTAGES

Each year the Federal Department of Health and Human Services publishes the federal poverty level and the State's median income. These figures are used to update Nevada's Sliding Fee Scale annually with an effective date of October 1st.

To determine the level of benefits a household is eligible for, the case manager must first determine the household size and the countable income. Under each household size heading (in gray) on the Sliding Fee Scale Chart, the applicable income range is listed. On the far right of the table is the percentage of child care benefits CCDP will pay on the client's behalf.

All households are required to participate in the cost of their child care and may qualify for a maximum of 95% subsidy with the exception of NEON, Foster/CPS, Wraparound, and homeless households who may have their co-payment waived and subsidy paid at 100%.

The bold figure indicates 130% of poverty and the following codes are used in the chart:

Poverty Level = (P) 85% of Nevada's median income = *

Sliding Fee Scale

STATE OF NEVADA
CHILD CARE & DEVELOPMENT PROGRAM

HOUSEHOLD SIZE & MONTHLY INCOME CHART
Effective October 1, 2015

ONE			TWO			THREE			Subsidy %
$ -	-	$ 981 (P)	$ -	-	$ 1,328 (P)	$ -	-	$ 1,675 (P)	95%
$ 982	-	$ 1,165	$ 1,329	-	$ 1,563	$ 1,676	-	$ 1,961	90%
$ 1,166	**1,276**	$ 1,350	$ 1,564	**1,726**	$ 1,798	$ 1,962	**2,177**	$ 2,247	80%
$ 1,351	-	$ 1,534	$ 1,799	-	$ 2,033	$ 2,248	-	$ 2,533	70%
$ 1,535	-	$ 1,718	$ 2,034	-	$ 2,269	$ 2,534	-	$ 2,819	60%
$ 1,719	-	$ 1,903	$ 2,270	-	$ 2,504	$ 2,820	-	$ 3,105	50%
$ 1,904	-	$ 2,087	$ 2,505	-	$ 2,739	$ 3,106	-	$ 3,391	40%
$ 2,088	-	$ 2,272	$ 2,740	-	$ 2,974	$ 3,392	-	$ 3,677	30%
$ 2,273	-	$ 2,448 *	$ 2,975	-	$ 3,201 *	$ 3,678	-	$ 3,954 *	20%
$ 2,449	+		$ 3,202	+		$ 3,955	+		0%
FOUR			**FIVE**			**SIX**			**Subsidy %**
$ -	-	$ 2,021 (P)	$ -	-	$ 2,368 (P)	$ -	-	$ 2,715 (P)	95%
$ 2,022	-	$ 2,358	$ 2,369	-	$ 2,756	$ 2,716	-	$ 3,153	90%
$ 2,359	**2,628**	$ 2,695	$ 2,757	**3,078**	$ 3,143	$ 3,154	**3,529**	$ 3,592	80%
$ 2,696	-	$ 3,031	$ 3,144	-	$ 3,531	$ 3,593	-	$ 4,030	70%
$ 3,032	-	$ 3,368	$ 3,532	-	$ 3,918	$ 4,031	-	$ 4,469	60%
$ 3,369	-	$ 3,705	$ 3,919	-	$ 4,306	$ 4,470	-	$ 4,907	50%
$ 3,706	-	$ 4,042	$ 4,307	-	$ 4,694	$ 4,908	-	$ 5,345	40%
$ 4,043	-	$ 4,379	$ 4,695	-	$ 5,081	$ 5,346	-	$ 5,784	30%
$ 4,380	-	$ 4,708 *	$ 5,082	-	$ 5,461 *	$ 5,785	-	$ 6,214 *	20%
$ 4,709	+		$ 5,462	+		$ 6,215	+		0%
SEVEN			**EIGHT**			**NINE**			**Subsidy %**
$ -	-	$ 3,061 (P)	$ -	-	$ 3,408 (P)	$ -	-	$ 3,755 (P)	95%
$ 3,062	-	$ 3,474	$ 3,409	-	$ 3,795	$ 3,756	-	$ 4,116	90%
$ 3,475	-	$ 3,887	$ 3,796	-	$ 4,182	$ 4,117	-	$ 4,478	80%
$ 3,888	**3,980**	$ 4,299	$ 4,183	**4,430**	$ 4,569	$ 4,479	-	$ 4,839	70%
$ 4,300	-	$ 4,712	$ 4,570	-	$ 4,956	$ 4,840	**4,881**	$ 5,200	60%
$ 4,713	-	$ 5,125	$ 4,957	-	$ 5,343	$ 5,201	-	$ 5,562	50%
$ 5,126	-	$ 5,538	$ 5,344	-	$ 5,730	$ 5,563	-	$ 5,923	40%
$ 5,539	-	$ 5,951	$ 5,731	-	$ 6,117	$ 5,924	-	$ 6,284	30%
$ 5,952	-	$ 6,355 *	$ 6,118	-	$ 6,497 *	$ 6,285	-	$ 6,638 *	20%
$ 6,356	+		$ 6,498	+		$ 6,639	+		0%
TEN			**ELEVEN**			**TWELVE**			**Subsidy %**
$ -	-	$ 4,102 (P)	$ -	-	$ 4,449 (P)	$ -	-	$ 4,796 (P)	95%
$ 4,103	-	$ 4,438	$ 4,450	-	$ 4,759	$ 4,797	-	$ 5,080	90%
$ 4,439	-	$ 4,773	$ 4,760	-	$ 5,069	$ 5,081	-	$ 5,364	80%
$ 4,774	-	$ 5,109	$ 5,070	-	$ 5,379	$ 5,365	-	$ 5,649	70%
$ 5,110	**5,332**	$ 5,445	$ 5,380	-	$ 5,689	$ 5,650	-	$ 5,933	60%
$ 5,446		$ 5,780	$ 5,690	**5,783**	$ 5,999	$ 5,934	-	$ 6,217	50%
$ 5,781	-	$ 6,116	$ 6,000	-	$ 6,308	$ 6,218	**6,234**	$ 6,501	40%
$ 6,117	-	$ 6,451	$ 6,309	-	$ 6,618	$ 6,502	-	$ 6,785	30%
$ 6,452	-	$ 6,779 *	$ 6,619	-	$ 6,920 *	$ 6,786	-	$ 7,061 *	20%
$ 6,780	+		$ 6,921	+		$ 7,062	+		0%

All households are required to participate in the cost of their child care and may qualify for a maximum of 95% subsidy with the exception of NEON, Foster/CPS, Wraparound, and homeless households who may have their co-payment waived and subsidy paid at 100%.

(P) Indicates 100% of federal poverty level.
* Indicates that the figure to the left is 85% of Nevada's median income.
Bold figures in center indicate 130% of Federal poverty level and is the cut-off between At-Risk and Discretionary Funding

180 CO-PAYMENTS

181 Co-Payment Requirements

Clients not receiving a 100% subsidy are required to participate in the cost of their child care by making co-payments to the provider. The household's co-payment amount is determined based upon their household size and countable income (manual section 170, Income Limits and Subsidy Percentages).

Co-payments may be evaluated and waived by the CCDP Chief, on a case-by-case basis, if unusual circumstances exist. The request must be submitted in writing and must detail the circumstances that suggest the co-payment should be waived.

182 Verification of Co-Payment

The Child Care office must verify clients are current with their required co-payments. Therefore, at least five (5) percent of the caseload must be randomly selected for review by the Child Care office on a monthly basis.

183 Failure to Pay Co-Payment

If the client fails to pay or is not current with their co-payments, the client must attempt to obtain a Repayment Agreement with their child care provider. Verification must be provided to the Child Care office within ten (10) calendar days. If the client fails to pay the co-payment in accordance with the provider's payment policy and/or fails to attempt to obtain a Repayment Agreement, benefits may be terminated allowing advance notice of adverse action as described in MS 500, unless the client is receiving a NEON funded subsidy. NEON clients must not be terminated.

190 CASE NOTES

Case notes tell a story to support the decision made by the case manager. Case notes must be clear, concise, and to the point. There must be enough information so anyone reviewing the case can determine the reason, logic and accuracy of the case manager's decisions/actions. After every contact with the client and/or an action taken on the case, case notes must be made in the computer system.

Examples of actions to be documented in the computer system are (not all inclusive):

- Approval of benefits
- Denial of benefits listing the denial reason
- Updates to the case which result in an increase or decrease of benefits
- Termination of benefits listing the reason the case is being terminated
- Changes reported by the client or any other source
- Change in an authorized representative
- Details of conferences and/or hearings results
- Client contacts (concerns or complaints from the client)
- Appointment dates and times scheduled
- Client no-show for appointments

Other information pertaining to the case may also be documented in the case notes as long as it is factual and not the opinion of the case manager. The case manager must document the actual date of the activity within the narrative if it is different than the date of entry.

Information reported by phone must be case noted in the computer system and contain the following information:

- The reported change; and
- The date the change occurred; and
- Who reported the change; and
- The date the change was reported.

Case notes for a change should include the date the change was reported by the client, the date the change affected the case, and the date the action was taken by the case manager.

191 "Prudent Person" Principle

The policies and procedures included in this manual are rules for determining eligibility. It is impossible to foresee and give examples for all situations; therefore, child care staff is encouraged to use reason and apply good judgment in making eligibility decisions. A reasonable decision made based on the best information available using reason and logic, program knowledge, experience, and expertise in a particular situation is referred to as the "prudent person" principle.

The case manager must document in the computer system the rationale used to make the decision and any applicable manual references and policy interpretations. Follow local office procedures for obtaining an interpretation from Child Care Specialists in Central Office, or submit Policy and Procedure Inquiry, Form 6018, requesting clarification or directives, to the CCDP Chief, when it is impossible or inadvisable to follow the prudent person principle because of a lack of information or program knowledge or the existing policy is unclear.

Non-Financial Factors of Eligibility

200 NON-FINANCIAL FACTORS OF ELIGIBILITY

To be eligible for child care subsidy benefits, households must meet each non-financial factor of eligibility (as applicable) detailed in this section.

> **Note:** For a foster or CPS child(ren), verification of age, SSN, and citizenship is not required; however, a copy of the placement letter/referral from the social service agency placing the child(ren) in the home is required at initial enrollment for each child.

210 AGE

A child must be under the age of thirteen (13) to receive a child care subsidy unless they are verified as a child with a special need; then, they are eligible until the age of nineteen (19). The day the child becomes age 13 (or 19 for a child with a special need) they are ineligible.

210.1 Verification

Verification of birth date is required at initial application. Once the birth date has been verified, it no longer needs to be requested with subsequent applications. Possible sources of verification are as follows (not all inclusive):

- Birth Certificate
- Hospital or public health birth record
- Church or Baptismal record
- Bureau of Vital Statistics documents
- Local, state, federal or military record
- Adoption papers or records
- Divorce and/or court custody decrees
- Bureau of Indian Affairs (BIA) or Tribal records
- School records
- Immigration and Naturalization Service records
- Child support paternity records
- Social Security Administration records
- Certificate of Naturalization

  > **Note:** Copying Certificates of Naturalization is prohibited by law. The case manager must note in the computer system the Certificate number, petition number, personal identifying information, date, and the city where the Certificate was issued.
- U.S. Passport
- PRISM>Person Search/Resolution>Search Results screen printout which has a “Y” in the SSA Verified column.

Exception: Households who meet the definition of "homeless" will be allowed up to 90 days to provide verifications that are not readily available or easily obtainable.

211 CHILD WITH SPECIAL NEEDS

A special need is defined as a physical or mental condition, which severely limits the child's ability to care for himself/herself, or an emotional condition that places the child or others at risk.

Note: A child who meets the criteria for special needs is no longer eligible for subsidy benefits effective the day of their 19th birthday. No advance notice is required.

Child care supervisory/managerial Child Care staff will determine if a child meets the definition as stated above. Special consideration must be requested to the CCDP DWSS Child Care Chief for those cases where the child's special needs status is questionable.

211.1 Verification

Current verification is only required at initial application; however, if the special need condition is not considered permanent verification is required with each application.

Verification must be in the form of a statement and/or other documentation (e.g., an Individualized Education Program (IEP) or an Individual Family Service Plan (IFSP)) which clearly states the child meets the definition of having a "special need". The statement must be signed by a physician or other licensed professional authorized to make such assessments.

Note: Verification of special needs for children under the age of 13 is not required; however, case managers should ensure that clients complete the special needs section of the application for data collection purposes.

212 IDENTIFICATION

All clients, required adult household members, and primary authorized representatives must provide identification at application.

If a social security card is provided, use the household member's name as listed on the card when entering the case in the computer system. If no social security card is provided, use the household member's name as provided on the identification verification.

212.1 Verification

Verification of identification is required at initial application. Once identification has been verified, it no longer needs to be requested for subsequent applications. Possible sources of verification are as follows (not all inclusive):

- Birth certificate
- Driver's License
- State Identification card
- Hospital or public health birth record
- Military ID (active, retired, reserve, dependent, etc.)
- U.S. Passport or citizen ID card
- Baptismal record
- Adoption papers or records
- Work or School ID card
- Voter Registration card
- Child Welfare records
- Consular identification card
- Printout of NOMADS MEMB screen which lists the individual's name, SSN, date of birth, citizenship status and birthplace.

  Exception: NOMADS cannot be used as verification of identity for the adult signing the application.

  Note: The printout must verify the individual was eligible for at least one type of assistance (i.e., TANF, SNAP, Medicaid).
- Any other document providing identifying data such as physical description, photograph or signature

Exception: Households who meet the definition of "homeless" will be allowed up to 90 days to provide verifications that are not readily available or easily obtainable.

213 SOCIAL SECURITY NUMBER

Social Security numbers (SSN) are requested for every household member at the time of application. If the application *does not* contain this information, the case manager must request the client's disclosure via the Request for Information form. If a client fails to provide the SSN(s) when requested, this will be considered a "refusal".

The case manager must not deny/terminate benefits due to client refusal but this must be documented in the computer system.

If a client expresses concern over the use of their SSN, the case manager must inform the client the information will only be used when determining their eligibility, verifying public assistance benefits and for federal reporting purposes.

213.1 Verification

If the SSN is provided, verification is required at initial application. Once the SSN has been verified, it no longer needs to be requested with subsequent applications. Possible sources of verification are as follows (not all inclusive):

- Social Security card or check
- Social Security Administration benefit letter
- Pay stub

- PRISM>Person Search/Resolution>Search Results screen printout which has a “Y" in the SSA Verified column

Note: NOMADS cannot be used as verification of social security numbers.

If the client fails to provide verification the case manager must not deny/terminate benefits however other sources of verification should be pursued by the case manager.

Exception: Households who meet the definition of “homeless” will be allowed up to 90 days to provide verifications that are not readily available or easily obtainable.

214 CITIZENSHIP

To receive subsidy benefits, the *child* must either be a citizen of the United States, or a non-citizen lawfully admitted to the United States. The parent/caretaker’s citizenship is not required for the household to be eligible for subsidy benefits.

214.1 Definition of Citizenship

For the purposes of qualifying as a U.S. Citizen, the United States is defined as the 50 states and the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands and the Northern Mariana Islands. In addition, nationals from American Samoa or Swain’s Islands are regarded as U.S. Citizens. Children of U.S. citizens born out of the U.S. are considered citizens unless questionable.

214.2 Eligible Non-Citizens

An eligible non-citizen is a person who is lawfully admitted based upon sections of the Immigration and Naturalization Act under which they are residing in the United States and provides valid verification as listed in MS 214.3.

214.3 Verification

If a child is a citizen, verification is required at initial application. One citizenship status has been verified, it no longer needs to be requested with subsequent applications.

If a child is a non-citizen, check the expiration date on the Unites States Citizenship and Immigration Service (USCIS) document that verifies that child is a non-citizen. If the child’s document has expired, evaluate th0e reason for the expiration as listed below and request new documentation.

Possible sources of verification are as follows (not all inclusive):

- Birth certificate (U.S. or its possessions)
- Hospital or public health birth record
- Baptismal record with date and place of birth
- U.S. Passport
- Military ID

- Indian census papers
- Naturalization papers

  Note: Copying Certificates of Naturalization is prohibited by law. The case manager must note in the computer system the Certificate number, petition number, personal identifying information, date and the city where the Certificate was issued.
- Printout of NOMADS MEMB screen which verifies the child is a citizen and the child is/was eligible for TANF or Medicaid.
- Consular Report of Birth or "Certification of Birth" issued by the U.S. Department of State.
- I-551 (Permanent Resident Card) – Expires ten years from date of issue. At At the end of the ten years, the Lawful Permanent Resident (LPR) does not lose his/her status, but must simply renew the card.
- I-94 (Arrival/Departure Record) – The status of non-residents holding these documents must have their status re-verified if expired. This is a temporary document issued while status is pending or the I-551 is issued.
- USCIS documents, USCIS letter, a court order or a passport and other resources.

Exception: Households who meet the definition of “homeless” will be allowed up to 90 days to provide verifications that are not readily available or easily obtainable.

215 MILITARY STATUS

For data reporting purposes, military status for all required household members must be verified. This includes full-time military status and reserves.

215.1 Verification

Client statement of military status is acceptable.

216 RELATIONSHIP/HOUSEHOLD COMPOSITION

Relationship must be established for all members of the child care household to determine the appropriate household size and countable income.

216.1 Required Household Members

The household must include the following required household members, regardless for whom assistance is being requested, when they are living in the same residence:

- The child(ren) for whom assistance is requested: and
- The natural/adoptive parent(s) of the child(ren); and
- The natural/adoptive parent’s domestic partner as defined by Nevada Revised Statute 122A; and
- The stepparent(s) of the child(ren); and

- The natural/adoptive/step dependent siblings of the child(ren) and their sibling's dependents (niece/nephews), regardless of citizenship status (as long as they are not included in another active child care household); and

  Note: A natural/adoptive/step dependent sibling is defined as a child 18 years old or younger. The sibling is no longer included as a household member as of their 19th birthday.
- Any adult who has guardianship/custody of the child(ren) for whom assistance is requested and the guardian/caretaker's spouse and dependent children. Refer to MS 217 regarding guardianship/custody of children; and
- The non-parent relative caregiver or Kinship Care household, designated by DWSS; and
- The major parent(s) and dependent siblings of the minor parent.

CPS and Foster parents/caretakers, their spouses/domestic partners and children are not included in the CPS/Foster group-set and their income is not included when determining eligibility for CPS/Foster child(ren). If the CPS/Foster parent/guardian is not requesting assistance for their own children, do not request verification for them or enter their information into NCCS. Refer to MS 216.5 regarding group set information.

Refer to manual section 216.5.3, Foster Parent and/or manual section 216.5.4, Child Protective Service (CPS), for information.

The household may not exclude a required member from the assistance unit. If verification necessary to determine eligibility is not provided for a required member, the entire household is ineligible.

216.2 Verification of Relationship

Verification of relationship of required household members is required at initial application or when a new member joins the household. Once relationship has been verified, it no longer needs to be requested with subsequent applications, unless a change in relationship has been reported/discovered (e.g., marriage, divorce, adoption).

Possible sources of verification are as follows (not all inclusive):

- Birth Certificates which verify relationship
- Legal court documents
- Adoption papers or records
- Hospital or public health birth records
- Bureau of Vital Statistics documents
- Church or baptismal record
- Local, state, federal government or military record
- School records
- Immigration and Naturalization Service records
- Child support paternity records
- Juvenile court records
- BIA or Tribal records
- Marriage license/tribal marriage certificate
- Divorce/Custody papers

- Court records of parentage
- Letter from case manager or social worker for foster, CPS and/or adoptive parents
- NOMADS printout which lists all household members and their relationship to the client

  Note: The client does not need to be a current recipient of DWSS benefits, but the printout must verify the household member **received** TANF or TANF
  Related Medicaid.
- Notarized letter from absentee parent(s)

Exception: Households who meet the definition of "homeless" will be allowed up to 90 days to provide verifications that are not readily available or easily obtainable.

If proof of relationship is not available, the case manager must make an evaluative decision and document the rationale for the decision in the computer system.

216.2.1 How to Make an Evaluative Conclusion

The case manager must examine and come to a conclusion of relationship based on any other documents not listed above.

Note: The case manager may offer assistance if the client has difficulty obtaining the information.

When complete, the case manager must obtain management approval of the evaluative conclusion and document the relationship in the computer system.

216.3 Verification of Household Composition

The client's statement of household composition is accepted unless the case manager has reason to question it, whereby verification would then be required.

Possible sources of verification of household composition are as follows (not all inclusive):

- Copy of the lease listing all household members;
- Statement from non-relative landlord/manager listing all household members;
- Statement from non-relative friend/neighbor listing all household members;
- NOMADS printout which lists all household members living in the client's residence and verifies all household members are currently receiving TANF, SNAP and/or Medicaid.

216.4 Group Identity

To ensure correct eligibility is determined per household composition requirements, four group identities (group-set) have been created – Traditional, Minor, Foster or CPS.

216.4.1 Traditional Group Set

Each application will have only one Traditional Group Set. The Traditional Group Set is usually a parent/child(ren) relationship and would include NNCT and Kinship households.

216.4.2 Minor Group Set

A minor parent is an individual under the age of 18, who is not emancipated *and* is the natural parent of a dependent child(ren). Individuals are no longer considered minors beginning the day they become age 18.

216.4.2.1 Additional Information

- A minor parent may remain on the major parent's case up to their 19th birthday. When the minor parent turns 18 years old notify the household of the minor parent's option to remain on the major parent's case or to open a case of their own. The minor parent will remain on the major parent's case until an application is received from the minor parent or the minor parent turns 19 years old, whichever occurs first.
- An emancipated minor is defined as:
  - A person under age 18 who has been married. The marriage must not have been annulled. If a minor parent's marriage ends due to divorce, the minor is still considered emancipated. A copy of the marriage certificate must be kept in the casefile; or
  - A person under age 18 who has received a Decree of Emancipation issued from a District Court or an established Tribal Court. A copy of the emancipation decree must be kept in the case file.
- A minor parent who is not emancipated cannot apply for subsidy benefits for their dependents. An adult household member must apply on the minor's behalf. If the minor parent is not living with any guardians, the case must be assessed for a CPS referral.

  Note: The individual signing the application must be able to be held legally responsible for the statements made on the application. A minor cannot be held legally responsible (unless they are emancipated), so they cannot complete the application process.

  Exception: If NEON Child Care Referral has been received for a minor parent, services must be provided based upon the referral information.
- If a minor parent has not graduated high school or obtained a GED, their primary purpose of care **must** be Student and full-/part-time care is based on the school schedule.

  Note: A minor parent can be attending school and working and receive subsidy assistance for both purposes of care. If the minor parent is out of school for a break with the anticipation of returning to school, subsidy assistance can continue for the other purpose of care during the school break.

216.4.3 Foster Group Set

A foster group set is a child who has been placed with a foster family or foster group home. The foster family or group home has been licensed by a child protective agency to care for a child who is a ward of the court.

216.4.3.1 Additional Information

- A copy of a valid foster care license is required at initial application and each reapplication.
- The foster parent(s) must provide a copy of the placement letter or referral from the court or social service agency, which defines the child as "foster" and the effective date of the transfer of custody. This documentation is required at initial application for a child or for a new foster child placed with the foster parent(s).
- The foster child is considered a household of one unless there are siblings in the household. All siblings must be included in the household size
- The child of a minor parent who is a foster child will be served under the Foster Group Set. The minor parent must meet the criteria as outlined in MS 216.5.2.

- Purpose of care and schedule must be verified for the foster parent(s) listed on the foster license at each application.
- Income received by the traditional household is not countable and not required to be verified.
- Foster parents may be eligible for services with a Job Search POC. For additional requirements refer to MS 400.

216.4.4 Child Protective Services (CPS) Group Set

A CPS group set is a child who has been placed with a relative family. The CPS family has been approved by a child protective agency to care for a child who is a ward of the court.

216.4.4.1 Additional Information

- The client and other required adult household members must become licensed foster parents during the initial 12 month certification period. Once the client provides a copy of their foster care license, the child(ren) must be moved to Foster group set. If the client fails to become a licensed foster parent during the initial 12 month certification period, the household must then be evaluated under another group set and meet all the eligibility requirements for that group set.

  Note: If the CPS agency places the child back with the natural/adoptive parent but retains custody, the child is no longer considered a CPS child and will be evaluated as a part of the natural/adoptive parent's household.
- The caretaker must provide a copy of the placement letter/referral from the court or social service agency, which defines the child as "CPS" and the effective date of the placement in the relative's home

- The CPS child is considered a household of one unless there are siblings in the household. All siblings must be included in the total household size
- Purpose of care and schedule must be verified for all required adult household members.
- Income received by the traditional household is not countable and not required to be verified.

217 CUSTODY

Children must be living with the person(s) applying for child care subsidy benefits. If the caretaker is not a parent then the caretaker must be either a legal guardian, a relative of specified degree or a person standing *in loco parentis*.

For households that have joint physical custody and both parents are applying for assistance for the common child(ren), both parents must sign an application and other required forms. To determine eligibility, both families will be evaluated as one household to determine if all eligibility requirements have been met (e.g., purpose of care, income). In addition, both parents are equally responsible to report changes. If the parents are not willing to meet these requirements or fail to cooperate, the case manager must deny or terminate benefits.

> **Note:** If a household claims joint physical custody of a child but only one parent is applying for assistance, the case manager must only consider the circumstances of the client's household when determining eligibility.

217.1 Verification

Clients are required to provide proof of custody for children in their care if they are not the natural/adoptive parents. Possible sources of verification are as follows (not all inclusive):

- Court custody documents
- Adoption papers or records
- Letter from case worker or social worker for foster and/or adoptive parents
- NOMADS printout listing all household members as current TANF or medical recipients and their relationship
- Divorce decree indicating custody arrangements
- Notarized letter from absentee parent
- Other documentation must be approved in writing by the CCDP DWSS Child Care Chief.

Exception: Households who meet the definition of "homeless" will be allowed up to 90 days to provide verifications that are not readily available or easily obtainable.

218 RESIDENCY

Applicants and eligible household members must be living in Nevada to be eligible for benefits.

218.1 Verification

Verification of current residency is required at each application and any time a change in residence occurs. Possible sources of verification are as follows (not all inclusive):

- Rent/Mortgage receipt listing the client's name and current physical address
- Current utility statements/receipts (electric, gas, telephone, cable, etc.) as long as the client's name and current physical address are listed on the document.
- Current statement from non-relative landlord not living in the home.
- Valid Nevada Driver's License or Department of Motor Vehicles ID Card with current physical address.
- Current employer's statement or records (e.g., client's physical address listed on pay stub or Employment Verification form).
- Valid foster parent license.
- Current CPS placement letter as long as the placed children are still in the home.
- NOMADS printout which lists the current physical address and verifies household members are currently receiving TANF, SNAP and/or Medicaid.

  Exception: For *timely reapplications*, if the household has not moved since the previous application, the verification of residency used with the previous application may be used as verification for the current application, with the exception of NOMADS verification. For timely reapplications, a new NOMADS printout verifying the client's address has been verified and is currently receiving a benefit is required.

Exception: Households who meet the definition of "homeless" will be allowed up to 90 days to provide verifications that are not readily available or easily obtainable.

218.2 Protected Address for Domestic Violence Victims

State law, NRS 217, allows victims of domestic violence to protect their location by applying for a fictitious address through the Secretary of State Office's Confidential Address Program (CAP). Anyone requesting to apply for this protection is referred to their local community domestic violence advocacy group. The local advocacy group Child Care staff will explain CAP and complete a domestic violence assessment. When advocacy group Child Care staff determines CAP is appropriate for the victim, they assist the victim in completing the application process and forward the application and a referral to the Secretary of State's Office.

When an advocacy group has submitted a CAP application to the Secretary of State's Office or a victim has been approved for CAP, the Child Care office must not require the person to provide their actual physical address. Persons pending a determination for CAP may use an alternative address (i.e., friend, relative or shelter address). Victims of domestic violence approved for CAP can use the fictitious address assigned by the Secretary of State's Office.

The Secretary of State's Office verifies Nevada residency; therefore, the Child Care office does not require residence verification for individuals who have applied or been approved for CAP.

218.2.1 Verification

The Secretary of State's Office verifies Nevada residency; therefore, the Child Care and Development Program office does not require residence verification for individuals who have applied or been approved for CAP. If the client has been approved for CAP, request a copy of the letter from the Secretary of State's Office for the case file. At reapplication, client's statement can be accepted to verify CAP status is still current.

If the client is pending a CAP approval, request a statement from the domestic violence advocacy group to verify the pending CAP application. If verification is received showing the actual physical address, the case manager must notate the details such as the household composition, move in date, etc., but it must not include the actual physical address. To conceal the client's location, the actual physical address must not be maintained anywhere in the case file or computer system.

218.3 Homeless

The CCDP recognizes the definition of a homeless household according to section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)),
A homeless household includes children and youths who:

(A) Lack a fixed, regular, and adequate nighttime residence
- *Fixed nighttime residence*: Stationary, permanent, and not subject to change.
- *Regular nighttime residence*: Used on a predictable, routine, or consistent basis.
- *Adequate nighttime residence*: Sufficient for meeting both the physical and psychological needs typically met in home environments.

AND

(B) Includes
(1) Sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;
(2) Having a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;
(3) Living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and
(4) Migratory children who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (1) through (3).

Households are considered homeless if they fit both part A and any one of the subparts of part B of the definition above.

218.3.1 Verification

Client statement of homeless status is acceptable.

219 PURPOSE OF CARE (POC)

To be eligible for a child care subsidy, the client and all other required adult household members and minor parents must be in an approved activity or the parent/caretaker is disabled/ incapacitated and unable to care for the child(ren). Refer to MS 400 for purpose of care categories.

An individual who is on strike does not meet the purpose of care eligibility requirement. A striker is anyone who participates with one or more employee in a work slow-down or stoppage. This includes a stoppage resulting from the expiration of a collective bargaining agreement.

> **Note:** Individuals affected by a lockout are not strikers. Additionally, if circumstances deteriorate during the strike to the extent the individual loses his job (e.g., the company is forced out of business, permanent replacements are hired by the company, etc.), the individual will not be considered a striker.

When a household is authorized for the reimbursement of child care services and fails to report timely that an adult household member is no longer participating in their approved purpose of care, the case must be evaluated for an overpayment and an intentional program violation (IPV). Refer to MS 500 for additional information on timely reporting and MS 700 for additional information on IPV.

219.1 Verification

Current verification of purpose of care is required at application, reapplication and any time a change in purpose of care occurs. Possible sources of verification are as follows (not all inclusive):

Employment:

- Pay stubs
- Letter from employer on company letterhead indicating days and hours of employment, the effective/hire date and signed/dated by the employer. The individual signing the document should be knowledgeable about the employee's wages, schedule, etc.
- Employment Verification, Form 2186-WA
- The Work Number

Job Search:

- Job Search Eligibility form issued by the Child Care office

Self-Sufficiency Plan:

- Copy of a plan created with another agency
- Letter from a social service agency
- Letter from social worker

Note: All homeless self-sufficiency plans will be discussed with the CCDP Chief and approval will be determined on a case by case basis.

School Attendance:

- Official class schedule
- Other documentation from the school which indicates the start and end date of the course(s)

NEON Activity:

- A completed NEON Child Care Referral, signed and dated by the DWSS case manager.

Temporary Disability:

- Letter/statement from a physician or other licensed professional authorized to make such assessments listing the start and anticipated end date of the disability. The letter/statement must state whether or not the client or required household member is *able* to care for the child(ren) due to the disability.

219.2 Schedule

The purpose of care schedule is required to determine when care is needed for the child(ren).

Set Schedule - Clients, required adult household members or, minor parents who have a set schedule must be authorized for the specific days which correspond to their schedule.

Varied/Rotating Schedule - Clients, required adult household members, or minor parents who have a varied/rotating schedule must be authorized for up to the number of days needed to meet their purpose of care per week.

> **Example:** The client or required adult household member is scheduled to work four (4) days a week; an open schedule must be noted on the Certificate with a note stating any four (4) days of the week are authorized. Anything over four (4) days is the responsibility of the client.

219.2.1 Verification

Current verification of the client's, required household member's or minor parent's schedule is required at application, reapplication and any time a change in schedule occurs.

> **Exception:** Schedule verification for homeless households with a self-sufficiency plan POC is not required.
>
> All homeless self-sufficiency plans will be discussed with the CCDP Chief and approval will be determined on a case by case basis.

If verification is unavailable (e.g., employer uses The Work Number, employer refuses to provide schedule information or the client is self-employed), the applicant's statement may be accepted. If this is done, the circumstances must be documented in the computer system.

Possible sources of verification are as follows (not all inclusive):

Employment:

- Letter from employer on company letterhead indicating days and hours of employment, the effective date and signed/dated by the employer
- Employment Verification, Form 2186-WA, completed by the employer

School Attendance :

- Official class schedule
- Other documentation from the school

NEON Activity:

- A completed NEON Child Care Referral signed and dated by the DWSS case manager.

220 CHILD SUPPORT

The purpose of the Child Support Enforcement Program (CSEP) is to assist custodial parents or caretakers in obtaining support from an absent parent(s) for their child(ren). CSEP can assist with the following:

- Locating the absent parent(s);
- Establishing paternity;
- Establishing and enforcing financial and medical support obligations; and
- Collecting and distributing child support payments
- All custodial parents or caretakers must be informed of the child support services offered by DWSS or county district attorney offices.

220.1 Completing the Application for Child Support Services

If a parent/caretaker would like to pursue child support, an Application for Child Support Services, Form 4000-EC must be provided to the parent/caretaker

Child Care staff should provide assistance, if requested, in completion of the Application for Child Support Services. If the completed application is received at the Child Care office, Child Care staff will forward the application, along with any available verification listed below, to the appropriate child support office.

- Identification of the parent or caretaker
- Birth certificate(s) for the child(ren)
- Social Security Card(s) for the child(ren) and the parent or guardian;
- Any court document(s) which have established child support payments

220.2 Responsibilities

At a minimum, the parent/caretaker must provide the following information about the NCP(s) on the Application for Child Support Services to initiate a child support case:

- The name of the NCP(s); and

- Information about the relationship (example: divorced, separated) with the NCP(s); *and*

- At least one of the following:
  - The Social Security number of the NCP(s); or
  - The last known address of the NCP(s); or
  - Employer information (current and/or previous employer) for the NCP(s); or
  - The name, address and telephone number of the parents of the NCP(s).

Note: In minor parent cases, the minor parent must provide information regarding the NCP(s) of the minor's child(ren) and for the NCP(s) of the minor, if any.

Once an Application for Child Support Services is received by the CSEP office, child support staff will take appropriate action to:

- Locate the NCP;
- Establish paternity;
- Establish and enforce financial and medical support obligations; and
- Collect and distribute child support payments.

Income and Assets

300 INCOME

301 Introduction

Income is any type of payment which is a gain or benefit to a household. The household's income is used to determine eligibility and subsidy percentage. Consider the income of any person who is a required member of the household.

When calculating a household's income, factors such as irregular and unpredictable income should be considered and a best estimate of the household's *annual* income should be used to determine eligibility. Using a 30 day history of actual income to determine a best estimate of future income is the most common budgeting method; however other methods should be used when they provide a better representation of the household's income. The budgeting method used must always be documented in the case file and/or case notes in NCCS.

When determining eligibility, income is either counted or exempt in the budgeting process. Households must fall below the maximum income limit for their household size as defined in MS 170 to be eligible for benefits.

Budgeting (MS 310) is a procedure used to determine eligibility and subsidy percentage based on the best estimate of income and circumstances which will exist in the year the household will be eligible.

302 Income Deductions

Per MS 310 the gross income is used to determine eligibility. The gross income can only be reduced by the following deductions:

- Repayment of an overpayment or wage advance to the same entity issuing the ongoing check; or,
- The deduction allowance for the amount of Drug Addiction and Alcohol (DAA), Social Security Disability Income (SSDI) fee collected by the authorized representative payee; or,
- The Average Cost of Care deduction; or,
- Child Support deductions.

Refer to MS 306.49.1 regarding employer fringe benefits (cafeteria plans).

302.1 Average Cost of Care Deduction

To be eligible for the Average Cost of Care deduction, the caretaker must be related to the child requesting assistance and receiving a Child-Only Temporary Assistance for Needy Families (TANF) grant as a relative caregiver or a Kinship Care Payment. In addition, children who are not eligible for TANF due to the receipt of Supplemental Security Income (SSI) are allowed this deduction if they are under the age of 13 or the age of 19 (if the child meets the criteria in MS 211).

The deduction amounts are based upon the child's care level and are as follows:

Infant	$425.00
Toddler	$398.00
Preschool	$358.00
School Age	$209.00

This deduction(s) must be applied to the household's gross countable income for each child under the age of 13 or under the age of 19 if the child meets the criteria in MS 211, regardless whether subsidy assistance is being requested for the child.

302.2 Child Support Deductions

Deduct child support payments that a required household member:

- Is legally obligated to pay; and,
- Actually pays.

> **Note:** This includes payments made for children who reside in the household part-time when custody is shared.

The payments must represent the household's child support obligation ordered by a court or administrative authority. Allowable deductions include:

- Current support payments;
- Arrearage payments;
- Medical support;
- Payments to third parties;
- Administrative and/or processing fees/charges assigned to court-ordered child support, such as unemployment benefit (UIB) fees for collecting and mailing child support, District Attorney-Family Support fees for processing support payments and employer processing fees.

Do not deduct payments for:

- Alimony or spousal support;
- Any portion of a court-ordered medical insurance expense paid for a child who resides in the home full time; or,
- Any portion of a court-ordered medical insurance expense the adult member pays or is required to pay to cover *themselves*.

To allow the deduction, the applicant must provide verification that:

- The required member has a legal obligation to pay;
- The amount of the obligation; and,
- The actual amount paid.

Verify the household's legal obligation to pay and the obligation amount by viewing (not all inclusive):

- Ledgers Child Support records;
- Court order;
- Administrative order;
- Legally enforceable separation agreement;

- Other official document; or,
- A collateral contact with access to an official document.

Verify amounts actually paid by viewing (not all inclusive):

- Child Support Enforcement Program (CSEP), District Attorney or county registry collection and distribution records;
- Ledgers child support records;
- Cancelled checks;
- Wage withholding statements;
- Withholding information from unemployment compensation;
- Statement from the custodial parent regarding direct payments or third party payments the household pays or expects to pay on behalf of the custodial parent; or,
- Pay stubs which clearly verify a deduction is for child support and the amount of the deduction

Note: Documents used to verify the household's legal obligation to pay child support are *not* acceptable verification of actual payments.

When budgeting the deduction, consider any anticipated changes in the legal obligation and any other changes that would affect the payment.

Note: If an absent or estranged parent returns to the household and continues to pay legally obligated support (current or arrearages) and this payment is received by the Child Care household, do not budget as income and do not allow the support payment as a deduction.

302.3 Budgeting Child Support Deductions

If the required household member is just starting to pay the child support payments and the verification received is for only a partial payment, allow the verified monthly obligation only.

Example: Court order verifies monthly obligation of $500 per month plus $50 per month in arrears and the required household members first payment is made on 7/15 for $250. Allow only the $500 at approval.

If the required household member has been paying, use a calendar month history of 2 months or longer and average to a monthly amount.

Example: Court order verifies monthly obligation of $500 per month plus $100 per month for medical support. The last two (2) calendar month history verifies payments made for $250, $275, $250 and $300. The total is $1,075 divided by two (2) equaling $537.50 which is allowed as the monthly deduction.

303 Verification of Income

Current verification of countable income is required at initial application, reapplication, and any time a change in income requires an action to the ongoing case. Refer to MS

500 for more information on changes.

Exceptions:

- Income verification is not required if a NEON referral is received from DWSS. Accept the income statement that is provided on the NEON Referral. Refer to MS 116.1 for additional information on NEON referrals.
- Income verification is not required for Wraparound cases. The Head Start or Early Head Start Agency verifies household income for Head Start eligibility and that income will be used for Wraparound eligibility. Refer to MS 800 for additional information on Wraparound cases.

The case manager should not verify income if the amount reported makes the household ineligible.

Example: The applicant reports monthly income of $5,000 for a household of four. This amount exceeds the maximum income limit; therefore, benefits should be denied without requesting further verification.

Verification of countable income already received is used to determine the gross monthly amount for initial and subsequent eligibility. If income fluctuates to the extent a 30-day period cannot provide an accurate estimate, income from the same source for up to 365 days prior to the application date stamp may be used. The prior income period begins the day prior to the application date stamp, the interview date, or the date of the household's income record, whichever is the most current, and extends backwards.

This 30-day period applies to timely or untimely case approval unless additional verification of income is provided by the household or discovered by the agency prior to approval. Changes in the best estimate calculation will only be evaluated if one of the following changes in income is reported or discovered prior to approval. Refer to MS 500 for information on updating changes an ongoing case:

- Change in employer
- Stopping or starting a job
- New source of countable unearned income
- Termination of unearned income

Examples:

Timely Processing

Client applies on September 4, and an interview is conducted on September 14; client reports no changes since the application was submitted. The client is employed and is paid biweekly on Fridays. The client provided paystubs for August 31, August 17, and August 3. The 30-day period is September 3 back to August 5. The case manager will use the paychecks received on August 17 and August 31 and no additional paystubs are required.

Note: Additional paystubs already provided by the household may be used if they provide a better estimate of the household's annual income.

Untimely Processing
Client submitted their application on June 13. The client reports on their application they are paid every Thursday, and provides paychecks received on May 15, May 22, June 5, and June 12 along with all other required verifications; no interview is held. Due to extenuating circumstances the case manager is unable to work the application until July 15. The additional paychecks received between June 13 and July 15 will not be required. The 30 day period will begin on June 12 and extending back to May 14.

If the application reflects a new source of income, without a 30 day history, a projected best estimate of the new income must be calculated. Refer to MS 312 for converting new income.

Independent verification of exempt income is not required. Self-declaration of exempt income on the application is acceptable. Refer to MS 306 for a list of exempt income.

If verification of income is required but unavailable (the individual's job would be jeopardized, the employer refuses to cooperate, the business has closed, etc.), the individual's statement may be accepted. If a statement is used, the reason the applicant's statement was accepted, along with all other methods of verification attempted prior to accepting the applicant's statement, *must* be documented in the computer system.

304 Documentation of Income

Verification and computation of all household income *must* be documented in the computer system at initial application, reapplication, or any time a change is reported or identified.

Additionally, as part of the federal monthly reporting requirements (ACF 801 Report), the income listed below must be documented in the computer system if the information is available:

- Housing Assistance
- Supplemental Nutrition Assistance Program (SNAP)
- Supported Living Arrangement (SLA)
- Family Preservation Program (FPP)
- Earned income Tax Credit (EITC)
- Indian General Assistance
- Native and Indian Claims
- Military Allowances
- Women, Infants, and Children (WIC)
- Medicaid

305 Income Limits

The household's gross countable income, less any allowable deduction, cannot exceed the following limits for the applicable household size. Refer to MS 302 for allowable income deductions.

Maximum Income Limit – 85% of the State Median Income

The maximum income limit is 85% of the state median income (SMI). The case manager must apply this test to all households in the application month.
The household is ineligible if the total countable gross income of all members, less any allowable deductions per MS 302, exceeds the maximum income limit for the household size. Refer to MS 170 for income limits.

130% of Federal Poverty Level

130% of Federal Poverty Level (FPL) is the income limit that determines which funding category should be debited for services. If the household is not eligible for NEON funding as described in MS 102, and their income is less than or equal to 130% of FPL, they must be paid from the At-Risk funding category. If the household's countable income exceeds 130% of FPL, they must be paid from the Discretionary funding category. Refer to MS 103 for any exceptions to the funding category.

306 Types of Income

When determining eligibility, count any income not specifically listed as exempt. Refer to MS 390 for budgeting procedures unless specified budgeting is explained with the income type (e.g., child support, self-employment).

Earned income is cash or income-in-kind received for performing work-related activities which is paid through salary or hourly wages. Other examples of earned income are self-employment, tips, wage advances, bonuses, commissions, and military pay.

Unearned income is income received without performing work-related activities. This includes benefits such as unemployment, Social Security, and veteran's benefits.

ALPHA LISTING OF TYPES OF INCOME AND INCOME STATUS

The following alpha list of income types contains coding to quickly determine whether income is earned or unearned and whether it is countable or exempt. The manual location is provided for quick reference to policy to ensure an accurate evaluation of income is made for budgeting purposes.

Coding Key:

TYPE: **E** = Earned **U** = Unearned

COUNTABLE: **Y** = Countable **E** = Exempt **M** = Maybe

INCOME	TYPE	COUNTABLE	MANUAL SECTION
Adoption Subsidies	U	E	306.1
Advances	E	E	306.47.1
Alimony	U	Y	306.2

INCOME	TYPE	COUNTABLE	MANUAL SECTION
Cash Contributions	U	M	306.3
Cash Gifts	U	E	306.4
Child Support	U	M	306.5
Contractual Earnings	E	Y	306.6
Crime Victim's Compensation Payments	U	E	306.7
Disability Insurance Benefits	U	Y	306.8
Dividends	U	Y	306.9
Earned Income Tax Credit (EITC)/Income Tax Refund	U	E	306.10
Educational Assistance	U	E	306.11
Energy Assistance	U	E	306.12
Family Preservation Programs (FPP)	U	E	306.18
Flexible Fringe Benefits	E	M	306.47.1
Foster Care Payments	U	E	306.13
Gambling Winnings	U	Y	306.14
General Assistance	U	Y	306.41
Gift Certificates	U	E	306.4
Government Disaster Payments	U	E	306.15
Incentive Payments/Bonuses	E	Y	306.47.1
Independent Living Payments	U	E	306.16
Indian General Assistance (IGA)	U	Y	306.41
Individual Development Account (IDA)	U	E	306.17
In-Kind Income	U	Y	306.19
Job Training and Training Allowances	U	E	306.20
Jury Duty	U	E	306.21
Kinship Care Payments	U	Y	306.40
Loans	U	E	306.22
Lump Sum Payments	U	M	306.23
Military Pay and Allowances	E	M	306.24
Minor Parent Wages	E	E	306.47
National and Community Services Act (NCSA)	U	E	306.25
Native and Indian Claims	U	E	306.26
Nutrition Programs	U	E	306.27

INCOME	TYPE	COUNTABLE	MANUAL SECTION
Pensions	U	Y	306.28
Property Income (Rental/Lease)	E	Y	306.29
Radiation Exposure Compensation Act Payments	U	E	306.30
Reimbursements	U	E	306.31
Relocation Assistance	U	E	306.32
Retirement, Survivors and Disability Insurance Benefits (RSDI)	U	Y	306.33
Retroactive Payments	U	M	306.23
Royalties	E	Y	306.34
Seasonal Employment	E	Y	306.35
Self-Employment	E	Y	306.36
Self-Sufficiency Grant (SSG) (TANF)	Y	Y	306.40
Sibling Income for Employment	E	E	306.47
Subsidized Housing Assistance	U	E	306.37
Supplemental Nutrition Assistance Program (SNAP)	U	E	306.38
Supplemental Security Income (SSI)	U	E	306.39
Supported Living Arrangement (SLA)	U	E	306.18
Temporary Assistance for Needy Families (TANF)	U	Y	306.40
TANF Loan Program (TANF)	U	Y	306.40
TANF Temporary Program (TANF)	U	Y	306.40
Temporary or Ongoing Assistance from Other Organizations	U	Y	306.41
Third Party Beneficiary	U	E	306.42
Tips	E	Y	306.47.1
Tribal TANF	U	Y	306.41
Trust Funds	U	Y	306.43
Unemployment Insurance Benefits (UIB)	U	Y	306.44
Veterans Administration Benefits (VA)	U	M	306.45
Victims of Nazi Persecution Payments	U	E	306.46
Wages, Salaries and Commissions	E	Y	306.47
Work Study	U	E	306.11
Workers' Compensation	U	Y	306.48

INCOME	TYPE	COUNTABLE	MANUAL SECTION
Workforce Investment Act of 1998 (WIA)	U	E	306.49

306.1 Adoption Subsidies *Unearned - Exempt*

A monthly cash benefit paid to the adoptive parents of a child involved in a "special needs" adoption. The subsidy is based on the needs of the child, not the adoptive parents and may or may not change year to year. Not all adoptions receive adoption subsidy benefits.

306.2 Alimony *Unearned - Count*

Money paid regularly by one marriage/domestic partner to the other as ordered by a court after a legal separation or divorce, or during proceedings for divorce or separation.

306.3 Cash Contributions *Unearned - Maybe*

Cash given to the household to assist with any financial needs the household is unable to provide for themselves.

Count as income any cash which is given to the subsidy household from someone not living in the home which is not required to be paid back by the subsidy household.

Exempt any payment made by a person outside of the household directly to the household's creditor or person providing the service (vendor payment) unless the vendor payment is made in lieu of child support. Refer to MS 306.5 for child support payments.

Exempt any contribution made for common household expenses (including food, shelter, utilities, and items for home maintenance) by an individual living in the same home with the subsidy household as long as that individual is not considered a required household member (refer to MS 216.1 regarding required household members).

306.4 Cash Gifts / Gift Cards / Gift Certificates *Unearned - Exempt*

A monetary gift which is given voluntarily without payment in return, as to show favor toward someone, honor an occasion, or make a gesture of assistance and is received too irregularly to be reasonably anticipated.

A gift certificate or gift card is usually presented as a gift that entitles the recipient to select merchandise of an indicated cash value at a commercial establishment.

306.5 Child Support *Unearned - Maybe*

The payment of funds by a non-custodial parent (NCP) to a custodial parent for the financial and medical care of a child.

Child support received by the child care household is countable income. Generally, payments from a non-custodial parent (NCP) are considered child support and are the income of the recipient, regardless if the support is intended for another individual (i.e., the child). This includes court-ordered medical payments paid directly to the applicant/client from a non-custodial parent.

Count as household income payments made by the NCP directly to the applicant/recipient's creditor or person providing the service in lieu of child support payments.
Count as household income any portion of child support received for a family member who no longer resides in the home and is retained by the participating household.

Do not count as income court ordered medical cash support turned over to, retained, or intercepted by Medicaid to offset Medicaid expenditures for the child in the support order.

> **Note:** Child support should be listed in the computer system under the recipient's name, not the child's name.

306.5.1 Lump Sum Child Support Payments

Count lump sum payments for child support arrears received for an eligible child as a non-recurring lump sum (see MS 306.23).

Child support payments considered to be lump sum payments are received from the following sources:

- IRS intercept program;
- Insurance settlements; or,
- Financial institution attachment.

306.5.2 Retained Child Support Payments

Child support received by CSEP for a child who is receiving TANF assistance is generally retained as reimbursement for benefits paid. However, the money may be sent to the assistance unit for the following reasons:

- Collections for Non-TANF Unit Members - The amount of support collected for nonmembers is returned to the household.
- Collections for Closed Cases - Once a case closes, the collection process does not stop for CSEP, unless the custodian requests case closure. The current support collected after closure is forwarded to the household.

For households who are transitioning from NEON subsidy to At-Risk or Discretionary subsidy, verify if child support was retained while the household was receiving TANF. If child support was retained, budget the monthly amount which was retained. Refer to MS 306.5.4 for information on calculating child support income.

306.5.3 How to Verify Child Support Payments

Verification can be in the form of (not all inclusive):

- A copy of the client's Child Support Debit Card statement;
- A printout of the CST Payment Record screen from Ledgers
- A copy of the check(s) or a printout of payments received from the out-of-state child support office;
- A copy of a support agreement issued by the court that reflects the current amount of support received, or to be received, by the applicant. The applicant's statement should correspond to the amount on the court order;
- A copy of an informal (not issued by the court) support agreement signed and dated by both parents;
- A Cash Contribution, form 2506-WC, completed by the NCP. The NCP must sign and date the form for it to be valid;
- A written statement from the NCP which includes their name, address, phone number, amount of child support paid and the frequency of the payments. The NCP must sign and date the document for it to be valid; or,
- When all other avenues of verifying child support are not available, the case manager can accept the applicant's statement; however, the circumstances and various attempts must be documented in the computer system. In addition, if the information provided by the applicant's is questionable, the case manager must request a copy of the applicant's bank statement and/or checks/money orders received from the NCP which can be used to validate the applicant's statement.

306.5.4 How to Calculate Child Support Income

There are some circumstances which require the factoring of child support income; however, each case must be individually evaluated for the correct budgeting method. It is best to review a 6 to 12 calendar month payment history when verifying child support income to help in the determination process of whether the income must be factored or an average needs to be used due to irregular payments.

Do not factor child support income if:

- There is a court order which specifics the monthly garnishment payment will never go over a specified amount per month.

  Example: Court ordered amount is $500/month with arrears of $50/month. The history verifies two payments made in the month of $275 each. Budget $550 and do not factor the income.
- A review of the child support history (6 to 12 calendar months) determines the support payments are irregular in amount **and/or** frequency, an average is the best available method for determining the best estimate of anticipated monthly income.

  Example: Case is processed on 07/15; payment received on 05/04 of $150, 05/16 of $75, 6/10 of $62.12, and 06/27 of $130. Amounts would be added together and divide by 2 (no factoring) for a monthly child support amount of $208.56.
- The NCP provides a statement that he gives the client a specific amount twice a month.

  Example: $50 twice a month from NCP - $50 x 2 = $100.00

Do factor child support income if:

- The applicant receives regular weekly or bi-weekly payments. A court order will sometimes allow the obligation to be annualized and garnished every payday.
  Example: The applicant receives $130 every 2 weeks from NCP - $130 x 2.15 = $279.50
- The applicant regularly receives money above the monthly child support obligation.
  Example: The child support order specified $200/month child support and $10/month in arrearages. The applicant has a long history of receiving $60/week. CSEP is applying the extra child support obligation received to the arrearages and forwarding the monies to the applicant. In this case, factoring is the best method to determine a monthly amount.

Refer to MS 311 for information on factoring income to determine a monthly amount.

Prudent worker judgment must be practiced when evaluating child support income; therefore, the reasoning behind the decision of how a best estimate or projection of income was determined must be documented in the computer system.
If court documents verify the NCP is required to pay monthly support, however the applicant and the NCP have a mutual agreement that the applicant will accept a specified amount to cover a specified time period, divide the amount received by the monthly obligation and use this amount as a monthly amount for the number of months it would cover if the NPC were paying the obligated amount monthly.

Example: NCP's monthly child support obligation is $400 per month and applicant has agreed to accept $4500 in April to cover the next 12 months. $4500 divided by 12 equals $375 per month to be budgeted for 12 months.

306.5.5 Newly Established Child Support Payments

When verification of a newly established court order for child support is received do not include the child support income until one calendar month of payment history can be verified. The case manager is responsible to follow-up within 45 days of the case approval or date the change is reported for an ongoing case. The case manager should verify if the information is available in Ledgers. If it is not available an RFI should be sent to the client for status of child support payments.

306.6 Contractual Earnings *Earned - Count*

A contract that applies to the terms of a work agreement, with the specific terms and conditions under which a person consents to perform certain duties as directed and controlled by an employer in return for an agreed upon wage or salary. Self-employment income, full-time employment with benefits (such as school employees), or income received on an hourly or piecework basis are not included in contractual earnings.

To budget contractual earnings monthly, divide the total gross amount of the contracted earnings by the number of months the contract covers.

306.7 Crime Victim's Compensation Payments *Unearned - Exempt*

Payments from funds authorized by state legislation to assist a person who:

- Has been a victim of a violent crime;
- Was the spouse, parent, sibling, or adult child of a victim who died as a result of a violent crime; or,
- Is the guardian of a victim of a violent crime.

306.8 Disability Insurance Benefits *Unearned - Count*

An insurance policy that pays benefits, for a specified period of time, in the event the policyholder becomes incapable of working; or

Employer-funded compensation paid to an individual who is disabled less than 12 months. The individual usually remains employed during recuperation from the temporary illness or injury pending their return to work.

306.9 Dividends *Unearned - Count*

A share of a company's profits that is divided among shareholders. People who own stocks, bonds, or mutual funds, may receive dividends from those investments.

306.10 Earned Income Tax Credits/Income Tax Refund *Unearned - Exempt*

A benefit for working people with children who have low to moderate income; it reduces the amount of tax owed and may also give a refund. Earned Income Tax Credit (EITC) may be included:

- In an employee's paycheck (advance EITC payments) before their income tax return is filed; or,
- In the household’s income tax refund.

306.11 Educational Assistance *Unearned - Exempt*

Educational assistance is any financial aid for vocational or educational courses from:

- An organization (such as fraternal, alumni, etc.); or,
- A government program or agency (such as U.S. Department of Education, Veteran's Administration (VA), etc.).

Most educational assistance programs are administered through the U.S. Department of Education under Title IV of the Higher Education Act. Some of the most common programs are:

- Pell Grants
- Stafford Loan Program
- Parent Loans for Students (PLUS Loans)
- Supplemental Educational Opportunity Grants (SEOG)
- College Work Study (CWS)
- Carl D. Perkins Loans (Title IV, Part E) (formerly National Direct Student Loans)
- VA Education Programs
- Bureau of Indian Affairs (BIA) Education Grants

Educational assistance is also provided by the National Community Services Act (NCSA) program. Individuals are awarded from $1,000 to $4,000 per year of completed services to apply toward past or future educational expenses.

College work-study programs provide a method for postsecondary education students to earn funds that are used toward their education. Work-study programs help students earn monetary awards towards their postsecondary education. The program is based on financial need and students must be accepted into the program to qualify.

306.12 Energy Assistance *Unearned - Exempt*

Energy assistance is a government or private program to reduce energy costs for low income people who might have difficulty paying for heating and cooling. The assistance may be in the form of cash, vendor, in-kind or two-party check payments.

306.13 Foster Care Payments *Unearned - Exempt*

A payment made to a licensed foster parent(s) or foster home for the care of a foster child(ren).

306.14 Gambling Winnings *Unearned - Count*

Any income that is the result of games of chance or wagers on events with uncertain outcomes. Count as lump sum income in accordance with MS 306.23

306.15 Government Disaster Payments *Unearned - Exempt*

Small Business Administration (SBA) loans and Individual and Family Grant (IFG) funds, made available to restore a home and personal possessions damaged in a disaster if the household is subject to legal penalties when the funds are not used as intended.

306.16 Independent Living Payments *Unearned - Exempt*

The Independent Living Program is designed to prepare foster teens to move out on their own following the end of Division of Child and Family Services (DCFS) custody and successfully live independently as an adult. Once custody has ceased, due to emancipation, these young adults may continue to receive limited financial assistance based upon need and available funding.
The Independent Living Program services are available to youth 15 and older who are currently in foster care and to former foster care youth who aged-out of the foster care system at age 18. Independent living services are also available to youth who were adopted from foster care on or after their 16th birthday. Young people who aged-out may continue receiving services until age 21. Nevada will extend independent living services to youth who have aged out of care in another state.

306.17 Individual Development Account *Unearned - Exempt*

The use of Individual Development Accounts (IDAs) is intended to improve the economic independence and stability of individuals and families and to promote and

support the transition to economic self-sufficiency. Federal funds match the amount of earnings low-income working individuals and families deposit into an IDA. IDA savings are to be used for a first home purchase, post-secondary educational expenses, or business capitalization.

The Social Security Act provides for State Family Assistance Grant funds to be used to establish IDAs. State Family Assistance Grant funds include (not all inclusive):

- Temporary Assistance for Needy Families (TANF); and
- Welfare-to-Work (WtW)

The Assets for Independence Act (AFIA) provides for IDAs to be established under:

- Head Start;
- Low Income Home Energy Assistance (LIHEA); and
- Community Services

306.18 Family Preservation Program / Supported Living Arrangement *Unearned - Exempt*

Family Preservation Program (FPP) payments and Supported Living Arrangement (SLA) payments are funds authorized by state legislation to assist individuals with disabilities or mentally disabled SSI individuals, so they can live in the community.
FPP and SLA payments are administered and distributed by the Nevada State Division of Mental Health Development Services (MHDS) for:

- Persons with profound or severe mental retardation, or
- Children under the age of 6 years with development delays.

306.19 In-Kind Income *Earned - Count*

Work performed in exchange for benefits such as room, board, rent or other needs.

306.20 Job Training and Training Allowances *Unearned - Exempt*

Monetary assistance provided to an individual for training related expenses.

306.21 Jury Duty *Unearned - Exempt*

To be summoned to serve or serve as a juror in a legal proceeding.

306.22 Loans *Unearned - Exempt*

An arrangement in which a lender gives money to the client and the client agrees to repay the money at some future point(s) in time. Usually, there is a predetermined time for repaying a loan.

306.23 Lump Sum Payments *Unearned - Maybe*

Any payment received in a month from a source that is not likely in the foreseeable future to make additional payments to the household. Lump sum payments may be

received in one or more individual checks but are considered a lump sum if all money received is a part of the *whole* payment due.

Lump sum payments include, but are not limited to, retroactive benefit payments (RSDI, UIB, VA, etc.), insurance settlements, awards or settlements received for personal injury, inheritance, winnings, employment severance pay, child support arrear payments, etc.

Exempt lump sum payments in the amount of $5,000 or less. Count as income any portion which is in excess of $5,000.

Lump sum income in excess of $5,000 must be budgeted as part of the household's annual income and annualized for the certification period.

> **Example:** Household is approved for 12 months on 03/01 and receives a lump sum of $12,000 on 07/01. $5,000 is exempt leaving $7,000 remaining to be budgeted over the whole certification period ($7,000 divided by 12 = $583.30 per month). $583.30 will be added to the household's monthly income for July – February). If the additional income makes the household's income exceed 85% SMI, the household is ineligible for the remainder of the certification period. If the additional income does not make the household's income exceed 85% SMI, follow procedures in MS 521.

If a lump sum is provided to assist with burial, legal, medical bills or replacement of damaged or lost possessions, disregard from the lump sum any amount earmarked and used for the purpose for which it was paid. A copy of the settlement may be requested to verify earmarked expenses if it is questionable the expenses are related to the lump sum.

306.24 Military Pay and Allowances *Earned - Maybe*

Wages based upon employment with one of the military branches of the United States Department of Defense. Military pay includes Basic Pay (BP) and Proficiency Pay (PRO). Count as income.

A military allowance is money necessary for the efficient performance of duty. Military allowances include Basic Allowance for Quarters (BAQ) and Basic Allowance for Subsistence (BAS). Exempt income.

306.25 National and Community Services Act *Unearned - Exempt*

The National and Community Services Act (NCSA) of 1993 established a corporation to administer paid volunteer service programs. The corporation provides funds, training, and technical assistance to states and communities to develop and expand human, education, environmental, and public safety services.

The corporation oversees existing programs created under the Domestic Volunteer Service Act (DVSA) of 1973, (Public Law (PL) 93-113), such as:

- Volunteers in Service to America (VISTA);

- Retired Senior Volunteer Program (RSVP);
- Foster Grandparents;
- Senior Companions;
- Community Service Employment Program (includes Senior Citizen Service Employment);
- Service Corp of Retired Executives (SCORE);
- Active Corps of Executives (ACE); and
- Mini Grant Program.

The corporation also administers new programs that include:

- AmeriCorps*VISTA (for participants 17 years and older);
- AmeriCorps*VISTA (for participants 18 years and older);
- AmeriCorps*NCCC (for participants 16 to 24 years old); and
- Youth Corp and Learn and Serve.

306.26 Native and Indian Claims *Unearned - Exempt*

Monetary court settlements to Native and Indian claims by the United States government.

Income applies to either distributions of funds appropriated in satisfaction of a judgment in favor of Indian tribes, bands, groups, pueblos, or communities by the Indian Claims Commission or the Court of Claims or per capita payments as permitted by the Per Capita Distributions Act of 1983, Public Law 98-64, made to Indians out of tribal trust revenue held by the federal government. The exception is funds held by Alaska Native Regional and Village Corporations (ANRVC) which are *not* held in trust by the Secretary of the Interior.

Exempt all income except ANRVC dividend distributions which are *not* excluded from countable income.

306.27 Nutrition Programs *Unearned - Exempt*

Programs administered by the Food and Nutrition Service (FNS) which provide better access to food and promote healthy eating through nutrition education programs.

306.28 Pensions *Unearned - Count*

A fixed amount of money paid regularly to somebody during retirement, for either age or disability, by the government, a former employer, or an insurance company.

306.29 Property Income (Rental/Lease) *Earned - Count*

Property bought or developed to earn income through renting, leasing or price appreciation.

Consider income from property (non-liquid resources such as equipment, vehicles, real property), whether from renting, leasing, or selling on an installment plan, as countable income.

Note: If the household member sells property on an installment plan, count the payments as income. Exempt the balance of the note as an inaccessible resource.

306.30 Radiation Exposure Compensation Act Payments *Unearned - Exempt*

A federal statute (PL 101-426) that provides monetary compensation for people, including atomic veterans, who contracted one or more specified diseases as a direct result of their exposure to atmospheric nuclear testing undertaken by the United States during the Cold War, or their exposure to high levels of radon while doing uranium mining.

306.31 Reimbursements *Unearned - Exempt*

An act of compensating someone for an expense the person incurred. Often, a person is reimbursed for out-of-pocket expenses when the person incurs those expenses through employment or in carrying out the duties for another party.

306.32 Relocation Assistance *Unearned - Exempt*

Specific government relocation payments for:

- Title II of the Uniform Relocation Assistance and Real Property Acquisitions Act of 1970;
- Title I of PL 100-383 (these payments are made to Aleuts or individuals of Japanese ancestry (or their heirs) who were relocated during World War II).

306.33 Retirement, Survivors and Disability Insurance *Unearned - Count*

A program administered by the Social Security Administration for individuals who have earned benefits based on their work history and earnings. Retirement, Survivors and Disability (RSDI) Benefits are paid to beneficiaries based on the Social Security earnings of the retired, disabled or deceased worker. Benefits may be payable to the claimant and certain family members (e.g., spouse, dependent children).

Count as income the amount of the entitlement (including the amount deducted from the check for the Medicare premium) less any amount that is being recouped for a prior overpayment.

Note: Do not count RSDI benefits which a member of the childcare household is entitled to receive, if the benefits are paid to someone outside the home and the benefits are not made available to the household member.

306.34 Royalties *Earned - Count*

A percentage of the revenue from the sale of a book, performance of a theatrical work, use of a patented invention or of land, etc., paid to the author, inventor, or proprietor.

306.35 Seasonal Employment *Earned - Count*

A short-term temporary position designed to fill a temporary need that occurs only during a certain period of the year as the need for the position is related to the time of year. Winter ski resort employee, certain types of farm work, sharecroppers, and summer or winter employment are examples.

Prorate seasonal employment that is a household's annual means of support over twelve (12) months. If the income supports only a portion of the year and the household supplements its earnings from other sources the rest of the year, average the earnings over the period of time they are intended to cover.

306.36 Self-Employment *Earned - Count*

The act of generating one's income directly from customers, clients or other organization as opposed to being an employee of a business (or person). An individual is self-employed if engaged in an enterprise for gain, either as an independent contractor, franchise holder, or owner-operator. This includes individuals working as an Avon, Mary Kay or Tupperware representative or a newspaper delivery person. Individuals are not considered self-employed if income taxes or FICA are withheld from the individuals' earnings.

Self-employment income is budgeted based on the actual income received and actual allowable expenses paid. *At least* a 2 calendar month history should be used.

> **Note**: Annual or quarterly income tax statements or updated business records/accountant records can be used.

306.36.1 Self-Employment — Budgeting Procedures

Determine monthly countable income based on the individual's income from self-employment and cost of doing business. If there are anticipated changes in income, expenses or both, use this information to determine the monthly amount of self-employment income.

1. Total all gross self-employment income (including the full amount of a capital gain) for the period of time over which self-employment is determined.

   Capital gain is the financial profit from a sale or transfer of capital assets (accumulated possessions such as products, raw materials, equipment, or ownership of a business).

   When calculating self-employment income, add any capital gains the household expects to receive during the certification period to determine monthly countable income. Use this amount for the entire certification period unless a new average is computed because the individual received an unanticipated capital gain or a different amount than anticipated.

2. Determine net self-employment income by subtracting allowable costs of producing the income (**Examples:** labor, sales tax, stock, raw materials, advertisement, insurance premiums, utilities, repairs that maintain income-producing property, supplies, fuel, linen service, property tax and interest from business loans on income-producing property).
   If receipts are not provided for expenses, the expense is not allowed.

   Note: Fuel expenses are not allowed without a detailed mileage record/log or other documentation showing beginning and ending mileage, and destination, which supports the expense. The mileage allowance is based on the current approved standard mileage rates established by the Internal Revenue Service.

   Do not deduct:
   - Payments on the principal of loans for income-producing property;
   - Capital asset purchases, such as real property, equipment, machinery and other durable goods;
   - Capital asset improvements;
   - Net loss which occurred in a previous period;
   - Work-related expenses, such as federal, state and local income taxes, retirement contributions, and travel to and from the place of business;
   - Depreciation; or
   - Costs that are not related to the self-employment; (e.g., entertainment, personal transportation costs).

306.36.2 Verification of Self-Employment Income

Business records and income tax forms are the ideal source of verification. However, if this information is not available or current, use of the Self-Employment Worksheet, form 2011-EG, is acceptable if the income and expenses cannot otherwise be verified by collateral contacts or documentary information. If the applicant claims little or no income, verification of how they are meeting their monthly obligations must be requested via the Request for Information. If the household fails to provide verification, their child care benefits must be denied/terminated. If the household provides the verification and it appears questionable, the case must be referred to Investigations and Recovery Unit (I&R) for an investigation. Do not delay case processing if the case is referred to I&R.

The following must be documented in the computer system:
- The method used to calculate countable self-employment income;
- Deductions for the costs of doing business;
- The number of hours engaged in the enterprise; and
- Other factors used to determine the amount of income.

If the only source of verification used is the Self Employment Worksheet, document the reason in the computer system.

306.37 Subsidized Housing Assistance *Unearned - Exempt*

Living spaces partially paid for by the government, including single-family homes, apartments, and assisted-living facilities.

306.38 Supplemental Nutrition Assistance Program *Unearned - Exempt*

A federally funded program to help low-income families buy nutritious food from authorized retailers. Supplemental Nutrition Assistance Program (SNAP) benefits are available to qualifying families, elderly people, and single adults.

306.39 Supplemental Security Income *Unearned - Exempt*

Supplemental Security Income (SSI) is a federal program that provides additional income for older and disabled individuals with little to no income stream. This program helps the participants meet their basic needs by providing them with monthly cash distributions.

Exempt income; exempt any retroactive SSI payments and Interim Assistance (IA) for pending SSI applicants.

306.40 Temporary Assistance for Needy Families *Unearned - Count*

The Temporary Assistance for Needy Families (TANF) program has been restructured to include five TANF programs: NEON Program, Child-Only Program, Self-Sufficiency Grant Program, Loan Program and Temporary Program.

- **NEON Program:** The NEON Program is a work program for households containing work eligible individuals. This is a TANF Cash Assistance Program. A NEON Child Care Referral is required for all work eligible caretakers. Refer to MS 116.1 and 410 for additional information on the NEON program.

  Count the total amount of the TANF grant as income in the month received.

  If the benefit is not going to continue, do not use it in the projection; however, any client who has received TANF cash is considered to be receiving TANF until it is verified they are no longer eligible.

- **Child Only Program:** This program is designed for households not having any work eligible caretakers. No adults receive assistance due to ineligibility or because the caretaker is a relative caregiver. Categories of child only households include:
  - Non-qualified non-citizen caretaker
  - SSI caretaker;
  - Relative caregiver; and
  - Kinship care caretaker

  Count the total amount of the TANF grant as income in the month received. If the grant is not going to continue, do not use it in the projection; however, any

household who has received a TANF cash grant is considered to be receiving TANF until it is verified they are no longer eligible.

Note: Relative caregiver grants and Kinship Care grants may be reduced using the Average Cost of Care deduction. Refer to manual section 302.1.

- **Self-Sufficiency Grant:** The Self-Sufficiency Grant (SSG) is a one-time, lump-sum payment designed to meet immediate needs until regular income is received from employment, child support or other ongoing sources.

- **TANF Loan Program:** The TANF Loan Program is a cash program that provides financial assistance to a household who has an eligible member who has a reasonable expectation of a future source of income which would repay the loan. For example, an applicant pending SSI may receive Loan benefits which will be required to be paid back upon approval and receipt of SSI benefits.

  Eligible households will receive a monthly payment designed to meet the family's needs until an anticipated future source of income is received.

- **Temporary Program:** This is a monthly payment designed to meet an immediate episode of need and is limited to no more than four months per episode of need.

  Count the total amount of the TANF grant as income in the month received. If the grant is not going to continue, do not use it in the projection, however, any household who has received a TANF cash grant is considered to be receiving TANF until it is verified they are no longer eligible.

306.41 Temporary or Ongoing Assistance from Other Organizations
Unearned - Count

Temporary or ongoing cash assistance from other agencies/organizations, such as County General Assistance (GA), Indian General Assistance (IGA), and Tribal TANF.

306.42 Third-Party Beneficiary *Unearned - Exempt*

Money a household receives that is intended and used for a non-household member.

306.43 Trust Funds *Unearned - Count*

A fund established by a grantor to provide financial security to an individual. Count any withdrawals or dividends the household receives from a trust fund as income.

Note: ALL trusts, including living trusts, are submitted to the DWSS Attorney General (DAG) for review and a determination of availability and accessibility; however, if the person is currently receiving income from the trust, it is countable.

306.44 Unemployment Insurance Benefits *Unearned - Count*

Unemployment Insurance Benefits (UIB) is an allowance of money paid, usually weekly, to an unemployed worker by a state or federal agency, or by the worker's labor union or former employer, during all or part of the period of unemployment. Count the gross benefit less any amount being recouped for a previous UIB overpayment.

> **Note:** Child support judgments against UIB payments are not considered an overpayment recoupment. However, a deduction may be allowed MS 302.

306.45 Veteran's Administration Benefits *Unearned - Maybe*

Veteran's Administration (VA) Benefits are a monetary benefit paid to a person who has served in one of the United States military branches. Count the gross benefit less any amount being recouped for a previous overpayment.

> **Exception:** Exempt all educational benefits
>
> **Note**: Do not count VA benefits which a member of the childcare household is entitled to receive, if the benefits are paid to someone outside the home and the benefits are not made available to the household member.

306.46 Victims of Nazi Persecution Payments *Unearned - Exempt*

Payments made to individuals because of their status as victims of Nazi persecution.

306.47 Wages, Salaries and Commissions *Earned - Count*

Money earned through paid employment. The payment can include salary, commissions, vacation and/or sick allowances, fees, bonuses, back pay and fringe benefits.

All money earned through employment must be counted as income. Gross wages must be budgeted and any money deducted from the gross income and paid to a third party for taxes, insurance or other fringe benefits are counted as income. Any amount reported on the pay stub or elsewhere as *taxable gross wages* is countable.

Exceptions:

- Exempt wage income for a minor parent who is attending school to acquire a high school diploma or a GED.
- Exempt wages received by a sibling; refer to MS 216.1 for definition of sibling.
- EITC received with wages from an employer must be deducted from gross earnings prior to the income deduction being given.

306.47.1 Definitions

- **Advance** – a payment of wages made ahead of the normal pay date.

Wage advances are a loan from the employer and should be considered as part of the household's annual income but not considered as additional income in a 30 day or 60 day history.

Example: Paychecks for 3/7 for $800.00, 3/21 for $1000.00, and 4/4 for $800.00 are used for a 30 day history best estimate of wages. The 3/21 paycheck includes a $200 a pay advance. Since this $200 will be deducted out of a future check(s) to pay the employer back, it should not be included in the best estimate and the best estimate would be $800 X 3 = $2,400 divided by 3 paychecks = $800 X 2.15 (bi-weekly pay) = $1720/mo. The same is true when the deduction shows on a paycheck for repayment of an advance; paycheck for 4/4 is $800.00, 4/18 is $600, and 5/2 is $800. The paycheck for 4/18 shows a deduction for the repayment of a wage advance so the best estimate would be $800 X 3 = $2,400 divided by 3 paychecks = $800 X 2.15 (bi-weekly pay) = $1720/mo.

- **Bonus/Incentive Awards** – additional compensation given to an employee above his/her normal wage. A bonus/incentive award can be used as a reward for achieving specific goals set by the company, or for dedication to the company. If a bonus/incentive award is received on a regular monthly basis or on regular paydays, include in the 30 day best estimate. If the bonus is received monthly, quarterly, semi-yearly or yearly, include in the best estimate of annual income.
- **Commissions** – money paid based on a percentage of the sales that the employee makes. If a commission is received on a regular monthly basis or on regular paydays, include in the 30 day best estimate. If the commission is received monthly, quarterly, semi-yearly or yearly, include in the best estimate of annual income.
- **Fringe Benefit** – the benefits, other than wages or salary, provided by an employer for employees (e.g., health insurance, vacation and/or sick time, disability income, paid holidays) received by an employee in addition to regular pay. If the employer pays the fringe benefit directly to the source (insurance carrier, child care provider, etc.) the benefit must not be included in the household's countable income. In addition, if the employee has a choice on whether or not they receive the benefit, it must not affect their benefits if it is rejected or accepted as long as it is sent directly to the vendor. If the employee receives any portion of the additional benefit in their paycheck or in addition to their paycheck, it must be considered countable income.

  Note: Do not include meals as income unless the meals are included in the taxable gross.
- **Overtime** – payment, usually at a higher rate, for time worked beyond the normal hours of employment. Budget income from overtime in the best estimate if is verified to be received on a regular monthly basis or is included on at least half of the pay stubs provided.

  Note: Do not budget income from overtime in the best estimate if it is verified it will not be received on a regular basis.

  Example: Client is paid bi-weekly and provides two pay stubs with overtime on one pay stub; YTD totals on the pay stub and discussion with the client confirms overtime is not received regularly.
- **Salary** – a fixed amount of money or compensation paid to an employee by an employer in return for work performed.

- **Tips** – A gratuity (also called a tip) is a sum of money customarily tendered to certain service sector workers for a service performed or anticipated.
  Note: If the tip compliance amount noted on the pay stub is less than the applicant's and/or employer's statement, the applicant/employer statement should be used when determining the tip income.
- **Wages** – Money paid for labor or services to a worker; payment is based on an hourly, daily, or weekly basis or by the piece (paid for each unit produced or action performed).

306.47.2 How to Verify Employment Earnings

Verification can be in the form of (not all inclusive):

- Pay stubs;
- Employment Verification, form 2186-WC;
- The Work Number;
- Statement from employer.

If an employer statement does not provide sufficient information to accurately determine the individual's ongoing income, the case manager must contact the employer for clarification.

When contacting the employer or hiring personnel directly, the contact person's name, title, date of contact, telephone number and all other pertinent income/employment status information (e.g., termination or beginning date of employment, type of position, days and hours of work, full-time or part-time employment, hours and hourly rate of pay, pay days, frequency of pay, bonus or commission pay, anticipated changes) must be documented in the computer system.

If the employer statement does not provide sufficient information to accurately determine the individual's ongoing income and the case manager is unable to contact the employer for clarification, the case manager must use the client's pay stubs to determine the household's ongoing benefit amount.

306.48 Workers' Compensation *Unearned - Count*

A form of insurance required from employers that provides money as compensation for workers who are injured at work or contract an occupational disease.

306.49 Workforce Investment Act of 1998 (WIA) *Unearned - Exempt*

A United States federal law passed August 7, 1998, which was enacted to replace the Job Training Partnership Act (JTPA) and certain other federal job training law with new workforce investment systems (or workforce development). It represented an attempt to induce business to participate in the local delivery of Workforce Development Services. The principal vehicle for this was Workforce Investment Boards (WIBs) which were to be chaired by private sector members of the local community. A majority of board members were also required to represent business interests. Today, WIA funds can be used to fund workforce education and career pathways programs.

310 BUDGETING

A procedure used to determine eligibility by calculating income and deductions of any person who is a required member of the household. Case managers should use a budgeting method which provides the most accurate reflection of the household's *Annual* income converted to a monthly amount. The method used and the reasoning for the method used must be documented in the computer system.

310.1 Definitions - The following terms are used:

- **Best Estimate Budgeting:** A process used to determine eligibility and subsidy percentage amount of benefits based on the best estimate of income and circumstances which will exist in the certification period month(s) a child care subsidy is authorized.
- **Prospective Eligibility Budgeting:** A projection of income, household composition and other circumstances anticipated to exist in the certification period benefit month based on verified data or the best information known at the time the eligibility/benefit determination is made.
- **Actual Income Budgeting:** Actual income is income that has already been received. Actual income is used in best estimate budgeting if it provides the best representation of the anticipated monthly income. Overpayment calculations involve budgeting actual income and evaluating circumstances which existed during the month in question.

310.2 General Income Budgeting Tips

To compute income, use one of the following methods, which most accurately reflects the best estimate of the household's income for the certification period:

- Actual income (income that has already been received); or,
- Projected income (the "best estimate" of income which is anticipated to be received).

Unless specified in an income manual section (i.e. child support, self-employment, contractual, or seasonal) use the budgeting methods described in this section.

Income is budgeted for the certification period and converted to a monthly amount. Documentation of the factoring method used in the eligibility determination must be recorded in the computer system.
Regular monthly income automatically deposited directly into a financial institution (e.g., RSDI, SSI, VA, retirement pension) is considered received in the month it is for.

> **Example**: RSDI (Social Security) benefit for May is direct deposited April 28. The payment is budgeted as income for May.

When an individual receives and returns a check to the issuing agency, determine whether to budget the payment using the following guidelines:

- If there is evidence the check was incorrectly paid and it is verified the check was returned, do not budget the amount as income.

- If the check was correctly paid and was voluntarily returned, budget the amount as income in the month received.

Unless listed in MS 302, the gross figure cannot be reduced by any deduction, voluntary or involuntary, such as child care deductions, insurance premiums, deductions for judgments, garnishments, federal taxes, etc.

311 How to Convert Income to Monthly Amounts

If necessary to manually convert income, which is not received monthly, to monthly amounts, use one of the following factoring methods:

- Multiply the average weekly income by 4.3
- Multiply the average semi-monthly income by 2.

  Note: a semi-monthly average can only be used if actual paystubs are provided. If an Employment Verification Form (EVF) or employer statement is used, multiply the average weekly income by 4.3.
- Multiply the average bi-weekly (received every other week) income by 2.15.
- Divide yearly income by 12.

If an additional anticipated payment is received outside the regular payment cycle, add this amount to the regular converted amount.

> **Example:** Household member is paid weekly, however receives a tip check once per month. The weekly income would be converted to a monthly amount and the tip income would be added to this monthly amount.

Anticipate income using the best available information. If income is ongoing, but the amounts fluctuate, it is best to anticipate by averaging income from past pay periods.

Always document your reasons for the methods used to budget income into the computer system case narratives.

312 Best Estimate Based on Projected Income from New Employment or an Employer Statement

Projected income is the “best estimate” of income which is expected to be received. Use the following procedures if the household has new income from employment and there is not enough history from which a monthly amount of income can be accurately projected or if an employer statement is provided

1. Determine the estimated number of hours to be worked per week. If the employer states the individual will work a range of hours, the case manager must average the hours to determine the approximate hours the individual will be working (e.g., the employer states the individual will work between 35 and 40 hours per week; the case manager must use 37.50 hours (35 + 40 / by 2 = 37.50) in the computation).

2. Estimate weekly gross income by multiplying the weekly estimated hours by the hourly wage.

3. Determine the monthly projected gross income by multiplying the estimated weekly gross income by 4.3. If verification substantiates the use of a specific factoring method which is more accurate than multiplying weekly gross income by 4.3, use what will accurately reflect the income to be received. The budgeting method used must be documented in the computer system.

   Example: Employer statement verifies the client works 30-35 hours per week, at $7.75 per hour. Wages would be calculated as: 30 + 35 = 65 / 2 = 32.5 (average hours per week) x $7.75 x 4.3 = $1,083.06

   If verification of tip income is included on the EVF or employer's statement, use steps above to determine the anticipated monthly tip income.

   Example: Client above also earns $10-15 per shift in tips and works 5 days per week. Tips would be calculated as: 10+15=25/2=$12.50 (average tips per shift) x 5 (number of shifts per week) x 4.3 = $268.75.

   Total income for the client for wages/tips = $1083.06 + $268.75 = $1,351.81.

313 Best Estimate Based on Actual Income

Actual income is income which has already been received. Anticipate income using the best available information. Use the household member's pay stubs as verification whenever possible.

If the application reflects current ongoing income, a 30-day history of income can be used to determine monthly income. The 30-day period begins the day prior to the application date stamp (or the date of the most current income verification, whichever is more recent) and extends back 30 calendar days. In those instances when a 30-day history does not provide a clear representation of the household's income, a history of up to 365 days should be evaluated. This includes households with irregular or sporadic income (day labor, on-call, temporary employment services).

Calculate the monthly income amount using verified gross income received in the 30 day period (or longer) and convert the income to a monthly amount using the appropriate factoring method. The monthly income calculated using the 30 day period (or longer) will be budgeted to the application month and to all ongoing benefit months.

314 Irregular Income

When converting and projecting earnings to a monthly amount do not include holiday pay and/or vacation/sick pay unless it is received in lieu of regular pay.

315 On-Call Employment

Income from on-call employment, such as banquet waitress, culinary union, or casual

labor, etc., is treated as monthly income when it fluctuates or is irregular or sporadic. Use a pay history (if available) and divide the total by the number of months it covers to project monthly income. If the pay history includes a month with no income and the member was on call, use the month with no income in the average.

> **Note:** Include pay periods with zero income into the factoring for on-call employment. Add all of the amounts together and divide by the number of pay periods that fall within the pay history period including the period with no income, and then multiply by the appropriate frequency to get the correct amount.

If income from on-call employment is received on a regular basis (e.g., 3 days per week, 80 hours per month), use normal budgeting procedures.

If income is received sporadically (e.g. day labor) throughout the month and not on a fixed pay frequency, add all of the amounts received in the 30-day period and use that figure as the total amount. If you use more than a 30 day history of sporadic income, add all of the amounts together and then divide by the number of months it covers to get a monthly amount.

316 Budgeting Steps

First Step
The maximum income is established based on the number of household members (see Income Limits and Subsidy Percentages chart, MS 170).

Second Step
Determine the gross income based on all countable income, less any allowable deduction(s), received by the household. Round the gross monthly income to the nearest dollar (i.e., 0-.49 round down, .50-.99 round up).

Third Step
Compare the gross countable income to the Income Chart (see MS 170) based on the appropriate household size. To the right of the income is the Percentage Paid field. This is the percentage the Child Care Subsidy Program will pay; this is the subsidy amount. If the gross countable income exceeds the 85% of Nevada's median income, deny/terminate the household.

320 ASSETS

The asset limit is $1,000,000 (one million dollars). If a household reports assets in excess of $1,000,000, the household is not eligible for child care assistance. Until further clarification from the Administration for Children and Families (ACF), Office of Child Care (OCC) is received, cases will be evaluated at the supervisor/manager level if excess assets are reported.

Purpose of Care Categories

400 PURPOSE OF CARE

To be eligible for a child care subsidy, the applicant and all other required adult household members and minor parents must be participating in an eligible activity or Purpose of Care (POC). For the Child Care and Development Program, POC is defined as one of the activities listed in this section. The CCDP Chief determines which POC categories are available and which are not based on funding. A Child Care Informational Memorandum will be issued any time there is a change to eligible POC categories.

When determining eligibility, the case manager must evaluate eligibility for all group sets under each POC category before approving or denying the application.

Subsidy benefits are paid according the parent/caretaker's verified schedule for an eligible POC. For a two-parent/caretaker household, evaluate both parents'/caretakers' schedules and allow subsidy coverage for the overlapping schedules only.

Additional requirements and/or exceptions are listed for each POC category. In addition to meeting these requirements, the household must also meet the non-financial requirements in MS 200 and income requirements detailed in MS 300, unless otherwise noted in this section.

410 DWSS TANF NEON Program

The DWSS NEON program is a work program for households with at least one work-eligible individual. Applicants who have applied for or are receiving assistance from one of the qualified TANF Cash Programs listed below are eligible for child care subsidy under the NEON POC category. The applicant may be a parent or other relative caretaker.

Eligible TANF Cash Programs are:

- NEON Program (TN): TANF household with one work-eligible parent. The household may include two parents; however one is not required to participate in the NEON program. For two-parent households purpose of care may be required for both parents.

  Examples:
  One-parent household
  Two-parent household – one parent SSI recipient
  Two-parent household – one parent ineligible non-citizen
  Two-parent household – one parent is a step-parent who is not NEON eligible

  For households with two parents but only one is mandatory to participate, a completed NEON Child Care Referral form is required for the mandatory parent only. Child Care staff must verify the parent who is not receiving NEON TANF has a valid POC or a reason that parent cannot care for the child(ren).

- NEON 1 Program (TN1): TANF household with two work-eligible parents however, one parent is disabled. Verification from a physician or qualified medical professional verifying the individual's inability to provide care for the child(ren) must be provided.

  Examples:

  Two-parent household – one parent pending a disability determination by Social Security Administration.

  Two-parent household – one parent temporarily disabled as verified by a physician or qualified medical professional.

  A completed NEON Child Care Referral form is required for the non-disabled parent only.
- NEON 2 Program (TN2): TANF household with two work-eligible parents. One or both parents may be disqualified household members but are still work-eligible.

  Examples:

  Two-parent household – one parent disqualified for non-cooperation

  Two-parent household – both parents disqualified for IPV

  A completed NEON Child Care Referral form is required for each parent in a two-parent household.

  Note: If job search is the approved NEON activity, Child Care staff must ensure there is justification for why one parent/caretaker cannot care for the child while the other is seeking employment. The justification must be documented in the case notes.
- Temporary Program (TP): The Temporary Program is limited to receiving no more than four months of payments designed to meet an immediate episode of need, such as flood, earthquake, etc. This program can be a one or two-parent household. A completed NEON Referral form is required for each parent in a two-parent household. Child care cannot exceed four months of coverage under this program per episode.

  Exception: Applicants must be receiving TANF cash under the Temporary Program to qualify for child care assistance. If an applicant is pending TANF cash under the Temporary Program, reject the referral and notify the DWSS case manager. Refer to MS 100 for information on NEON Referrals.

410.1 Additional Information

- A completed NEON Child Care Referral form must be received for each parent/caretaker as appropriate. Refer to MS 100 regarding criteria for a completed NEON Child Care Referral.
- For the NEON POC, the specific details of the activity are not required as the activity is monitored by DWSS Child Care staff.
- Individuals will not be eligible for NEON job search activity during school hours if the only eligible child(ren) is school age (6- to 12- years old) or has special needs (13- to 19- years). However, part-time child care is allowed to cover before and after school hours if required NEON participation hours are greater than school hours. Child care assistance for job search for child(ren) not in school (e.g., summer break, track break, holidays.) will be allowed.

Exception: Subsidy assistance for job search is allowed if a child is enrolled and attending part-day kindergarten.

- Certificates are issued per the start and end dates requested on the NEON Child Care Referral and cannot exceed 90 days.

  Note: The application date entered in the computer system for NEON referrals must be either the start date on the referral or the date care is requested to begin, whichever is later. Do not use the referral date or the application date stamp date for NEON referrals.

- Non-financial and financial eligibility factors which are verified by DWSS Child Care staff are not required to be re-verified by Child Care staff. However, once the applicant is no longer eligible under the NEON Activity category, all non-financial and financial eligibility factors must be verified. The following chart confirms which eligibility factors are verified by DWSS case managers.

ELIGIBILITY FACTOR	TANF-NEON PROGRAM	TEMPORARY PROGRAM
Age	Yes	Yes
Special Need	No	No
Identification	Yes – See Exception below	Yes – See Exception below
Social Security Number	Yes	Yes
Citizenship	Yes	Yes
Immunization	Yes – See Exception below	Yes – See Exception below
Relationship	Yes	Yes
Custody	Yes	Yes
Residency	Yes	Yes
Household Composition	Yes	Yes
Purpose of Care	Yes	Yes
Child Support	Yes	No
Income	Yes	Yes

Exceptions:
Identification – all applicants and authorized representatives must provide identification at application.
Immunizations – Immunization records are maintained by all providers; therefore, verification is not required to be maintained in the case file. Refer to MS 600 for additional information on immunization records.

420 WORKING

Applicants may be eligible for child care subsidy while they are working. This includes travel to and from their employment. To be considered *working* the individual must receive monetary compensation for their services. Refer to MS 300 for information on individuals who claim no compensation for a period greater than 30 calendar days.

Note: Individuals who are working in exchange for a benefit (income in kind) may be eligible for child care. The CCDP DWSS Child Care Chief will evaluate these cases via a special consideration request.

420.1 Additional Information

- Travel time is allowed for individuals to commute to and from work; however, it must not exceed 60 minutes each way.
- Eight hours of sleep time is allowed for individuals who work a graveyard shift when there is not another parent/caretaker available to provide care during that time period. Sleep time should only be allowed for parents/caretakers of non-school age children unless the school age children are on summer or track break. Clients must choose either care for sleep time or care for employment; care cannot be subsidized for both.

  Note: Graveyard shift = shift starts between 9:00pm and 4:00am.
- A client with a working POC is allowed to use subsidy assistance if required to attend court. A copy of the applicable court document must be provided as verification.

430 JOB SEARCH

Job search is defined as an activity that demonstrates an individual is actively seeking potential employment. Job search purpose of care is subject to available funding and may not be offered. The CCDP Chief makes this determination and notifies the Child Care offices. Qualifying job search activities include:

- Completing applications in person or on-line computer applications; or
- Interviews; or
- One-time resume preparation; or
- Employment preparation (testing, sheriff's card, purchasing appropriate work clothes, etc.).

Applicants, including foster and CPS households, may be eligible for child care while seeking employment.

430.1 Additional Information

The following guidelines apply to individuals who participate in the Child Care and Development Program Job Search.

- Child Care Job Search is limited to 4 weeks in a calendar year (January through December).

  Note: The job search start date can start on any day of the week. The 7-day (week) period will be determined by the start date entered in the computer system. Child Care staff must work with the client to determine what start date best suits the needs of the client.
- Certificates can be issued up to a maximum of 4 weeks each time the household is eligible for job search. To allow flexibility during the job search period the Certificate schedule should allow for a maximum 5 full-time-days with a varied schedule.

  Note: The 4-week time period is tracked in the computer system. If the provider bills and is paid for at least 1 day of service during an approved week, the computer system applies a full week of job search as used.

- Households will not be eligible for job search if the only eligible child(ren) is school age (6-to 12-years) or "special needs" (13-to 19-years). The job search can be done while the child(ren) is in school. If the child(ren) is not in school, (e.g., summer break, track break, holidays) job search will be allowed.

  Exception: If a child is enrolled and verified to attend part-day kindergarten, coverage can be provided for job search.
- Individuals must sign the Job Search Eligibility form which informs them of all job search requirements.
- If employment is secured during the job search period, or within 45 days of completing an approved job search period, the household may qualify for continued services as long as all other program guidelines are met. Refer to MS 100 regarding exceptions to wait list placement.
- Providers must be reimbursed based on the number of authorized days the child was in care.

TWO PARENT/CARETAKER HOUSEHOLDS

Two parent/caretaker households may be eligible for job search activities, if one of the parents/caretakers is unable to care for the child due to their activity schedule (e.g., one parent is working during the day when most employers are open for business and/or conducting interviews).
If both parents/caretakers are requesting job search, justification for why one parent/caretaker cannot care for the child while the other is seeking employment must be provided. The extenuating circumstances must be examined and approved by the case manager prior to authorizing benefits.

440 HOMELESS SELF SUFFICIENCY PLAN

A homeless self-sufficiency plan is a plan created by the household to help them work towards regaining housing and meeting other needs in regards to food, utilities, transportation, clothing, and child care with minimal or no assistance or subsidies from others.

Homeless households may be working with another agency or organization to help them regain housing and to become self-sufficient. Other homeless households may have their own plan and are working independently.

All homeless self-sufficiency plans will be discussed with the CCDP Chief and approval will be determined on a case by case basis.

450 STUDENT

Part-time or full-time students who need child care while attending school. Student purpose of care is subject to available funding and may not be offered. The CCDP Chief makes this determination and notifies the Child Care offices. To be eligible as a student, an individual must attend an accredited community college, college or university program. In addition, enrollment and attendance of six (6) or more credit semester hours is required.

If a student is taking a series of classes within a semester which as a whole meet the minimum credit requirement, but the classes are only taught one at a time, they are still eligible as long as they acquire a minimum of six (6) credit hours within the semester.

450.1 Minor Parents

Minor parents must be attending school to acquire their high school diploma or their GED. Minor parents can be part-time or full-time students who need child care while attending school. As long as school is the primary POC category, the minor parent may qualify for additional child care services under another category (i.e., working).

Minor parents must qualify under another eligibility category if they have graduated high school or received their GED.

450.2 Additional Information

- A schedule of classes from the school must be submitted for verification of the schedule.
- Travel time is allowed for students to commute to and from class/school; however, it must not exceed 60 minutes each way.
- Study time is allowed for up to 2 hours per day, as long as it is on the same day for which care is already authorized per the class schedule. Additional days will not be authorized for the sole purpose of studying.

460 TRAINING

Clients can be eligible for subsidy benefits while attending vocational school, GED preparation, or an employment preparation program.

To be eligible for subsidy benefits, the client must attend:

- Twenty (20) hours or more per week.
- A post-secondary institution that offers vocational educational programs; or
- A program which provides for the completion of the equivalent to a secondary school diploma (such as a GED); or
- A program that offers defined and verifiable employment preparation training.

460.1 Additional Information

- To be eligible under this purpose of care category, the client must not receive compensation for their services. If the individual receives compensation, they must be served under the “Employed” eligibility category.
- The client must submit verification from the designated training organization of:
    - The name, address and phone number of the training organization;
    - The client’s start date with the program;
    - The client’s expected schedule;
    - The location of the training site;
    - The length of each session;
    - If additional study time is required; and

  - The client's expected completion date.
- Travel time is allowed for clients to commute to and from the training sessions; however, it must not exceed sixty (60) minutes each way.
- Study time is allowed for up to two (2) hours per day, as long as it is on the same day for which care is already authorized per the client's training schedule and it was noted as a requirement in the verification completed by the training organization.

470 DISABILITY

Applicants who have a disability can request child care subsidy during the disability period, as long as they have someone else to care for the child when the child is not in daycare.

Example: The spouse or other responsible adult individual in the home of an individual who is disabled is employed during the day, but can care for the children before and after work.

If the household does not have anyone else to care for the children, they are ineligible for benefits under this POC. In addition, if circumstances warrant concern for the care and safety of a child a referral must be made to Child Protective Service (CPS) by submitting the CPS & Child Care Licensing Report form.

470.1 Additional Information

- A disability is defined as an incapacity or health condition, which severely limits the individual's ability to care for the child. The household must provide verification from a physician or qualified medical professional verifying the individual's inability to provide care for the child(ren).
- The certificate schedule may vary depending on the purpose of care schedule for the alternate caretaker.

Ongoing Case Management

500 CHANGES

501 Introduction

Changes are situations that occur in a household, which may affect eligibility or the subsidy percentage the Child Care and Development Program will pay on the client's behalf. Action must be taken on reported changes to ensure program integrity is maintained by issuing benefits timely and accurately.

Changes can be reported by:

- The client
- The authorized representative
- Another household member
- An employer
- A provider
- Another agency
- A DWSS employee (I&R, QC, FSS, NEON case manager, etc.).

Note: All changes reported by a third party (other than the client or authorized representative) must be verified before an action can be taken on the case.

510 HOUSEHOLD REPORTING REQUIREMENTS

511 What to Report

Households are advised of their responsibility to report the changes listed below:

- Household composition;
  Examples: required household member moves in or out, marital status changes, etc.
- Residence and/or mailing address;
- Child care provider;
- Schedule changes;
- A new or increased source of income.

Note: If a NEON eligible client reports a change in their NEON activity refer the client to their DWSS case manager and notify the DWSS case manager of the change. Do not terminate the NEON case. A NEON case can only be terminated if it is verified the TANF case has ended or the DWSS case manager requests the child care case be terminated.

These changes may require a new certificate be issued for Certificate cases; however, the original end date of the certification period must not change unless the change caused total ineligibility (i.e. over income, etc.), or it is discovered the certification period end date was incorrectly authorized.

512 Timeframes for Reporting Changes

Timely - changes reported within 10 calendar days from the date the change occurred.

Untimely - changes reported after 10 calendar days from the date the change occurred.

513 How to Report

Household members or their authorized representative (AR) may report changes in person, by telephone, fax, email, or through the mail.

Note: All Changes reported must include information to identify the client and/or case.

514 Receipt of Reported Changes

Upon receipt of a reported change, the case manager must ensure the following actions are completed:

- Date stamp the reported change document with the date the information is received by the Child Care and Development Program office; or if a change is reported by phone, the following information must be documented:
    - The reported change; and
    - The date the change occurred; and
    - Who reported the change; and
    - The date the change was reported;

      Note: If change report is received via email or fax, use the date the change is transmitted electronically.
- Identify all related cases affected by the change and notify the applicable case manager or delegate agency.

520 PROCESSING REQUIREMENTS

521 Updating Changes

No changes to the household's initial eligibility or increased subsidy percentage or authorized schedule will be made until the recertification period unless:

- It is a benefit to the household; or
- The result of an Intentional Program Violation (IPV); or
- The change causes ineligibility; or
- The initial or increased eligibility determination was incorrect or based on incomplete information.

Examples:

- Upon a case review, it is discovered that income was budgeted incorrectly
- Client statement was used for a best estimate of new employment income and now the client has a sufficient pay history

Changes in income and purpose of care must be made in the computer system for reporting purposes, but subsidy percentages and authorized schedules must not decrease.

Examples:

- Household reports a raise of $2.00 per hour. Once verification is received, calculate the new income but do not decrease the subsidy percentage.
  Note: An income deduction for the amount of the increased income must be used to keep the subsidy percentage the same.
- Household reports that 2 required members have moved out of the household. Remove any income associated with the 2 members but do not remove the members from the household.
  Exceptions:
  - If the 2 members that left the household apply for benefits on their own, remove the household members from the original case and override eligibility to keep the original subsidy percentage the same. The case for the 2 members that left the household will be processed as a new application.
  - Foster and CPS children must be removed from the foster/CPS group set when they are no longer in the home or are adopted by the foster family (see MS 525.1 for more information).
  - Household reports that employment hours have decreased from 40 hours per week to 30 hours per week. The household's income will be adjusted, once verification has been received, but the authorized schedule must not be reduced.
  - Household reports a change in purpose of care (i.e. job search to employment). Purpose of care category must be changed to the appropriate category.

Once a change has been made on a case to increase the initial subsidy percentage or schedule, a subsequent reported change must not negatively impact the case unless that change causes ineligibility (over 85% of SMI).

Example: Household is approved on 3/1 with an employment POC and her schedule is Monday – Friday, 8:00am – 5:00pm. On 5/10 client reports that she lost her job. Case is updated to remove employment income, increase the subsidy percentage, and no change is made to the schedule. On 6/15, client reports that she found a part-time job. Income and POC will be added for data collection purposes, but the subsidy percentage and FT schedule must not change.

Changes to funding/eligibility categories, providers, schedule, subsidy percentage, etc., may require a new Certificate to be issued for Certificate cases; however, the original end date of the certification period must not change unless the new purpose of care requires it , or it is determined the case was approved in error and benefits must be terminated.

The case manager must update the case or request required verification within 10 calendar days from the date the change is reported/discovered. Multiple changes reported at the same time must be verified and updated at the same time.

522 Actions on Changes

Case managers are responsible to act timely on all changes reported by the client, or discovered another way. The household has 10 calendar days to report the change; the agency has 10 calendar days to act on the change; and, notification must be sent to the household of any changes to their benefits. If advance notice of an adverse action is required (refer to MS 532) 10 calendar days is allowed. Case managers must review the change to determine how and when it will affect the household's benefits.

If the case can be updated without obtaining additional verification, update the case within 10 calendar days from receipt of change. If the change results in a subsidy decrease as the result of an IPV or ineligibility, refer to MS 532 for adverse action rules.

If verification is required to update the case, request the information via a Request for Information (RFI), form 2156-WC allowing the client 10 calendar days to provide the verification. When the due date falls on a weekend or holiday, the due date is the next working day.

> **Exception**: Victims of Domestic Violence approved for a fictitious address through the Secretary of State's CAP program must be allowed seventeen (17) calendar days to provide verifications due to mail forwarding.
>
> **Note:** If a change reported by email or fax is received on a weekend or holiday, the 10 calendar day period to update the case starts on the business day following the weekend or holiday. Notify the household of any increase/decrease/termination with a Notice of Action, form 2158-WC and a new Certificate must be issued for all Certificate cases.

Receipt of third-party calls or verification reporting changes may also be used. Third-party calls reporting changes need clarification and/or supporting verification before impacting eligibility and/or subsidy benefits.

522.1 Moves within the State

If a household moves to an area covered by a different child care office, the case must remain open and be transferred to the appropriate office within 3 business days of the reported change. Once received by the new office, the case manager must update the case and request any necessary verification within 10 calendar days. Requests must be made via a Request for Information (RFI), form 2156-WC allowing the client 10 calendar days to provide the verification. When the due date falls on a weekend or holiday, the due date is the next working day.

> **Note:** If the move results in the need to change providers, the case manager should end the current child enrollment record prior to transferring the case.
>
> Case managers must not calculate eligibility at this stage.

522.2 Mass Changes

The state or federal government initiates changes that affect all or a large number of households.

Mass changes generally occur in:

- Income eligibility standards; or
- State maximum provider rates; or
- Other eligibility criteria based on legislative or regulatory actions.

Some mass changes, such as the income standards, are updated automatically and benefits are adjusted effective the date of the change. Cases may require the case manager to update manually. For manual updates, mass changes may be applied to the household on a flow basis (i.e., reported change update, reapplication or the next time the case is reviewed), unless otherwise specified.

If the change affects the subsidy percentage, a NOA and Certificate (for Certificate cases only) must be sent to the client and a Certificate (for Certificate cases only) or NOD must be sent to the provider.

522.3 Changes Affecting Funding Categories or Programs

Changes reported in the middle of a certification period which necessitate the transfer of funding categories or programs are updated as follows:

NEON to At-Risk or Discretionary:

- An application must be submitted within 30 days of the NEON/TANF grant ending (due to no fault of their own);
  Note: Applications received after the 30 day window will be processed as a new application. Refer to MS 100 for new application processing.
- Verification of all non-financial and financial information is required;
- Certification period will be approved for no more than 365 days.

At-Risk or Discretionary to NEON:

- A valid NEON Child Care Referral must be received (new application is not required;
- Certification period will be approved based on the start date on the NEON Child Care Referral.

Contracted Slots or Wraparound Services to At-Risk Certificate:

- A new application must be submitted and the household must requalify for benefits based on current income;
- Current wait list rules apply;
- Certification period will be approved for 365 days.

At-Risk Certificate to Contracted Slots or Wraparound Services:

- Child Care staff must verify that a slot is available;
- Current application and verifications will be retained at the appropriate Child Care office;
- Certification period will be the remainder of the original certificate period for Contracted Slot cases and up to the maximum certification period allowed for Wraparound Services (refer to MS 800).

Note: If a certificate household transfers to a contracted slot or wraparound program, they can transfer back to certificate care without a new application as long as it is within the original 12 month certification period.

523 Complete Report of Change

If the household reports a change and provides enough information to warrant a termination of subsidy benefits, the case manager must act on the change within 10 calendar days whether or not it is verified. Termination dates must not be backdated.

> **Note:** Changes in earned income that result in a subsidy percentage decrease will not affect the case until the household's next recertification period unless the reported income exceeds 85% SMI which causes ineligibility.

524 Incomplete Report of Change

If the household reports a change without sufficient information to update the case, the case manager must send a Request for Information form, 2156-WC, allowing the household at least 10 calendar days to provide the needed information. The day after the request date is the first day of the 10-day period. When the due date falls on a weekend or holiday, the due date is the next working day. If the verification is received within the required time period, the case manager has 10 calendar days to update the case in the computer system.

If the required verification is not provided, terminate benefits allowing for 10 calendar days advance notice. If the verifications are provided during the 10-day adverse period and the household is eligible, the case may be reinstated. If the verifications are received after the 10-day adverse period, the client must provide good-cause prior to reinstatement of the case or they must reapply. Refer to MS 115 for additional information on reinstatement.

> **Exception:** If the reported change would result in an increase of benefits and the household failed to provide verification, do not terminate or update the case until the change is verified. The day verification is provided becomes the effective date of the change.
>
> **Example:** Household reports on 7/5 that her employment hours decreased from 40 hours per week to 32 hours per week on 7/1. An RFI is mailed to the client with a due date of 7/15. Client fails to provide the verification of reduced hours and does not request an extension. The case remains open budgeting 40 hours per week. On 8/1, verification of reduced hours is received by the case manager and income is adjusted effective 8/1.

When a change is reported that is questionable or conflicts with information already in the file or information from another source contradicts statements made by the household, the case manager must attempt to resolve the issue prior to approving eligibility. The household must be provided an opportunity to resolve any discrepancy by providing proof or designating a suitable collateral source. The case manager must include case notes in the computer system regarding the clarification received.

525 Effective Date of Changes

Based on the reporting timeframes in MS 512, case managers have to determine how and when a reported change becomes effective on a case.

Below is a guide to use to determine effective dates for commonly reported changes other than household composition changes:

Type of Change	Timely Reporting	Untimely Reporting
Income Increase	Date reported/discovered	Date change occurred
Income Decrease	Date change occurred	Date reported/discovered
Provider change	Date change occurred	Date reported/discovered
Schedule change	Date change occurred	Date change occurred

525.1 Household Composition Changes

When required household members leave or join the household, case managers must determine if the change has a positive or negative impact on the case. For changes that make a positive impact, the effective date of the change is the date the change occurred for timely reporting and the date the change is reported or discovered for untimely reporting. For changes that have a negative impact, the effective date of the change is the date the change is reported/discovered for timely reporting and the date the change occurred for untimely reporting.

Temporary absences for up to 90 days are allowed when the child(ren) is expected to return to the household. If the child(ren) remains in Nevada, child care can continue to be used without an eligibility determination for the 2nd household as long as they are using the same provider and the responsible parent on the case agrees to pay any fees or overages incurred during the temporary absence time period.

> **Note:** When a child leaves one subsidy household and joins another subsidy household (other than a temporary absence as explained above), the left household date is the first full day the child was not present in the home. The entered household date in the new case is the first day the child was present in the home. These dates may be the same, if the child left one subsidy household in order to join another subsidy household, as in the case of foster or CPS children reunified with their family.

When it is reported or discovered that a foster child has moved out of the home, the case manager must evaluate all cases which are affected by the change and update the cases appropriately.

> **Note:** Foster children who are adopted by their foster parent(s) must continue to receive child care for the remainder of the certification period as long as all countable household income is below 85% SMI. Since there are system requirements regarding name and social security number changes for adopted children, the adopted child must be removed from the foster group set and added to the traditional group set in NCCS but should still be served at 100%.

If the adopted parents have an existing case for other natural or adopted children (traditional group set), they must be given the choice of adding the adopted child to that traditional group set at the subsidy percentage they are eligible for or to end child care for the other children and continue to receive 100% subsidy for the newly adopted child.

All changes that are reported untimely must be evaluated for a possible IPV and/or overpayment.

526 Underpayments/Overpayments

Some actions on reported/discovered changes may result in an underpayment or overpayment of subsidy benefits.

526.1 Underpayments

For all underpayments, the effective date of the change is the date it is reported by the household or the date the change is discovered by the Child Care staff or DWSS, regardless of when the change actually occurred. Normal budgeting rules must be applied when determining if an increase to a previously paid benefit month should be considered due to changes in the household.

If it is discovered that the Child Care staff made a mistake in determining the household's eligibility, which resulted in an underpayment, the household must be paid the difference. The underpayment must be calculated beginning on the date the incorrect decision was made. Reimbursements may be made directly to the client or through a subsidy credit with the provider. Resolution must be acceptable by all parties (Child Care staff, client and/or provider if applicable).

Examples:

- On 3/28 client reports that she is no longer receiving child support as of 03/25. RFI is mailed to client for verification on 3/29 and verification is provided by the client on 4/5 (payment has already been made to the provider for March). The household would be eligible for a potential underpayment effective 3/28.
- On 6/10 it is discovered that the case manager miscalculated the household's income at the time of case approval on 4/20 and the household should have been eligible for 95% subsidy instead of 90%. The household is eligible for an underpayment effective 4/20.

Note: If the need for an underpayment is discovered for a period in which the subsidy payment has not been made yet, eligibility must be recalculated so the correct payment is made to the provider.

If an underpayment is due when there is an existing overpayment balance, the entire amount of the underpayment is offset against the overpayment balance. No underpayment may be issued against a closed case when there is an existing overpayment balance.

526.2 Overpayments

If it is discovered the household reported untimely or failed to report a change, and they received benefits they were not entitled to, the case manager must evaluate for an overpayment of benefits and a possible IPV. When multiple changes are reported at the same time, the overpayment period must include all the changes.

Determine the period of overpayment using the following method:

1) Determine the date the change was effective.
2) Add 10 calendar days for reporting the change.
3) Add 10 calendar days for updating the case.
4) Add 10 calendar days if advance notice is required. Refer to MS 532 regarding advance notice of an adverse action.
5) The resulting date is the first day of the overpayment period.

Examples:

- On 6/13 it is discovered the client started receiving RSDI for two children effective 4/1. Verification is obtained from DWSS on 6/15 and the case is updated the same day terminating the case for excess income (over 85% SMI) effective 6/25 (advance notice of the adverse action is allowed). Allowing the 10 days + 10 days + 10 days, the effective date of the overpayment would be 5/2 thru 6/25.
- On 6/25 I&R reports the father of the client's child has been living in the household since the application date and does not have a purpose of care. Verification is requested and received on 7/3. The action to terminate the case is taken on 7/8 with 7/18 as the effective date of the termination. Since the case would have been ineligible due to the father of the child not having a purpose of care, the overpayment would be calculated from the first day benefits were issued.
- It is discovered and verified on 5/15 that the only eligible child permanently left the household on 4/1. Case is closed on 5/16 not allowing for 10 days advance notification and the overpayment is calculated from 4/1 – 5/16.

Note: Refer to MS 530 if there are multiple eligible children and some remain in the home.

530 NOTIFICATION TO THE HOUSEHOLD

Clients must receive a Notice of Action, when changes are made to their case, regardless if the benefits have been increased or decreased.

Note: A new certificate must be issued for all Certificate cases with a change to benefits, schedule, or certification period.

If the client did not report timely or failed to report a change, a Timely and/or Accurately Reporting form, 2184 must be sent to the client. If the client fails to report or untimely reports after receiving form 2184, the case manager should evaluate whether or not the circumstance requires an IPV. Refer to section 700 for IPV information.

531 Notice of Action

The Notice of Action must advise the household the reason for the case record change, benefit increase/decrease amount and the effective date of such action.

If a corrected notice is sent, a new advance notification period is created. Action to deny or terminate benefits based on the original notice no longer applies.

531.1 Certificate

A new Certificate must be sent for all Certificate cases.

The original Certificate must be signed and dated by the case manager or program staff and kept in the eligibility case file and copies provided to:

- The applicant; and
- The provider; and
- The DWSS case manager for all TANF and SNAP cases.

532 Adverse Actions

An adverse action is any action that negatively impacts a case after approval of benefits. All adverse actions require a notice of action be mailed to the household. Examples of possible adverse actions are (not all inclusive):

- The only eligible child permanently leaves the household
- Household reports income over 85% of SMI
- Household moves out of state
- An IPV is imposed against the household
- Household fails to provide requested verification (Refer to MS 532)
- Change in household composition
- The household requests a reduction or termination
- The parent/caretaker is deceased and there is no other required adult member in the household
- The household's address is unknown and mail has been returned by the post office; or information verifies the household is no longer at the address last provided and a new address is not known. The case manager must attempt to contact the client by phone or email prior to termination of the case.

Most adverse actions require that the household receive written notice 10 calendar days before the change is effective. Clients may continue to use child care during the 10 day advance notification period. The day after the notice is sent is the first day of the 10 day period for cases requiring advance notice.

> **Example:** The case manager imposes an IPV on 1/8 that decreases a client's subsidy from 95% to 80%. A Notice of Action is sent the same day. The effective date of the subsidy decrease would be 1/19.

532.1 10-Day Advance Notification *Not* Required

The following adverse actions do not require 10-day advance notification:

- The only eligible child permanently leaves the household
- Household moves out of state
- The household requests a reduction or termination

> **Example:** The case manager takes an action on 1/8 to terminate the case per the client's request. The effective date of the termination would be 1/9. A Notice of Action is mailed to the client.

540 REAPPLICATIONS

At-Risk and Discretionary funded households must re-qualify for benefits at the end of each certification period to continue to receive assistance. Refer to MS 541 for information regarding reapplications for NEON funded households.

For certification periods greater than 30 days, the household must be notified in writing that they must reapply. Written notification must be sent no sooner than 45 days or less than 20 days prior to the end of the current certification period. The household must submit a new application for benefits by the last day of the current certification period to be considered a timely reapplication.

If funding is not available and the household reapplies for benefits prior to the end of their current certification period and all eligibility requirements are met, they may receive continued benefits without being placed on a wait list. If the household submits an application after the end of their certification period and funding is not available in the category for which they qualify, they may be placed on a wait list.

Verification used to re-establish eligibility must be current (within the last 30 calendar days from the date the application is date stamped received). The case manager must review the previous income, to project the future income. If the client is changing jobs or anticipates a change, their income must be projected as explained in MS 312.

> **Note:** If the new income projection reduces the household to a subsidy percentage that is not currently being served because of funding shortages, but remains under 85% of SMI, eligibility will continue for an additional 365 days at the new subsidy percentage.

If all required verification is not received with the application, a Request for Information form must be sent to the household allowing at least 10 calendar days to provide the information. When the due date falls on a weekend or holiday, the due date is the next working day.

If the required verifications are received within the requested period and all other eligibility requirements are met, the case manager must take action on the application within 10 calendar days from the date the required verifications are received.

If the required verification is not received within the requested period, take no action to deny the renewal application until date the renewal would have been effective. If the required verifications are provided before the date the renewal would be effective and

all other eligibility requirements are met, the case manager must take action to complete the renewal process within 10 days of receipt of the required verifications.

Renewal applications must be evaluated for changes that would affect the current certification period. The effective date of the change is the date the renewal application is dated stamped as received by the Child Care office. Do not take a negative action on the current certificate if advance notice of adverse action is required and there is less than 11 days to the end of the current certificate.

> **Note**: If the required verifications are not provided within the requested period, terminate the current application allowing advance notice as required per MS 532.

541 Reapplications for NEON Funded Households

Once a client has been approved for NEON funded subsidy, a new application, Service Agreement and Program Penalties form is not required to continue receiving NEON funded services unless an interruption in TANF benefits, greater than a calendar month, has occurred since the previous referral was received.

Case managers must notify the DWSS case manager that a new NEON referral is needed at least 10 days before the expiration date. Case managers are not required to notify clients that they must reapply; it is the DWSS case manager's responsibility to evaluate the clients child care needs and issue a new referral when needed.

If the child care certification period has expired and a new referral is received, the new certification period should be based upon the dates requested on the new referral. Refer to MS 116.1 for more information on NEON Referrals.

Provider Information

600 PROVIDER INFORMATION

601 Introduction

Providers must be registered by Child Care staff in order for the provider to be reimbursed through the Child Care and Development Program. Certain provider types are required to be licensed according to state or county regulations.

Clients have a choice in selecting a Licensed, Non-Licensed, or License-Exempt Child Care Provider. Child Care staff must not recommend or endorse any child care provider programs or services. Families should be encouraged to explore quality child care, check the QRIS website, and visit/interview several provider sites prior to making a final decision.

The following individuals are not authorized to be reimbursed for providing child care services:

- The natural/adoptive parents or legal guardians, whether or not they are living with the child; or
- Anyone living in the same residence as the child, unless the child is verified to have a special need (refer to MS 211 for special needs requirements); or
  Note: To be considered a separate residence each dwelling must be self-contained (have its own kitchen, bathroom, bedroom, etc.), have its own mailing address recognized by the U.S. Postal Service and a separate utility meter for the applicable utility company.
- Anyone who is a parent/caretaker on their own subsidy case (i.e., an individual cannot simultaneously be an applicant/recipient of the Child Care and Development Program and receive payments as a child care provider).
  Note: This includes owners of licensed or home child care facilities unless care is provided by another authorized provider.

610 PROVIDER REQUIREMENTS

All providers are required to cooperate with the Child Care and Development Program in securing all information needed to determine initial or continuing eligibility. All documents may be mailed, dropped off in person, faxed or scanned (faxed and scanned documents are considered original documents). Individual requirements for the different provider types are listed in the Provider Types Section. Failure to provide required information results in denial or termination from the program. Reimbursement for services cannot be made until all required registration items are received by Child Care staff.

611 Provider Registration Packet

All providers must complete a Provider Registration Packet which includes:

- Provider Registration Form
- Provider Payment Option Form
- W-9 Request for Taxpayer Identification
- Provider Service Agreement or MOA

611.1 Provider Service Agreement

The Service Agreement details the requirements and penalties for providers while participating with the Child Care and Development Program. For providers who are licensed through a state or county licensing agency, the Service Agreement notifies providers of their requirement to adhere to all state and county regulations.

The provider must sign a new Service Agreement when amendments to the Service Agreement are made. The original signed document must be kept in the provider case file and a copy given to the provider for their records.

> **Note:** If it is determined that any provider has not adhered to provisions of the Service Agreement Child Care staff must follow procedures in MS 690. Additionally, if Child Care staff discovers a licensed provider has violated any licensing requirements, they must report the violation to the appropriate licensing agency using the CPS & Child Care Licensing form and follow procedures in MS 690.

612 Immunization Records

All providers are required to keep the child's immunization record on file and verify with the parent that the record is current. These records must be made available to Child Care staff upon request.

Exceptions:

- In-home care and care provided by a "qualified relative" in the relative's home is exempt from this requirement unless there are other unrelated children present. A "qualified relative" is defined as grandparents, great grandparents, siblings, aunts, and uncles; or
- The child has a medical condition that prohibits immunization and this is verified by a physician's written statement; or
- Kindergarten through 12th grade students who attend a public or private school.

613 Cooperation with DWSS

Provider records may be selected by DWSS to be reviewed as to the accuracy of subsidy benefits paid or allotted. All providers are required to cooperate with the review process. Failure to cooperate can result in an overpayment for the review month. If the provider fails to cooperate, DWSS will notify the child care office in writing of non-cooperation. If the provider contacts the child care office wishing to cooperate, the child care office must advise the provider to contact the applicable department responsible for reviewing the case (i.e., Investigations or Quality Control).

620 PROVIDER TYPES

There are 3 types of providers in the Child Care and Development Program:

1. Licensed Providers
2. Non-Licensed Providers
3. License-Exempt Providers

621 Licensed Providers

All providers licensed for child care services through a state or county licensing agency must adhere to the state or local child care licensing statutes/regulations, including maintaining the applicable child/caregiver ratios and authorized hours/days of operation. If Child Care staff discovers a provider has violated any licensing requirements, they must report the violation to the appropriate licensing agency using the CPS & Child Care Licensing form and follow procedures in MS 690.

Licensed Providers Include:

Child Care Centers (Includes Nursery Schools and Preschools)
Offer care for a minimum of 13 or more children in various age groups in a non-residential setting. Nevada requires centers to be licensed. Licensing does not insure quality but it does set minimum health, safety and caregiver training standards which centers must maintain.

Note: State-funded Pre-K programs are currently exempt from child care licensing.

Group Family Child Care Homes
Generally offer care in the providers' residence. Often the home has a specific area for the children and has been approved to accommodate up to 12 children.

Family Child Care Homes
Offer care in the providers' home. Family child care providers can care for up to 6 children. Some family child care providers also receive approval to care for 3 additional school-age children.

In addition to the requirements in MS 611 – 614, all licensed providers must provide:

- Copy of Current Child Care License at initial registration and license renewal verification annually; and
- Copy of center/program Parent Contract

The provider must be allowed 30 calendar days from the date the Provider Registration Form is date stamped to submit all required paperwork (the day after the date stamp is day one in the 30 day count). If the information is received within the requested time period, reimbursements can begin the date of the client's subsidy application (or reported change) or the first day care is provided, whichever is later. If the information is received after the allowable 30 day period, reimbursements will begin the date all required information is submitted.

622 Non-Licensed Providers

The Family, Friend, or Neighbor (FFN) Provider is a Non-Licensed Provider. FFN providers can be a relative or non-relative and may provide services in the child's home (in-home) or in their own home (out-of-home). FFN providers who offer in-home services must care for a minimum of two (2) subsidy children to be eligible as an in-home provider.
In addition to requirements in MS 611 - 614, all FFN providers must:

- Provide proof that they are at least 18 years of age; and
- Be a U.S. citizen or Lawful Permanent Residence; and
- Provide a picture ID; and
- Provide a Social Security Card; and
- Have a working telephone for emergency situations at the location where care is being provided; and
- Provide verification of home address (see MS 216.3 for acceptable verifications); and
- Complete a Background Disclosure Form; and
- Report any public assistance received from any state, city or county agency using the Notice to Report Form; and
- Complete the Employers Responsibility Form; and
- Complete the Parent/Provider Agreement; and
- Complete Health & Safety training (see MS 622.3 below)

FFN providers must also meet all state, county, or city child care provider requirements which are in effect within the jurisdiction in which they provide services, including maintaining applicable child/caregiver ratios.

The provider must be allowed at least 10 calendar days to submit all required information. If the required information is received within the requested time period, reimbursements can begin the date of the client's subsidy application (or reported change) or the first day care is provided, whichever is later. If the required information is not received by the 10th calendar day, reimbursements will begin with the date the child care office received and date stamped all the required information as long as it is within 30 days of the original request and the client is still eligible. The parent is responsible for payment to the provider for any days not covered by the Child Care and Development Program. Any exceptions must be submitted to the DWSS Child Care Chief, for special consideration.

The client must be notified in writing if the provider is not eligible through the Child Care and Development Program. Services are not covered until the provider cooperates or until they choose a new provider that is eligible.

622.1 Provider Background Disclosure Form

Section 658H of the amended Child Care and Development Block Grant Act states that a child care provider or staff member shall be ineligible to receive Child Care and Development Funds if the individual has been convicted of a felony consisting of:

- Murder, as described in section 1111 of title 18, United States Code;
- Child abuse or neglect;
- A crime against children, including child pornography;
- Spousal abuse;
- A crime involving rape or sexual assault;
- Kidnapping;
- Arson;
- Physical assault or battery; or
- A drug-related offense committed during the preceding 5 years.

OR

- Has been convicted of a violent *misdemeanor* committed as an adult against a child, including the following crimes: child abuse, child endangerment, sexual assault, or of a misdemeanor involving child pornography.

Case managers must ensure that a background disclosure form is completed by all potential FFN providers and that all potential FFN providers are free of any of the charges listed above.

All household members over the age of 18 and any adult non-household members who will have access to the child(ren) being cared for must also be free of any of the charges listed above.

Any questionable situation involving a potential FFN provider, a household member, or someone who will have access to the child(ren) must be discussed with a supervisor and the decision to approve or deny the provider must be documented.

622.2 Home Visits

Child Care staff is responsible for inspecting all providers being reimbursed with CCDF (Child Care Development Fund) funds to ensure they are complying with minimal health and safety requirements. Out of home non-relative providers must have a current negative TB test or good health statement from a medical professional at initial enrollment and then every two years as long as they are enrolled as a provider with the Child Care and Development Program.

All FFN providers are subject to a home visit within 45 calendar days of enrollment and a minimum of once a year thereafter. All home visits can either be scheduled or unannounced.

Follow procedures in MS 690 for providers who fail to comply with this requirement after reasonable attempts to accommodate the providers schedule have been made.

Note: Unannounced visits to providers are encouraged when Child Care staff believes that compliance with the program rules and/or regulations or the health and safety of the children receiving subsidized benefits are compromised.

The FFN Annual Health & Safety Checklist must be completed during the home visit and providers must meet the standards outlined in the Administration for Children and Families, Caring for Our Children Basics in the following areas:

- Monitoring Children's Development/Obtaining Consent for Screening
- Methods of Supervision of Children
- Supervision near Bodies of Water
- Prohibited Caregiver/Teacher Behaviors
- Active Opportunities for Physical Activity
- Safe Sleep Practices and SIDS Risk Reduction
- Routine Oral Hygiene Activities
- Diaper Changing Procedure
- Situations that Require Hand Hygiene
- Prevention of Exposure to Blood and Body Fluids
- Routine Cleaning, Sanitizing, and Disinfecting
- Use of Tobacco, Alcohol, and Illegal Drugs
- Emergency Procedures
- Recognizing and Reporting Suspected Child Abuse, Neglect, and Exploitation
- Preventing and Identifying Shaken Baby Syndrome/Abusive Head Trauma
- Sun Safety Including Sunscreen
- Strangulation Hazards
- Care Plan for Children with Special Health Care Needs
- Infectious Disease Outbreak Control
- Medication and Training for Administration and Storage of Medication
- Fire Extinguisher (not included in Caring for Our Children Basics)
- Smoke Detectors-Detectors Installed and Operational (not included in Caring for Our Children Basics)
- Safety Covers and Shock Protection Devices for Electrical Outlets
- Location of Electrical Devices near Water
- Integrated Pest Management
- Household Pets (not included in Caring for Our Children Basics)
- Use and Storage of Toxic Substances
- Safety of Equipment, Materials and Furnishings
- Cribs – Infants/Toddlers
- Firearms
- Play Areas/Playgrounds
- Prohibited Surfaces for Placing Climbing Equipment
- Inspection of Indoor and Outdoor Play Areas and Equipment
- Lifesaving Equipment
- Water in Containers
- Qualifications for Drivers
- Child Passenger Safety
- Interior Temperature of Vehicles

- Immunization Documentation/ Unimmunized Children
- FFN Binder
- Written Plan and Training for Handling Urgent Medical Care or Threatening Incidents
- Disaster Planning, Training and Communication
- Authorized Persons To Pick Up Child

If the provider is found to be in non-compliance at the home visit, they must be given up to 30 calendar days to make the noted corrections. Recommendations for improvement must be made in writing to the parent and provider and a follow-up visit must be scheduled. If improvements are not made within the required time period, the provider must be terminated from the Child Care and Development Program giving the client 10 days to find a new provider.

Exception: In-home care. Recommendations for improvements must be made however termination must not occur if recommendations for improvement are not pursued.

If at any time Child Care staff believe the health and/or safety of the child is at risk, regardless of the type of care, Child Care staff must assess the situation to validate if a report with the Department of Child Protection Services should be made. If there is validation for a report, the CPS & Child Care Licensing form will be completed, the original copy sent to the applicable licensing agency and a copy of the form kept in the provider file.

622.3 Pre-Service and Annual Training

Non-licensed providers must take 30 hours of health and safety training pre-service or during an orientation period of 90 days.

Mandatory Training Topics:

- Prevention and control of infectious diseases
- Prevention of sudden infant death syndrome and use of safe sleeping practices
- The administration of medication, consistent with standards for parental consent
- The prevention of and response to emergencies due to food and allergic reactions
- Building and physical premise safety
- Prevention of shaken baby syndrome and abusive head trauma
- Emergency preparedness and response planning for emergencies resulting from a natural disaster, or a man-caused event (such as violence at a child care facility)
- The handling and storage of hazardous materials and the appropriate disposal of bio contaminants
- Appropriate precautions in transporting children (for providers that offer transportation)
- First aid and cardiopulmonary resuscitation
- Nutrition and physical activity (optional)

To be completed with the recommended schedule as follows:

Within 30 days:

- Administration of medication
- Prevention of and response to emergencies due to food and allergic reactions
- Building and physical premises safety
- Emergency preparedness and response planning
- Handling and storage of hazardous materials and the appropriate disposal of bio contaminants
- Precautions in transporting children (for providers that offer transportation)

Within 60 days (all of the above, plus):

- Recognition and reporting of child abuse and neglect
- Nutrition and physical activity (optional)

Within 90 days (all of the above, plus):

- Prevention and control of infectious diseases (including immunization)
- Prevention of sudden infant death syndrome and use of safe sleeping practices
- Prevention of shaken baby syndrome and abusive head trauma
- First aid and cardiopulmonary resuscitation (CPR) certification

After the first year, FFN providers are required to take a minimum of 24 hours of early education and child care training annually.

Case managers must work with the FFN provider to develop a training schedule to ensure that all training is completed within the allowable time frames.

Verification of completed training must be provided prior to the end of the orientation period or the end of the yearly time frame for annual training. FFN providers who fail to comply with this requirement will be ineligible to be a provider until they meet the requirement.

622.4 Changes

The following changes must be reported:

- Address (mailing or physical)
- Phone number
- Location where care is being provided
- Rates and hours
- Number of children being cared for
- Household composition (people moving in or out)
- Name change

The provider has 10 days to report changes and Child Care staff has 10 days to act on those changes. If verification of reported changes is needed, the provider has 10 days to provide verification and Child Care staff has 10 additional days to take the

appropriate action. If requested verification is not received in the allotted timeframe, the provider may be inactivated allowing 10 additional days for the client to find a new provider.

622.5 Reactivating an Inactive Non-Licensed Provider

If a provider becomes inactive and is reactivated within 60 days of the inactivation date, they can be reactivated without filling out additional paperwork as long as they are in compliance with all program requirements, their provider information has not changed, and the client remains the same.

623 License-Exempt Providers

License-exempt providers are unlicensed before and after school programs which are recreational or non-recreational, operate more than 10 hours per week, are offered on a continuous basis, provide supervision of children who are school age, and provide regularly scheduled, structured and supervised activities. These programs may be offered before and after school, on the weekend, during summer, holiday, and track breaks in the school calendar.

Examples of License-Exempt Providers Include:

- Latch Key and Safe Key
- Boys and Girls Clubs
- YMCA

In addition to requirements in MS 611- 614, all license-exempt providers must provide:

- Copy of center/program Parent Contract

630 PROGRAM RATES/ALLOWABLE FEES

631 Care Level

Rates are established based on the age of the child. Care levels have been established for 5 age groups within the Child Care and Development Program, which are:

- Infant – newborn up to 1 year.
- Toddler – 1 year up to 3 years.
- Preschool – 3 years up to 6 years.
- School Age – 6 years up to 13 years.
- Special Needs, 13 years to up 19 years (manual section 211).

Note: Care level changes are effective on the child's birthday.

632 Provider Rates

The provider can charge any rate however, the Child Care and Development Program will only pay *up to* the State Maximum Daily Rates based on provider type, care level and geographical area (manual section 633.1).

Note:

- If the provider charges a discounted rate (e.g., multiple child discount, weekly rate) which is less than the Child Care and Development Program's reimbursement rate and this results in the client owing no additional monies to the provider, the client may not be responsible for a co-payment.
- If the provider offers multiple rates within a recognized care level category, the rates will be averaged when compared to the state maximum rate. Therefore, this may result in the client being charged an amount less than what is listed on the Certificate. In this instance, the client may not be responsible for a co-payment.

At the time a provider is enrolled with the Child Care and Development Program, they must declare their daily rate for each of the care levels they serve. If a provider does not offer a daily rate but they offer weekly or hourly rates, Child Care staff must use the following procedures to determine the provider's daily rate:

- If a provider only charges by the hour, multiply the hourly rate by 10
- If a provider only charges a weekly rate, divide the weekly rate by 5
- If a provider offers multiple rates for age groups within a care level category, the various rates within the care level group must be averaged to determine the daily rate.

  Note: The Child Care and Development Program does not recognize multiple child discounts; therefore they are not to be considered when determining the least expensive rate.

Providers must not charge a subsidized client a different rate than the general populous. It is the provider's responsibility to inform Child Care staff of any rate changes they may have. Verification of changes must be received and Child Care staff must implement the changes no later than the second month following the month it was reported. Once the change is made in the computer system, the new rate is effective the second month after the month the change is made.

Example: If the rate change is entered in the computer system on 8/15, the effective date would be 10/1.

633 State Maximum Rates

Every two years the maximum state reimbursement rate is evaluated for each care level provider type and geographical area as determined by DWSS. If a provider's rates exceed the State Maximum Rate, the client is responsible for payment of the overages to the provider.

If a provider is being paid at the State maximum rate and a state rate increase occurs, the provider records must be reviewed to determine if they provider will continue to receive the state maximum rate or the provider's reported rate (whichever is less). This process must be completed by the effective date of the state maximum rate change.

633.1 Daily Rates

Market Area	Provider Type	Infants (0 up to 1 yr)	Toddlers (1 yr up to 3 yrs)	Preschool (3yrs up to 6 yrs)	School Age (6 yrs and older)
CLARK COUNTY:					
	1	31.00	28.00	23.00	19.00
	2	28.00	24.00	21.00	21.00
	3	30.00	27.00	26.00	23.00
	4	23.00	20.00	19.00	18.00
	5	N/A	N/A	15.00	15.00
WASHOE COUNTY:					
	1	35.00	30.00	26.00	26.00
	2	28.00	24.00	21.00	23.00
	3	31.00	27.00	24.00	23.00
	4	23.00	20.00	18.00	17.00
	5	N/A	N/A	15.00	15.00
CARSON/DOUGLAS COUNTIES:					
	1	29.00	24.00	24.00	21.00
	2	24.00	23.00	21.00	21.00
	3	27.00	24.00	22.00	22.00
	4	20.00	18.00	17.00	15.00
	5	N/A	N/A	15.00	15.00
RURAL COUNTIES: (Churchill, Elko, Esmeralda, Humboldt, Lander, Lincoln, Mineral, Nye, Pershing, Storey, White Pine)					
	1	27.00	24.00	22.00	19.00
	2	24.00	23.00	21.00	21.00
	3	24.00	22.00	21.00	21.00
	4	18.00	17.00	16.00	16.00
	5	N/A	N/A	15.00	15.00
PROVIDER TYPE CODES					
1 = Licensed Child Care Center, Nursery School, Preschool (Over 13 Children)					
2 = Licensed Group Care Home (7 – 12 Children)					
3 = Licensed Family care Home (1 – 6 Children)					
4 = Non-Licensed					
5 = License-Exempt (Before & After School Care Center)					

634 Reimbursable Fees

The Child Care and Development Program will pay up to $40 per child in registration and/or annual fees per calendar year. In addition, the registration fee can only be paid if the child is enrolled and attends the facility during the month the registration fee is being charged.

635 Non-Reimbursable Charges

Child care payments are not made for:

- Transportation costs
- Special activities or meal fees charged by a facility
- Absences of the child from a child care facility beyond the specified time limits (manual section 642 and 651)
- Two week advance notice for provider change/termination
- Late charges
- Tuition for private K-12 education
- Clothing/uniforms
- Any cost for a Certified Kindergarten Program (certified by the Nevada Department of Education)

640 ATTENDANCE

641 Hours in Attendance

Attendance must be noted on the Child Care Attendance and Provider Reimbursement Timesheet and billed as follows:

Infant, Toddler, and Pre-School Children
Part-time = 15 minutes to 4 hours and 29 minutes
Full-time = 4 hours, 30 minutes and greater

School-Age Children
Part-time = 15 minutes to 2 hours and 59 minutes
Full-time = 3 hours or more

Note: If the provider transports the child to/from school this time period is included when determining the child's attendance time.

If care is provided for a time period which extends between two days (9pm to 9am), reimbursement will be paid at a full time rate for one day of service.

Attendance of 14 minutes or less will not be eligible for reimbursement. In addition, 24-hour care is not eligible for reimbursement. Anyone in care in excess of 14 hours in a 24-hour day may be referred to CPS using the CPS & Child Care Licensing Report form.

642 Child Care Attendance and Provider Reimbursement Timesheet

All providers are required to submit a Child Care Attendance and Provider Reimbursement Timesheet (Timesheet) for payment and must keep a copy for each child receiving child care subsidy benefits. Timesheets must include the provider's signature and date the Timesheet is validated by the provider. The signature date cannot be prior to the date of last attendance in the reimbursement month.

Reimbursements will be processed based upon the signed and dated Timesheet from the child care provider which must include, at a minimum:

- The name of the provider; and
- The provider ID; and
- The enrollment/attendance period (Month and Year); and
- The child's first and last name; and
- The child's identifying information such as UPI, date of birth, etc.; and
- The client's name, UPI, and phone number
- In and out times for each day the child attended the facility; and

  Note: For before and after school programs, providers are required to include an in and out time for both morning attendance and afternoon attendance. Billing for a full time day when only a part-time day is warranted based on school attendance will be considered a provider violation, and an overpayment will be established against the provider for the incorrectly billed days.
- Client/Child's anticipated schedule for the month (this must be completed not later than the first day of attendance in the service month); and
- School Bell schedule (if applicable); and
- Absent day reason codes for all days the child was scheduled to attend but did not. Absent reason codes are as follows:
  - S = Sick
  - V = Vacation
  - T = Track Break
  - D = Discretionary Day (client must initial for these days)
  - U = Unenrolled
  - C = Closed (facility closed or provider not available on that day)
- The signature of the individual who dropped off/picked up the child certifying the information listed is truthful and accurate to the best of their knowledge. .If a computer generated attendance log is used to verify attendance, a signed Timesheet must still be provided to show the anticipated schedule.

Note: See MS 800 for additional information and requirements for Delegate Agencies

If the Timesheet does not include all in and out times for the child, the provider will not be reimbursed for that day. In addition, if Child Care staff has reason to believe the child was in school during the reported period on the Timesheet, school attendance should be requested before payment is made. In the event the school attendance draws a red flag, the case will be referred to DWSS I&R unit and could result in a provider penalty and overpayment.

If a client fails to sign the Timesheet after the last day of enrollment, the provider can still request reimbursement if they provide supporting documentation as to the reason the client did not sign. All attempts must be made to obtain the parents signature and Child Care staff must use prudent judgement to determine if the supporting documentation is acceptable. If supporting documentation is not available, the provider's statement can be accepted; however the reason for accepting the statement must be documented in the provider's case notes.

If a client initials in the wrong column for a discretionary day, reimbursement can occur as long as Child Care staff validates the attendance with the client and the contact is documented.

650 CHILD CARE PAYMENTS

Child care payments are made based on the parents *approved schedule* for licensed and non-licensed (FFN) providers when:

- The parent uses only one provider; or
- The parent uses multiple providers with set schedules (*example*: uses a licensed center on weekdays and a FFN provider on weekends).

Child care payments are made based on *actual attendance* when:

- The parent uses multiple providers with varying schedules (example: uses a licensed center on some days and a FFN provider on others but the days can't be determined in advance); or
- The Provider is prohibited from receiving payments that are *not* based on actual attendance (this must be determined during the provider registration process).

Child care payments are made based on a *slot* when:

- The child attends a Delegate Agency provider

  Exception: NEON children who attend a Delegate Agency provider with a certificate will be paid by approved schedule unless the provider requests/requires that payments be made based on actual time and attendance.

651 Discretionary Days

When a household's child care subsidy payment is based on actual attendance, discretionary days can be used as follows:

Each eligible child is allowed 21 days per calendar year to be absent from care for any reason and the provider can be reimbursed for these days as long as the provider has obtained the parent/caretaker written authorization prior to the reimbursement request.

The client and provider must be notified in writing when all 21 days have been used. Anything claimed over the 21 day limitation is the responsibility of the client.

Exception: Clients using multiple providers may not claim discretionary days for days that care was provided by another provider.

652 Timesheet Due Date

The provider must sign and date the completed Timesheet for each eligible child and submit the original record to the Child Care office no later than the last day of the month following the service month to be considered timely. The provider must keep a copy for their records.

Exception: Providers approved to submit Timesheets via Web Attendance may do so weekly, bi-weekly or monthly.

652.1 Processing Timesheets

Timesheets must be date stamped to reflect the date the Child Care office received it.

652.2 Stale Dated Claims

Provider billings and registration/annual fees must be submitted no later than the last day of the month following the month of service (e.g. service month of June must have the billings dated stamped by July 31). Billings submitted after the last day of the month following the service month may be rejected as stale dated and may not be eligible for payment approval.

Exception: All delegate agencies will be allowed 60 days after the month of service to submit their billings and registration/annual fees. Billings submitted after 60 days will be rejected as stale dated and may not be eligible for payment approval.

Any provider who has a payment rejected for stale dating may request special consideration for payment approval to the Chief of the Child Care and Development Program via the Child Care office. The special consideration must be in writing (email requests are acceptable) and include the circumstances which warrant the special consideration, the month(s) of service and the amount of the payment for each month requested. A written decision will be issued to the provider and the contracting agency. The Chief's decision is final and cannot be appealed.

653 Provider Reimbursements

Child care reimbursements must be paid at the least expensive rate; therefore, if the provider charges less than the State maximum rate, the provider must be paid at the lesser rate, unless noted otherwise in the policy manual.

Reimbursements must be paid based upon the approved schedule and the approved level of care (FT/PT). In addition, if the child is scheduled for part-time and the parent authorizes a Discretionary Day, the reimbursement must be made at the part-time rate.

Note: The rate for part-time care is the least expensive daily rate divided by two.

654 Provider Payments

Child care subsidy payments must be paid directly to the provider. Other arrangements may be necessary in unusual circumstances and are made at the discretion of the Child Care and Development Program Director/Administrator of the contracting agency.

Payment for the service period must be sent to the provider within 30 business days. This is 30 business days from the receipt of the Timesheet.

Child Care staff is responsible to ensure the child care billings concur with the parent's/caretaker's hours of participation in the approved purpose of care activity and the Client/Child section of the Timesheet If significant differences occur between the hours authorized on the child care Certificate and the hours indicated on the Timesheet, further investigation is warranted. Communication may also be necessary between payment staff and eligibility staff and the DWSS case manager.

For payments made based on approved schedule, Child Care staff must compare the daily hours reported on the Timesheet to the Client/Child Schedule section of the Timesheet in weekly increments. Minor discrepancies are acceptable and expected but when the child's attendance varies significantly from the schedule, payments should be evaluated a week at a time to determine if the child is no longer attending or if an adjustment needs to be made to the schedule. No payment should be made in a week without any attendance unless there is a justifiable reason.

655 Payment Adjustments

There may be times when a provider will bill for days when the child has attended, but was not authorized (e.g., the parent/caretaker works an additional day, school gets out early for parent/teacher conferences). Prior to payment being made for the unscheduled time/day(s), it must be verified that another provider wasn't paid for that day. Once verified, an adjustment to the provider payment must be made and the case manager must document the action in the computer system.

Providers have 60 calendar days from the payment date to request an adjustment if they disagree with the amount of their payment. All payment adjustment requests must be resolved and responded to in writing by the Child Care office within 30 calendar days of the request.

656 Provider Underpayments

Child Care staff must resolve all provider underpayments in the next available reimbursement period from the date the underpayment is validated.

If an underpayment is discovered as the result of a Management Evaluation or Quality Control review, the underpayment must be validated by the contracting agency. If the underpayment was due to a mistake of the contracting agency, the supplemental payment must be issued with the next available reimbursement period after validation.

657 Provider Overpayments

If an overpayment is discovered as the result of a Management Evaluation or Quality Control review, the overpayment must be validated by the Child Care staff within 60 calendar days from the date the overpayment is discovered.

Child Care staff is primarily responsible for the collection of all provider overpayments. Recovery is accomplished through retention of future provider payments until the debt is retired in whole. If the provider suggests that repayment of the debt will cause a hardship they may seek special consideration from the DWSS Child Care Chief. To do so, the provider must submit a written request to the DWSS Child Care Chief fully disclosing the circumstances which warrant special consideration.

If the provider's contract is terminated prior to full repayment of the overpayment, the Child Care office must refer the debt to the appropriate DWSS I&R office for continuation of the recovery action. I&R referrals must be made using the Child Care Overpayment Referral and must include all information and evidence used to substantiate/calculate the debt.

If the provider initiates a new contract with Child Care staff prior to full recovery of the debt by DWSS I&R, the Child Care office must suspend approval of the contract until the remaining overpayment balance is paid. The provider retains the right to seek hardship consideration using the aforementioned process. If a hardship is granted, Child Care staff must submit a written request to DWSS I&R seeking to reclaim the debt and assume responsibility for collection of the outstanding balance through reimbursement reduction.

Overpaid providers are afforded the right to an administrative review with the designated Child Care office if requested within 90 days from the date of the initial overpayment notice. If requested, the Child Care office must exercise a full internal review process to assure the Child Care office's action is consistent with published policy. Child Care providers *are not* entitled to a hearing before a DWSS Hearing Officer.

658 Attendance/Billing Audits

At the discretion of DWSS or Child Care staff, the provider's attendance logs may be compared to the provider reimbursement records. Any overpayments/underpayments resulting from the audit must be resolved with the provider.

659 Attendance Record Retention

After submittal, provider attendance records must be retained by Child Care staff for a period of 36 months after the month of reimbursement.

660 USE OF MORE THAN ONE PROVIDER

Clients may have multiple providers for the same child when the following circumstances apply:

- If the child is enrolled with a provider who is not open on weekends, the client may choose to have an additional provider for weekend use only.
- If the child attends a program or facility that is closed routinely for holidays, track breaks, etc., the client may receive an additional certificate for a second provider for use during "track breaks or holidays only." Child Care staff will request the client provide a copy of the track break schedule for the child to monitor provider

usage. The certificate needs to specifically state that care is authorized for "track breaks and holidays only," etc. and schedule notes must be entered in the system.

Note: Clients *may not* use multiple providers on the same day

670 PROVIDER CHANGES

Clients can change providers as often as they choose. However, there is a limit to the number and amount of registration fees that will be paid by the Child Care and Development Program. Refer to manual section 634, Reimbursable Fees.

Note: If a client changes from a delegate agency provider to a certificate provider mid-month, the payment will not be made to the delegate agency due to the child not being eligible for the entire service month. Refer to MS 522.3 for more information on program changes.

If the client chooses to change providers, verification that they do not have an outstanding co-payment balance with the current provider must be obtained.

If the client does have an outstanding co-payment balance with the current provider, verification must be received stating they have either paid off the outstanding balance or they have signed a Repayment Agreement with that provider to pay off their balance before the change can be made. If the client fails to provide verification within the requested time period, their case must be terminated.

Note: If the client is claiming neglect/abuse is the reason for the provider change, they must be allowed to transfer the child to a new provider immediately, even if they have an outstanding co-payment balance. The client must still provide verification that a Repayment Agreement has been signed with the previous provider.

The Child Care and Development Program does not cover late charges or charges for tuition, meals, transportation and/or clothing/uniforms (refer to MS 635). Therefore, an outstanding balance on these issues must not delay the child care transfer. However, the client should be encouraged to sign a Repayment Agreement.

If the provider refuses to cooperate with providing written verification of the co-payment balance, the case manager must not penalize the client. The transfer must be allowed and the case manager must contact the provider directly to obtain the verification.

A new Certificate must be printed for the new provider for Certificate cases and a Notice of Termination must be given to the previous provider. The case manager must follow the procedures outlined in manual section 100 and 500.

The case manager must issue the new Certificate for the remainder of the certification period only. The end date must not extend beyond the original end date.

680 COMPLAINTS AGAINST PROVIDERS

Clients may file a written complaint against a provider through the Child Care office. These complaints must be forwarded to the appropriate Licensing Bureau for review within 24 hours of receipt.

When Child Care staff have determined a provider has failed to meet child care licensing requirements they must complete the CPS & Child Care Licensing Form, send the original copy to the applicable licensing agency within 24 hours and keep a copy of the form in the provider file.

690 PROVIDER NON-COMPLIANCE

If Child Care staff determines that a provider has not followed licensing requirements or the provisions of the signed Service Agreement and/or has violated program policy the following actions must be taken:

1. Send the provider a Provider Non-Compliance form explaining the non-compliance issue, the time period allowed to correct the issue, and possible penalty if the issue is not corrected. The time period for correction cannot be less than 10 calendar days or greater than 30 calendar days from the date of the notice.

   Note: For licensed providers who fail to follow the applicable licensing regulations, the CPS & Child Care Licensing Form must be completed and sent to the applicable licensing agency within 24 hours of discovering the violation.

2. The Child Care staff initiating the Provider Non-Compliance form must follow-up with the provider within 30 days of the end of the corrective action period to ensure action has been taken to resolve the non-compliance issue.

3. If the provider fails to correct the issue or fails to maintain compliance with licensing or program requirements after receiving the Provider Non-Compliance form, the following penalties will be applied:

   a. First Violation – the provider will be suspended from the Child Care and Development Program for 90 days, and will be ineligible for payment for any childcare provided to subsidy families during the sanction period.
   b. Second Violation – the provider will be suspended from the Child Care and Development Program for 180 days and will be ineligible for payment for any childcare provided to subsidy families during the sanction period.
   c. Third Violation – the provider will be permanently terminated from the Child Care and Development Program.

   Note: If it is determined by the DWSS Investigations Unit that a provider made false/misleading statement(s) and/or concealed/withheld facts in order to establish/maintain eligibility for a client *or* to obtain payment for care that they were not entitled to, the Child Care Chief can choose to impose a more stringent penalty period than those listed above or may terminate the provider

immediately. Additionally, the provider may be criminally prosecuted or otherwise penalized according to state and federal law.

4. The penalty period start date must allow for a 14 day administrative review period and a 10 day notification to the subsidy participant(s). The day after the request date is the first day of the 10 day period.

   Example: Notification is mailed to the provider on 06/05 that a 90 day suspension program penalty will be imposed. Allowing for 25 days, the penalty period will start on 6/29 and end on 9/26. (This is 14 days for the administrative review, one day to send notification to the participant and 10 days for the participant to respond.)

   a. If a request for an administrative review has not been filed at the end of the 14 day period, notification will be sent to all participating clients to decide whether to terminate their subsidy case or select a new provider.
   b. If a request for an administrative review is filed by the end of the 14 day period and there is no request for continued services as a provider, notification will be sent to all participating clients allowing them 10 days to decide whether to terminate their subsidy case or select a new provider.
   c. If a request for an administrative review is filed by the end of the 14 day period and an eligible provider requests continued services, child care services will continue until a decision is made by the DWSS Child Care Chief. Notifications will not be sent to the clients until the Chief validates the provider penalty is appropriate.
   d. Child Care staff submits the provider's request for an administrative review and any substantiating evidence to the Child Care Chief. The Chief will review the evidence and provide a written decision to the appropriate Child Care staff.
   e. A copy of the Chief's written decision will be placed in the provider's file and a copy will be sent to the provider.

   If the Chief disagrees with the penalty findings, the provider's services with the Child Care and Development Program will continue without interruption.

   If the Chief agrees with the penalty findings, Child Care staff will send notification to all participating clients allowing them 10 days to decide whether to terminate their subsidy case or find a new provider. Child Care staff will send an updated Provider Penalty Notification form with the new timeframe for the penalty, including the 10 day notice to the subsidy client(s). Additionally, an overpayment must be assessed from the date the continued services were requested until the 10 day notification is mailed to the subsidy participant(s).

Providers may request special consideration from the Child Care Chief via the Child Care staff to have a penalty waived. The special consideration must be in writing (email requests are acceptable) and include the circumstances which warrant the special consideration. A written decision will be issued to the provider and the contracting agency. The Chief's decision is final and cannot be appealed.

Refer to MS 700 regarding provider fraud and overpayments.

Program Violations, Overpayments, & Hearings

700 INVESTIGATIONS & RECOVERY

Investigations are used to promote program integrity in the Child Care and Development Program. Investigations & Recovery staff (I&R) use collateral sources to secure factual information and/or evidence to determine violator intent and program consequence.

701 Objectives

The general objectives of the I&R Unit are:

- Detection, prevention, reduction and identification of program fraud and abuse by applicants/recipients of child care subsidy benefits and/or child care providers. Investigations may lead to administrative action and/or criminal prosecution.
  "Fraud" means an intentional deception or misrepresentation made by a person knowing that by doing so it could result in some type of unauthorized benefit to them or to another person. It includes any act that constitutes fraud under applicable federal or state law.
- Timely recovery of all incorrectly paid program benefits acquired through fraudulent or abusive acts committed by any persons receiving benefits/payments from the Child Care and Development Program.
- Sanction of any and all individuals who willfully violate rules for the Child Care and Development Program.

702 Responsibilities

The Division of Welfare and Support Services (DWSS) I&R Unit are responsible for, in whole or in part:

- Investigation of any individual or group of individuals suspected of attempted or accomplished fraud and/or abuse of any benefit program administered by the Child Care and Development Program and funded by DWSS.
- Administrative penalty of Child Care and Development Program applicants or recipients who are suspected of intentionally violating program rules.
- Criminal prosecution of individuals suspected of criminal acts against programs administered by the Child Care and Development Program, and funded by DWSS.

703 Types of Investigations

Fraud and abuse investigations are broken down into four primary types:

1. Pre-eligibility (after application, but before case approval);
2. Ongoing eligibility (while a client is still eligible for subsidy benefits);
3. Post eligibility (client previously received subsidy benefits, but is no longer on assistance)
4. Provider fraud and/or abuse

704 Investigation Referrals

Child Care staff must review all case circumstances when determining eligibility. When inconsistencies are discovered among prior and current applications, client statements, verifications, etc, staff need to evaluate if these inconsistencies warrant an investigative referral. Listed below are some examples of “red flags” that case managers should be aware of as these types of issues warrant further clarification and/or investigation.

A RED FLAG GOES UP FOR APPLICANTS/CLIENTS WHEN:

Verifications appear to be altered or completed by applicant

Household costs, i.e. rent, utilities, child care co-payment, are more than the client’s claimed income

Client has past history of incorrectly reporting income

Client lives with absent parent’s family (but absent parent doesn’t)

Client works in a profession that routinely receives tips, but doesn’t report receiving them

Newborn is given a last name different than the applicant/client

Children attend school outside their area

Client is self-employed and has a Zero net income for a long period of time and indicates they have no living expenses

Frequent changes in employment or working for an individual that pays cash

No pay stubs available or unable to contact employer with phone number provided

Out of state or country NCP that can provide a mutual agreement of child support in less than 2 days from request

If information is discovered that warrants an investigative referral, DWSS or Child Care contractors will make referrals through the I&R Information System (IRIS). If electronic submission is not possible, Investigative Referral Form 2682-AF should be submitted to the I&R office. In the event a DWSS or Child Care contractor employee receives a community complaint or anonymous call, all information must be recorded on a referral form and forwarded to the DWSS I&R Unit.

710 CASE INVESTIGATION

All Child Care and Development Program investigations are performed by DWSS I&R staff and in accordance with rules and regulations as defined in DWSS Administrative Manual Section 3200.

711 Reporting Case Findings

Upon completion of the investigation, the investigator completes an Investigative Follow-Up Form and keeps the original in the investigation case file and forwards copies to the Child Care and Development Program office staff who submitted the referral.

If the case is associated with a DWSS public assistance case, a copy of the report may also be forwarded to the appropriate DWSS eligibility caseworker.

720 PROGRAM VIOLATIONS/PENALITIES

Administrative penalties are used to promote program integrity. Applicant/Recipient fraud is a violation of both federal and state law. If convicted, individuals may receive penalties, which include any or all of the following:

Administrative program penalties and/or disqualification

- Criminal conviction
- Full program restitution
- Criminal fines and/or penalties
- Confinement in county, state or federal prison

An intentional program violation (IPV) is an action by the accused for the purpose of establishing or maintaining program eligibility, or increasing or preventing a reduction in the benefit amount when they:

- Made a false or misleading oral or written statement, or misrepresent, conceal or withhold information;
- Committed any act that violates NRS 422A.700 or intentionally violated any rule or regulation established by the DWSS;
- Made an attempt to obtain, increase or continue child care benefits for themselves or others to which they would otherwise not be entitled;
- Received child care benefits to which they would otherwise not be entitled;
- Failed to comply with reporting requirements as set forth in manual sections 100 and 500;
- Submitted a false document to the Child Care and Development Program Staff and/or DWSS;
- Altered a Child Care Certificate to receive benefits to which they would not otherwise be entitled to.

These actions do not have to result in a claim. If there is potential for erroneous benefits being issued, an IPV may exist. IPVs are addressed in detail in the Investigations & Recovery (I&R) Policy Manual, section 200. Reference should be made to this manual section for issues/events not addressed in this chapter.
Intent may be demonstrated in a number of ways, such as:

- The accused individual had reason to know or had knowledge of the information withheld or misrepresented; or
- The accused individual failed to report or clarify the information withheld or misrepresented during contact with DWSS or Child Care contractor staff, either in person, by mail, by phone, FAX or Electronic Mail; or

- The accused individual has demonstrated the ability to report or clarify required information in the past; or
- The accused individual has a history of previous program violations and/or client caused claims.

The Division of Welfare and Supportive Services (Division) bears the responsibility of proving program violations are intentional acts by the accused individual; however, the presumption of intent may be overcome by the accused when the accused individual can bring forth clear and convincing evidence to rebut the allegation.

The following acts are illustrative but not exclusive:

- Concealing or misrepresenting – identity, Social Security number, employment information, paternity information, pregnancy information, marital status, persons living in the home, income, residency, non-custodial parent information, citizenship, household members temporary absence from the home, receipt of public or government assistance, child support issues, medical conditions of persons living in the home, lump sum disbursements, winnings, subsidized housing, prior IPVs or any other information specifically addressed on the child care assistance application.
- Altering, forging, duplicating or transferring of Child Care program forms, checks, affidavits, or any documents submitted to the Child Care program and/or the DWSS.
- Misuse of child care services.

  Note: The applicant or recipient's eligibility will not be compromised based solely on the Division's pursuit of a penalty action. If all other eligibility requirements are met, the accused individual remains eligible pending the outcome of the administrative penalty action.

Recovery of incorrectly paid benefits *is not* interrupted or affected by the pursuit of the administrative penalty action.

721 IPV Forms

Form 6021-AF, Administrative Disqualification/Penalty Waiver, is the only form used to pursue an administrative penalty for IPVs. Included in this form are the:

- Program and Violation Penalty;
- Violation Summary;
- Rights of the Accused Individual; and
- Waiver of Right to Administrative Disqualification Hearing/ Acceptance of Penalty

722 IPV Penalty Methods

There are three separate methods by which the accused individual may be penalized, they are:

1. Acknowledgment and voluntary acceptance of the penalties by the accused individual, via a signed IPV Waiver;

2. By formal order of a DWSS hearings officer after conclusion of the administrative penalty/disqualification hearing process;
3. By conviction in a criminal court for any offense related to violation of Child Care program rules.

723 IPV Penalties

Accused individuals found to have committed an IPV through one of the methods described in manual section 720 are penalized as follows:

NON-NEON RECIPIENT PENALTIES

Child care subsidy benefits are decreased by two (2) subsidy percentage steps for a period of six (6) calendar months for the first occurrence, three (3) subsidy percentage steps for twelve (12) calendar months for the second occurrence and the household is permanently disqualified from the receipt of child care assistance for the third occurrence.

> **Example:** The household qualifies at 95% at-risk subsidy and they are convicted of a child care 1st occurrence IPV, the maximum subsidy percentage paid by the Child Care Program would be 80%.

If the IPV penalty takes the household out of an eligible funding category, the household would be ineligible for the length of the IPV period.

> **Exception:** Foster/CPS cases will be paid at the reduced subsidy percentage for the duration of the penalty period.

NEON RECIPIENT PENALTIES

NEON recipients are eligible for child care subsidy benefits based on a NEON Child Care Referral, therefore if a child care IPV is identified it will be imposed by the TANF program rather than the Child Care and Development Program. All adults in a TANF NEON case are required to participate in NEON work activities, unless otherwise exempt, and therefore are entitled to child care as a NEON support service without a penalty.

If a non-NEON recipient is serving a child care IPV penalty and becomes NEON eligible, the penalty period is suspended and they will be served as a NEON client with no penalty while receiving NEON. Once NEON ends, the penalty period begins again until the penalty is fulfilled.

> **Example:** A first occurrence IPV is imposed in January for an at-risk client and the household is reduced to 80% subsidy for six (6) months. In March the household becomes NEON eligible and remains NEON eligible for four (4) months. The IPV will be suspended in March and will resume in July through October.

724 Identification of IPV's

IPVs may be identified through a variety of means. The violation *does not* have to be discovered through an investigation or omission by the accused individual and does not have to include an incorrect payment of benefits. As defined in manual section 720, the mere *attempt* to acquire benefits incorrectly may be reason enough to pursue disqualification penalties.

Substantiation of a violation may be accomplished through, but is not limited to, collateral contacts, automated interfaces, case investigations or eligibility interviews.

725 IPV Penalty Occurrences

When one or more IPVs are discovered, each occurrence must be separated by an Administrative Disqualification/Penalty order or signed and approved Administrative Disqualification/Penalty Waiver or criminal court Judgment of Conviction (JOC) before the next level of penalty may be pursued. Occurrences are separated in the following manner:

1st Violation	Program violations occurring from the date of the accused individual's birth until: • the date of disqualification/penalty (date of the hearing officer's notification letter) order; or • date of signed and approved Waiver (date signed by designated I&R staff member); or • date of the JOC, regardless of the number of violations committed in between.

2nd Violation	Program violations occurring after approval date of initial signed Waiver or being found guilty of committing a 1st violation until: • the date of disqualification/penalty (date of the hearing officer's notification letter) order; or • until date of signed and approved Waiver (date signed by designated I&R staff member); or • until date of the JOC, regardless of the number of violations committed in between.

3rd or subsequent Violation	Program violations occurring after approval date of a second signed Waiver or being found guilty of committing a 2nd violation until: • the date of disqualification/penalty (date of the hearing officer's notification letter) order; or • until date of signed and approved Waiver (date signed by designated I&R staff member); or • until date of the JOC, regardless of the number of violations committed in between.

730 INTENTIONAL PROGRAM VIOLATION (IPV) PROCEDURES

731 Referring to DWSS for IPV Action

Staff authorized by DWSS may recommend disqualification be initiated against an accused individual by completion and transmittal of Form 6021-AF, "Administrative Disqualification/Penalty Waiver."

731.1 Signed IPV Waiver

If a signed waiver is obtained, the worker shall:

- Create an Investigations and Recovery Information System (IRIS) referral by completing the applicable referral detail fields;
- Select the "IPV Waiver Attached" option;
- Enter IPV waiver information and save the referral; and
- Scan and attach the signed IPV waiver document to the referral.

Upon successful referral generation, IRIS will route the referral to the Referral Management Unit (RMU) for case establishment and routing through the IPV process.

731.2 Request I&R Pursue IPV

If the accused individual refuses to sign the waiver, the worker must refer the case to the Investigations and Recovery Unit for an investigation to pursue an IPV by:

- Creating an IRIS referral by completing the applicable referral detail fields;
- Selecting "I&R to Complete IPV Waiver;" and
- Entering IPV waiver information and then saving the referral

Upon successful referral generation, IRIS will route the referral to the RMU for case establishment and routing through the investigative process.

When completing Form 6021-AF, staff must limit their actions to "one person per form" and "one program per form." Evidence to support the IPV *is not required but can be* included or attached to Form 6021-AF.

Documentary evidence of prior occurrences must be attached when other than a first program occurrence is marked.

I&R Unit staff will pursue the administrative hearing in accordance with the policies set forth in the manual sections to follow and the Division's I&R Policy Manual, section 200. The Child Care case manager may be called as a witness to provide additional testimony at the Administrative Hearing.

732 Initiating IPV Actions

The I&R Unit is principally responsible for activities associated with Child Care and Development Program penalties of an accused individual suspected of program rule violations. However, any employee of the Division or the Child Care Staff may initiate

penalty/disqualification action against an accused individual by completing Form 6021-AF, Administrative Disqualification/ Penalty Waiver.

Staff initiating a penalty action must complete all required administrative penalty paperwork and be prepared to act in the capacity of a witness in front of the hearings officer.

733 Determining IPV Penalty

The Division's Central Office Investigations & Recovery (I&R) Unit maintains a central repository for all Nevada Child Care and Development Program IPVs.

Before completion or submittal of Form 6021-AF, the worker must check for prior disqualifications by sending an email to welfinvest@dwss.nv.gov (Welfare Investigations) to ensure the appropriate penalty period is requested. The email must specify the program type (e.g., Child Care), last name, first name, date of birth, Social Security Number, and any alias of the accused individual.

If past IPV penalties are identified, the I&R worker shall obtain a copy of the previous IPV waiver, hearing decision or criminal court disposition. These documents must be attached to the new IPV paperwork (Form 6021-AF) to substantiate pursuit of enhanced penalties.

734 IPV Hearing Waiver

The IPV waiver may be used to address an accused individual's program violations without prior submittal of the 6021-AF to the Hearing Unit. This permits accused individual acceptance of IPV penalty without the formality of the actual hearing. If this method is used, the accused individual must also sign the "Rights of the Accused and Waiver of Right to Administrative Disqualification Hearing/Acceptance of Penalty" section of Form 6021-AF acknowledging their understanding of their rights under program laws, regulation and rules.

> **Note:** If a signed IPV waiver is obtained, penalties must not be imposed until the case manager has forwarded the signed waiver, via referral to IRIS, and received notification from I&R staff.

No further administrative appeal procedure exists after an accused individual waives his/her right to an administrative disqualification hearing and a disqualification penalty has been imposed. The accused individual however, is entitled to seek relief in a court having appropriate jurisdiction.

735 Coordination of IPV Actions

To eliminate confusion and duplication of effort, all administrative penalty/disqualification requests and signed IPV waivers must be sent to the I&R Unit assigned responsibility for the submitting office. The approval of the I&R supervisor or their designee is mandatory to ensure prior penalty occurrences have been checked and case manager actions are not duplicating the actions of I&R staff.

740 INTENTIONAL PROGRAM VIOLATION (IPV) HEARING

Administrative Disqualification Hearings and pre-hearing resolutions are set forth in the Division's Administrative Manual, section 3103.

On the hearing date, the employee who initiated the IPV action (see manual section 862) must be available to act as a witness if necessary; however I&R will represent the Division and present the case to the hearings officer.

741 Consolidation of Administrative Penalty Hearings

Penalty/disqualification hearings for Child Care, TANF, SNAP, Energy Assistance and Employment & Training programs may be combined into a single hearing if the factual issues arise out of the same or related circumstances and the household received prior notice the hearings will be combined.

Combining hearings permits presentation of issues at a common hearing time. However, an individual Administrative Disqualification/Penalty Waiver, Form 6021-AF, must be completed for each accused individual and for each program.

If combined, a separate file must be established for each case, and separate presentations must occur for each program. This permits individual rulings for each separate program violation.

742 IPV Hearing Process

The DWSS Hearings Office will schedule the date and time of the hearing and notify all involved parties.

> **Note:** If legal counsel is representing the accused individual, the worker may request attendance by one of the Division's assigned deputy attorneys general.

At the hearing, the worker presenting the case introduces testimony and evidence demonstrating the accused intentionally violated program rules. Evidence should be organized and presented in a manner consistent with the chronological events associated with the violation.

743 Pre-Hearing Resolutions

IPV issues may be resolved without a hearing or prior to a scheduled date of hearing if:

- The Division or Child Care Program Staff formally withdraws their request for a penalty/disqualification hearing; or
- The accused individual signs both the Administrative Disqualification/Penalty Waiver section of Form 6021-AF and the Waiver of Right to Administrative Disqualification Hearing/ Acceptance of Penalty (manual section 864, IPV Hearing Waiver).

Requests for modification of an IPV order must be routed through an I&R supervisor or their designee.

744 IPV Hearing Outcome

Issues sent to the Hearings Unit are resolved on a case-by-case basis. Only *written decisions* issued by the hearings officer and state or federal courts are enforceable. The formal written decision order may:

- Deny or approve the request for a hearing;
- Deny or approve the request for a administrative penalty based on a hearing;
- Approve, with modification of the penalties.

Individuals who disagree with the decision of the hearings officer may appeal their case to district court within ninety (90) days of the date of the hearing officer's decision.

745 Reconsideration of a Hearing Decision

The hearing officer may reconsider the hearing decision and reopen the record for presentation of evidence by either party if, within thirty (30) days from the date of the hearing decision, it is shown to the satisfaction of the hearings officer that the additional evidence is material and that there was good cause for failure to present it in the hearing.

746 Modification of the IPV Order

If errors are noted on the IPV documentation (wrong Social Security Number, incorrect IPV penalty, etc.), corrections cannot be made without bringing the matter before the hearings officer.

Requests for modification of an IPV order must be routed through an I&R supervisor.

750 IMPOSING IPV PENALTIES/REPAYMENT OBLIGATIONS

If a signed IPV Waiver or judgment of conviction is obtained, penalties shall not be imposed until the case manager has received notification from I&R staff.

For open cases, penalties are imposed against current benefits as soon as administratively possible after the signed Waiver is approved by the designated I&R staff or receipt of the hearing officer's penalty order or criminal court JOC and notification is received from I&R staff. Penalties will continue for the ordered or applicable period of time. Worker inability to affect benefits because of computer programming restriction does not negate the case manager's ability to impose the full penalty period.

For closed cases, the penalties will be imposed immediately after the signed waiver is approved by the designated I&R staff or, receipt of the hearing officer's penalty order or a criminal court JOC and notification is received from I&R staff. Penalties will continue for the ordered period of time.

> **Example:** An accused individual's benefits cease in May and an IPV penalty is imposed effective July through June. If the accused individual applies for

assistance and is approved in December, the case manager must impose the penalty for the remainder of the penalty period (December through June).

If subsequent penalty orders are received, the new penalty must be implemented as soon as administratively possible.

Example: If the accused individual is currently serving a first level penalty and the Hearing Officer orders a second level penalty, the case manager must wait until the entire first level penalty period has been exhausted before imposing the second penalty; however, if the accused is serving a second level penalty and is ordered to serve a third IPV penalty, impose the third IPV penalty immediately upon receipt of the hearing officer's decision, regardless if the accused individual is still serving the second penalty.

If the case manager fails to apply penalties within specified time frames, only the remaining months of the penalty may be imposed (unless permanently ineligible).

If the penalty is associated with the incorrect payment of benefits, the I&R worker will initiate action to reclassify the claim as an IPV.

751 Nevada's Central Repository for Program Penalty Information

The Hearings Unit forwards all Child Care penalty records to the Division's I&R Central Office Unit for maintenance and storage. This information is available for use by all the Division or Child Care and Development Program staff. Its primary purpose is to provide documentary evidence of why a penalty was imposed and substantiate previous penalty occurrences.

760 CLAIMS (OVERPAYMENTS)

761 Introduction

A claim/overpayment means any subsidy benefit paid to, or on behalf of, any individual, household or business that exceeds the amount the individual, household or business was eligible to receive.

The claim amount is the difference between what the individual, household or business actually received in the form of a benefit less the amount they were entitled to receive.

Individuals, households or businesses that owe money to the Child Care Program must repay the claim amount. If approved in advance by Division of Welfare and Supportive Services (DWSS), the overpaid individual or household may be allowed to make monthly payment arrangements, but must make the minimum payment according to the terms of their Repayment Agreement.

Note: Claims are addressed in detail in the I&R Manual, Section 300 and 400. Reference should be made to these manual sections for issues/events not addressed in this chapter.

762 Definitions Date of Discovery

The date of discovery is the date the Child Care and Development Program staff confirms through investigation of the claim allegation an over issuance has occurred.

Exception: Program, Review and Evaluation (PRE) conduct investigations which may generate a potential claim for the review month. Claims resulting from a QC error finding must show the date of discovery as established by the Chief of PRE.

763 Claim Classifications

A claim is calculated for client errors, provider errors, DWSS errors or contractor errors. Every claim must be classified through use of one of the definitions below:

1. **Client Error**
   A claim may be classified as a "Client Error" if the error was caused by:
   - A misunderstanding or unintended error by any or all members of the child care household; or
   - Misrepresentation, concealment or withholding of information by any or all members of the child care household.

     Note: In this instance, evaluate for possible fraud.

2. **Provider Error**
   A claim may be classified as a "Provider Error" if the error was caused by:
   - A misunderstanding or unintended error by the provider; or
   - Misrepresentation, concealment or withholding of information by the provider.

     Note: In this instance, evaluate for possible fraud.

   Child Care contractors are responsible for the calculation and collection of provider claims for active providers. Refer to manual section 656 regarding collection of provider claims. Collection activities are defined in the individual provider contracts.

3. **Division of Welfare and Supportive Services (DWSS) Error**
   A claim may be classified as a "Division Error", if:
   - DWSS failed to notify the Contractor of a known change to the client's household and/or DWSS benefits; or
   - DWSS reported incorrect information to the Contractor regarding the client and/or their DWSS benefits.

4. **Contractor Error**
   A claim may be classified as a "Contractor Error", if the:
   - Contractor failed to take timely action on a reported change; or
   - Contractor incorrectly determined and paid any benefits; or
   - Contractor erroneously issued duplicate benefits which were used by members of the child care household; or
   - Contractor makes any other error which is not related to the client's withholding or incorrect reporting of eligibility information.

770 REPAYMENT RESPONSIBILITY AND RIGHTS

All adult members of the child care household are jointly and separately liable for the value of any over issuance of benefits received by the child care household, unless the over issuance is the result of a DWSS or contractor error as described in section 763.

Non-Needy Caretakers, Kinship Care Recipients, Foster Parents and/or Authorized Representatives are considered part of the child care household when their failure to report or their incorrect reporting of eligibility information causes a claim occurrence.

In cases where the identified claim is a result of a child's absence from the child care household, the claim is collected only from the adult members of the overpaid household.

> **Example:** The child moved out of their mother's home and into their father's household. The mother failed to report the change. Using the father's income, the child would not be eligible for benefits; however, they continued to use the service. The mother would be liable for repayment of the claim, not the father.

771 Right to Appeal

The responsible individual may appeal the amount and/or how the claim was determined within ninety (90) calendar days from the date of the claim notification. The request must be in writing and forwarded to the Child Care Program Office.

All recovery actions are suspended during the appeal/hearing process until a decision is rendered. If the hearing office determines the claim does in fact exist, responsible person(s) must be re-notified of the claim.

> **Note:** Refer to manual section 550 through 563 for further details on the appeal/ hearing process.

780 CALCULATING A CLAIM

Claims are calculated whenever documentary evidence substantiates the Child Care and Development Program incorrectly paid benefits to any individual or group of individuals. Claim classifications (Client, Provider, Welfare or Contractor errors) play no part in determining whether a claim is or is not calculated.

781 Request Claim Calculation

Any authorized Child Care and Development Program staff member may request a claim calculation be made by completing section one of the Child Care Overpayment Referral form 2154 –WC A or B and forwarding the original to designated contractor personnel for follow-up. A copy of the form must be kept in the eligibility case file.

782 Determining if an Claim Exists

To determine whether a claim exists, the child care contractor must obtain written verification of the questionable issue. Contractor staff may pursue evidence necessary to proceed with the claim calculation; however, it cannot be requested at the same time information to determine initial and continuing eligibility is being requested. If the information/verification to determine past eligibility/benefits is not provided, it cannot cause a denial/termination for failure to cooperate.

If reasonable attempts made to secure documentary evidence prove unsuccessful, the Contractor may, with written approval from the Child Care and Development Program Chief, terminate calculation efforts.

783 Calculation of the Claim Amount

All claims must be calculated by the child care contractor within sixty (60) calendar days of receipt of all necessary collateral information. Prior to initiating the calculation process, the Contractor must ensure they possess credible evidence, which clearly substantiates, verifies or confirms the client received benefits they were not entitled to for a specific period of time.

The calculation of any subsidy claim requires a comparison of benefits already received by the child care household minus benefits to which the household was retrospectively entitled. The difference is the claim amount.

Determine the child care claim amount for each month incorrect benefits may have been paid. Budgeting procedures and policy in effect at the time the claim was incurred must be used in the determination of the claim amount.

> **Note:** If a Quality Control claim is identified, staff must expand the claim review to the entire certification period to be able to determine the total amount of the claim.

784 Claim Referral to I&R

Following the calculation of a client error claim, the debt must be referred to DWSS Investigations & Recovery (I&R) Unit via the Investigations and Recovery Information System (IRIS) for pursuit and collection. Use the Child Care Referral form (2154-WC/A) for the claim to be established in the NOMADS system.

Child Care staff shall compile a “claim packet”. The packet must include:

1. Copy or original of all pertinent documents (application, service agreement, picture ID, etc.) contained within the case file;
2. Copy or original of substantiating documentation relative to the claim;
3. A case narrative containing at a minimum how the claim occurred;
4. Documentation of the claim calculation; and
5. A copy of the referral form

The packet must be sent to the I&R Unit responsible for their program office as soon as possible for review and establishment.

> **Note:** Claims for active providers are not referred to DWSS. Provider claims are pursued by the Child Care Contractor in accordance with their individual contracts with the child care providers. If a provider is not active, and retention of future payment is not possible to recover a debt, then the case must be referred to I&R for collection, as with a client claim. All supporting evidence of the provider must also be provided in the "claim packet" (see manual section 656 for details).
>
> **Exception:** The Child Care and Development Program Chief or their designee may refer a Provider to DWSS for investigation. Subsequent actions related to the investigation ie prosecution, debt recovery etc. will be performed by I&R staff.

Reimbursement for Contractor and DWSS caused claims will not be pursued from the clients except where the error was the result of:

- An action resulting in a benefit which the client should have reasonably known was an error or mistake; or
- The Child Care case manager and client took action enabling the client to receive benefits he/she was not entitled to.

Contractor and DWSS errors resulting in a claim must be reported quarterly to the Child Care and Development Program Chief.

790 HEARINGS

A hearing is an orderly, readily available proceeding before a DWSS Hearing Officer which provides an impartial process to determine:

1. The correctness of an agency action being appealed, and
2. The eligibility of the applicant/recipient as it relates to the issue of the hearing.

> **Note:** Hearing Officers may neither hold hearings nor render decisions on the issue of discrimination.

A hearing may be requested by an adult household member or an A/R on any action to deny, reduce or terminate benefits. An adult household member can also request a hearing of an overpayment or an overpayment amount.

All hearings, including a copy of the agency action being disputed, must be submitted to the DWSS Administrative Adjudications Unit (AAU) as soon as possible but no later than 10 calendar days after receipt. The request can be sent by mail, email or fax. The request must contain the claimant's name, address, case number, date received in the Child Care office or DWSS Central Office and the name and address of the A/R, if applicable.

791 Time Period for Submitting a Hearing

Negative Actions:

To request a hearing on a negative decision made by Child Care staff, the client and/or A/R must either complete the Notice of Appeal section on form 2158-WC or submit a written request to the appropriate Child Care office, DWSS District Office or Central Office within 90 calendar days from the date of the Notice of Action. The day after the notice date is the first day of the 90 day period.

If a hearing request is received after the 90 day period, a copy of the hearing request must be sent the DWSS AAU who will notify the household in writing the hearing request has been denied.

Copies of the hearing request and any correspondence with the household regarding the hearing must be kept in the eligibility case file.

Overpayments:
To request a hearing on an overpayment, the household must submit the request in writing within 90 days from the date on the Notification of Debt, form 2521-EG. The day after the notice date is the first day of the 90 day period.

791.1 Continued Benefits

Households are entitled to continued benefits if the request for a hearing is received no later than 14 calendar days after the effective date of the proposed action. Assistance continues unchanged until the hearing decision is made unless one of the criteria listed in MS 791.2 is met.

Benefits are not continued if:

- The client's request is received after the 14-day period;
- A change affecting the client's subsidy occurs after the hearing request, but before a decision is given and the client does not request a hearing after receiving notice of the change;
- Federal law or regulations require reduction or termination of benefits, or
- Benefits are reduced or terminated as a result of mass change without individual notice of adverse action. Benefits can only be reinstated if the issue being appealed is a misapplication of policy or benefits were improperly computed.

If subsidy benefits are continued, such benefits are subject to recovery by the Child Care and Development Program if the client withdraws the hearing request, abandons the hearing, or the Child Care and Development Program's action is upheld by the Hearing Officer.

791.2 Reducing or Ending Benefits Before the Hearing Decision

Benefits continued or reinstated during the hearing process cannot be reduced or ended before the hearing decision unless:

- Another change adversely affects the household and a hearing is not requested on the later change, or
- A mass change affects the household's eligibility. (Benefits must be adjusted accordingly.), or
- The client or A/R requests in writing benefits not be continued, or

- The certification period expires.

  Note: If benefits are continued and the certification period expires, the client can submit a timely reapplication and have eligibility determined for the new certificate period.

792 Hearing Procedures

792.1 Pre-Hearing Conference

Child Care staff must contact the client or A/R within 10 calendar days of receipt of a hearing request to schedule a pre-hearing conference to discuss the action being contested. The pre-hearing conference shall be held as soon as possible, but no later than 30 days of receipt of the hearing request. The conference can be held in-person or by telephone.

Rescheduling of a pre-hearing conference should be kept to a minimum, assuring completion by the required due date. Rescheduling at the client's request is allowed only if "good cause" is substantiated. Good cause is defined as a factor(s) beyond the client's control such as illness or an unavoidable absence from their area of residence.

Every effort is made to reconcile the contested action without the necessity of a hearing; however attempted resolution at the Child Care office level *DOES NOT* in any manner affect the right to a hearing.

If a pre-hearing conference is held, Child Care staff must complete Conference/Hearings form 2254-EH detailing the conference and the resulting conclusion. Child Care staff must include on the form if the conference is held in-person or by telephone. The client's or A/R's signature is required on the report if the conference is in-person.

If at the conclusion of the pre-hearing conference a withdrawal of the hearing request is requested by the client or A/R, a copy of the Conference/Hearings form detailing the reasons why the request for a hearing is being withdrawn must be completed. A copy of this form must be forwarded to the DWSS AAU within 3 business days following the date of the pre-hearing conference.

If at the conclusion of pre-hearing conference the client or A/R wants to continue with the hearing process, the Conferences/Hearing form will become part of the documents to be presented at the hearing. Refer to MS 794 for additional information on hearing participation.

792.2 Disposition of a Hearing Request

A copy of *every* hearing request, whether it is appealable or not, must be forwarded to DWSS AAU within 10 calendar days of receipt. Only a DWSS Hearing Officer can dispose of a hearing. The Hearing Officer will render a written decision within 90 days from the date the hearing was filed. A copy of the written decision will be provided to

the client and A/R (if applicable). A copy of the decision will be provided to the applicable Child Care office to be placed in the case file.

792.2.1 Agency Withdrawal of a Hearing Request

The Child Care office may reverse its noticed action at any time during the hearing process. If the contested action is reversed after receiving a hearing request, a report must be prepared by Child Care staff. This report must include verification the action under dispute has been resolved and, if applicable, documentation verifying the application/case has been reinstated. The report must be forwarded to DWSS AAU within 3 business days following the reversal decision date. A copy of the report must be kept in the eligibility case file.

792.2.2 Client Withdrawal of a Hearing Request

The client may withdraw their hearing request verbally or in writing. The written withdrawal must be signed and dated by the client or A/R.

For verbal withdrawals, Child Care staff must provide a written report of the verbal conversation narrating the date of the request, the name of the person requesting the withdrawal and why the request for a hearing is being withdrawn.

A copy of the withdrawal report must be forwarded to the AAU within 3 business days following the date of the withdrawal request.

If the hearing request is withdrawn by the client or A/R, and continued benefits were requested, the previously contested action must be taken immediately (e.g., update the case, reinstate benefits, terminate, etc.). Any excess benefits the household received during the pending period must be referred to DWSS Investigations and Recovery for collection.

792.2.3 Denial of a Hearing Request

A hearing need not be granted when:

a. The sole issue is either a state or federal law that requires an automatic grant/subsidy adjustment.
b. Benefits are reduced or terminated as a result of mass change without individual notice of adverse action.
c. The request is not received timely (see MS 791).
d. No negative action has been taken; an application which is placed on the wait list is an example of no negative action being taken.

The Hearing Officer will send a denial notification to the client and A/R, if applicable.

792.2.4 Abandoned Hearing Request

A hearing is considered abandoned when neither the client nor their A/R appears for a scheduled hearing after having been properly notified. The Hearing Officer will send appropriate notification to the client and A/R, if applicable. The hearing is considered

abandoned unless the client or A/R submits to the Hearing Officer substantiation for good cause for failing to appear. The Hearing Officer must receive the substantiation within 10 days of the date of the abandoned decision notification.

If the hearing is abandoned by the client or A/R, and continued benefits were requested, the previously contested action must be taken immediately (e.g., update the case, reinstate benefits, terminate). Any excess benefits the household received during the pending period must be referred to DWSS Investigations and Recovery for collection.

793 Scheduling and Location of Hearing

Upon receipt of the Notice of Appeal (or a written request), the AAU notifies the household and appropriate Child Care staff of the date, time, and location of the hearing. The household is given at least 10 calendar days advance notice prior to the scheduled hearing unless the household requests the hearing be held in a shorter period of time. Clients are given a written explanation of the hearing procedures (Form 2076) with the scheduling letter.

At the discretion of the Hearing Officer, a hearing may be postponed if requested by either party.

Hearings may be conducted via telephone or video conference upon the approval of the Hearing Officer. The Hearing Officer may schedule telephone/video hearings for the sake of economy and expediency for outlying areas or for other extenuating circumstances. If a telephone/video hearing is held, the following procedures apply:

1. Child Care staff must be at the location designated by the scheduling letter.
2. The Hearing Officer may request the Child Care office and the client provide copies of any evidence or exhibits to be presented during the hearing to the Hearing Officer and the other party prior to a scheduled telephone hearing. This does not preclude additional information from being presented during the hearing or, if requested, after the close of the hearing.
3. All telephone/video hearings must be tape/digitally recorded by the Hearing Officer.

794 Hearing Participation

Attendance at a hearing is limited to those directly concerned; namely, clients and/or their A/R, interpreter, witnesses and representatives of the Child Care and Development Program. Others may be allowed at the discretion of the Hearing Officer.

It is the responsibility of Child Care staff to organize oral and written evidence and prepare a "BASIS OF ACTION" summary substantiating the decision for presentation at the hearing. The summary must quote applicable law, federal regulations or DWSS policy as it pertains to the action. This summary is read into the record and entered into evidence at the hearing.
Confidential information, such as documents or records containing the names of individuals who have disclosed information about the household without its knowledge or the nature and status of pending criminal prosecutions, is protected from release.

Information so protected which the client will not otherwise have an opportunity to challenge shall not be introduced at the hearing.
Child Care staff shall have the right, without undue interference, to question the client and/or A/R or any witnesses who present testimony.

795 Hearing Decision

The Hearing Officer will render a written decision after a hearing has been held, unless the dispute is otherwise resolved. The decision will be based on evidence and testimony presented at the hearing, as well as applicable law/policy.

Within 90 calendar days after the request for a hearing has been filed the Hearings Officer must notify the household and appropriate Child Care staff of the hearing decision. If the hearing supports the original Agency action, the previously contested action must be taken and the household is required to repay any EXCESS benefit received for the period of time during which the hearing was processed.

> **Note**: Child Care staff will forward a copy of the decision to the CCDP Chief.
> If necessary to restore or increase benefits, refer to manual section 555.

795.1 Client's Right to Appeal the Hearing Decision

The client or A/R may appeal the hearing decision to the appropriate district court in Nevada within 90 days from the date of the decision letter.

796 Restored and/or Increased Benefits

If it is determined through the hearing process that the client is entitled to restored and/or increased benefits the following procedures apply:

NO ADDITIONAL INFORMATION OR VERIFICATION IS NEEDED
Within 10 calendar days from the date the hearing results are date stamped received in the office, benefits for future months must be restored/increased and all benefits for the current and past months for which the household is eligible are to be supplemented.

ADDITIONAL INFORMATION OR VERIFICATION IS NEEDED
Within 10 calendar days from the date the hearing results are date stamped received in the office, the household must be provided a Request for Information which identifies information needed to determine eligibility. The household must be allowed at least 10 calendar days to provide for the needed information.

All needed information requested is received:

- Within 10 calendar days of the receipt of information, benefits for future months must be increased and/or benefits supplemented for the current and past months.

Part, but not all, of the information requested is received:

- Within 10 calendar days from receipt of the information/ verification, benefits must be increased or supplemented accordingly for only those months the information/verification is provided.

  Note: The household's statement is acceptable verification if no other information is available. Restored benefits should not be denied solely because a third party refuses to provide verification. Upon request, Child Care staff may assist the household in obtaining the needed verification.

797 Hearing Timeline

Responsibility	Action	Time Frame
Client	Submit hearing request for negative action	90 calendar days from date of date on the NOA
Client	Submit hearing for an overpayment	90 calendar days from date on the Notification of Debt
Client	Submit request for continued benefits	14 days from effective date of proposed negative action
Child Care	Submit hearing request to AAU	10 calendar days from date of receipt of hearing request
Child Care	Schedule pre-hearing conference	10 days from receipt of hearing request
Child Care	Date of pre-hearing conference	must be held no later than 30 days from receipt of the hearing request
Child Care	Agency or client withdrawal	Within 3 days of action, prepare and send a pre-conference report to AAU
Client	Abandoned hearing	With 10 days of the date of the abandoned decision notification, provide good cause substantiation to AAU
AAU	Schedule Hearing	Provide at least 10 calendar days advance notice of when & where hearing will be held
AAU	Hearing Decision	Within 90 calendar days from receipt of hearing request provide a written decision to the client and Child Care staff
Client	Hearing to district court	Within 90 days from the date of hearing decision
Child Care	**Restore or increase benefits**	
	No additional information required –	Within 10 calendar days from date of hearing decision
	Additional information required – RFI to be sent	Within 10 calendar days from date of hearing decision; allow at least 10 days for client to provide
	All required information provided	Within 10 calendar days from date of receipt of information
	Not all required information proved	Within 10 calendar days from date of receipt of information; update only those months information provided

Delegate Agencies

800 DELEGATE AGENCIES

A Delegate Agency is a public or private not-for-profit or for-profit organization which provides childcare through a school-age recreational program or an Early Head Start or Head Start agency.

801 Subsidy Type Selection

To ensure low income families have access to child care, DWSS, directly or through The Children's Cabinet or Las Vegas Urban League, contracts to purchase a number of child care openings (slots) with a school-age recreational program, an Early Head Start or Head Start agency.

The Delegate Agency must choose to provide services through the Certificate program or the Contract program.

If the Delegate Agency chooses to provide services through the certificate program, they must refer the client to the applicable Child Care staff to apply under the certificate program. An Application for Child Care Subsidy is required to process a case under certificate guidelines.

If the Delegate Agency chooses to provide services through a contract program (Contracted Slots or Wraparound), the Delegate Agency must enter into a written Memorandum of Agreement (MOA) with a Child Care staff or have a contract with DWSS. The contract fund amount provided to each Delegate Agency will be approved by the CCDP DWSS Child Care Chief. The contract amount will be provided to the Delegate Agency as written notification in the MOA or DWSS contract.

810 CONTRACTED SLOT PROGRAM

The Contracted Slot Program provides contract funding for an approved number of slots for a before and after school recreational program. Children must be between the ages of 5 and 12 (or 13 through 18 for children with special needs) and the household must have income below 85% of the State Median Income limits (refer to MS 170 for income limits). School–age recreational programs include Boys & Girls Clubs, Safe Key, Latch Key, YMCA, etc.

The Contracted Slot Program cannot be used in conjunction with the Certificate or Wraparound Program for the same child.

The Contracted Slot Program is only allowed to accept certificate case types for clients with a NEON purpose of care. No other certificate case types will be allowed.

810.1 Eligibility Requirements

All Delegate Agencies under the Contracted Slot program must meet the following requirements regardless of who is making the eligibility determination:

1. Accept the participant's completed and signed Delegate Agency Enrollment form (contractor form) or Application for Child Care Subsidy form (DWSS form).

2. Request the verifications listed below within 10 days from date application is received by the Delegate Agency Program. The client must be given at least 10 calendar days to provide the required verifications. Refer to MS 133 regarding pending information.

   a. Obtain a copy of identification for all required adult household members. Refer to MS 212 for additional information.

   b. Obtain the participant's written self-disclosure (under penalty of perjury) of all non-financial factors of eligibility for all household members which include:

      - Age

        Note: If services are requested for a child between the age 13 up to age 19, the child must meet all the requirements for a child with special needs as listed in MS 211 and 211.1

      - Social Security Numbers; refer to MS 213 regarding SSN requirements
      - Citizenship
      - Child Immunizations
      - Relationship (of applicant to household members)
      - Custody
      - Residency
      - Household Composition
      - Purpose of Care Schedule

   c. Inform custodial parents of the assistance listed below that can be provided through the DWSS Child Support Enforcement Program and provide the Child Support Services form 4000-EC to custodial parents if requested:

      - Locating the absent parent(s);
      - Establishing paternity;
      - Establishing and enforcing financial and medical support obligations; and
      - Collecting and distributing child support payments

   d. Obtain a copy of valid foster license for all foster households

e. Obtain a copy of the placement letter or referral from the court or social service agency, which defines the child as “foster” or “CPS” and the effective date of the transfer of custody. This documentation is required at initial application for a child.

f. Obtain the verification per MS 219 through MS 219.2.1 of purpose of care for all required adult members and minor parents of the household. If the participant(s) is not in an activity, i.e., purpose of care, allowed by the Child Care and Development Program, the household is not eligible for subsidy.

   Exception: The Job Search and NEON Categories are not allowed for anyone applying with a Delegate Agency. Applicants applying for these categories should be referred to the appropriate Child Care and Development Program Office

g. Obtain the proper verification for all reported countable household income (Employment Verification form, pay stubs, child support payments (informal payments or through court system), Social Security benefits, unemployment benefits, etc.).

3. Within 10 calendar days from receipt of all required verifications, Delegate Agency staff must:

   a. Convert the reported income into a monthly amount in compliance with the budget methodology set forth in MS 310 through MS 316

   b. Using the Household Size and Monthly Income Chart in MS 170 determine if the household is eligible for delegate funding based upon their countable income and household size.

   c. Approve eligibility and forward the information listed below to the appropriate Child Care staff for formal subsidy program enrollment in the computer.

4. At the end of the current eligibility period, obtain a new application and verify all eligibility requirements before approving any household.

810.2 Delegate Agency Determines Household Eligibility for Contracted Slots

If the Delegate Agency elects to determine the household’s eligibility for the contracted slot program, the Delegate Agency must follow the guidelines listed below:

1. The Delegate Agency requirements:
   a. Approve eligibility and forward the information listed below to the appropriate Child Care staff for formal subsidy program enrollment in the computer system within 10 calendar days of approval.

- The completed and signed application or Delegate Agency Enrollment form;
- A cover sheet which provides the following information
  - Delegate Agency name
  - Site Location;
  - Subsidy household size;
  - Names of all children subsidy care is being requested for;
  - Household subsidy percentage;
  - Type of application (new or renewal);
  - Length of certification period
  - Signature of Delegate Agency staff that completed the eligibility determination and the date completed;
- An income worksheet listing all income and how the delegate agency calculated the monthly income amount

b. If the Delegate Agency is made aware of changes in a household's circumstances, they must re-address the subsidy eligibility and provide the information/verification of the change to the appropriate Child Care office within 10 calendar days of receipt of the change/verification.

2. Child Care staff requirements:
   a. Formal subsidy program enrollment by Child Care staff must be completed in the computer system within 10 calendar days from receipt of the information listed above. Once enrolled in the computer system, Child Care staff will provide the following forms to the Delegate Agency:
      - A Notice of Decision (NOD): an eligibility status notification letter for the Delegate Agency records; and
      - A Notice of Action/Notice of Appeal (Form 2158 WC): an eligibly status and appeal form which the Delegate Agency must provide to the household
        Note: The Notice of Action/Notice of Appeal must also be provided to the household if the case is denied.
   b. Within 10 calendar days of receipt of any changes/verification in a household, update the computer system and notify the Delegate Agency as noted in 2,a above.

810.3 Delegate Agency Does Not Determine Household Eligibility for Contracted Slot Program

If the Delegate Agency chooses not to determine the household's eligibility for a contracted slot program, the agency must work with Child Care staff to obtain information necessary to determine eligibility for the Contracted Slot Program

1. Delegate Agency requirements:
   a. Within 10 calendar days of receipt of a completed and signed Delegate Agency Enrollment form or Application for Child Care Subsidy form the Delegate Agency must send a request to the household to provide any required verification listed in MS 810.1. The Delegate Agency will allow the household at least 10 calendar days to return the requested verifications.
   b. Within 10 calendar days of receiving all required verifications, the delegate agency must forward the completed and signed Delegate Agency Enrollment form or Application for Child Care Subsidy form along with all required verifications to the appropriate Child Care office.
   c. If the Delegate Agency is made aware of changes in a household's circumstances they must report these changes in writing to Child Care staff within 10 calendar days after gaining knowledge of the change.

2. Child Care staff requirements:
   a. Determine eligibility within 10 days of receipt of a completed and signed Delegate Agency Enrollment form or Application for Child Care Subsidy form and the required verifications;
   b. Send a Notice of Decision (NOD) to the Delegate agency
   c. Send a Notice of Action/Notice of Appeal (Form 2158-WC) to the household;
   d. Within 10 days of receipt of a change, reevaluate eligibility and notify the Delegate Agency and the household of any change in the subsidy case;

820 WRAPAROUND SERVICES

The Wraparound Subsidy Program is a program which provides contract funding for an approved number of slots for an Early Head Start or Head Start agency. Children must be between the ages of birth and 5 and be eligible for and attending an Early Head Start or Head Start program.

The Wraparound Program cannot be used in conjunction with the Certificate or Contracted Slot Program for the same child.

The Wraparound Program is only allowed to accept certificate case types for clients with a NEON purpose of care. No other purpose of care certificate case types will be allowed.

820.1 Additional Information

The eligibility criteria for Wraparound Subsidy is that a child has been determined eligible for Early Head Start or Head Start based on the Early Head Start or Head Start program rules/criteria and the meet the child care criteria listed below.

a. All required adult and minor parent Head Start and Early Head Start household members must have POC as defined in MS 219;

b. The household's total gross income cannot exceed 85% of the State Median income;

c. The subsidy percentage is based on the Income Limits as defined in MS 170.

Note: The rules/criteria for the Early Head Start or Head Start include the definition of household composition, countable income and reporting requirements.

d. After initial eligibility for Early Head Start is determined, reapplications are not required until the child moves from Early Head Start to Head Start.

e. After initial eligibility for Head Start is determined, reapplications are not required until the child is no longer eligible for Head Start.

f. Purpose of Care and schedule must be re-verified every 12 months.

g. Updates to the Wraparound case are based on written changes/verifications provided by the Early Head Start or Head Start program.

830 Additional Requirements for All Delegate Agencies

Delegate Agencies must:

1. Submit a signed MOA to the Child Care staff or have an approved contract in place with DWSS prior to payment being issued. A new MOA or contract must be signed annually or more often if necessary due to amendments in the MOA or contract.
2. Inform parents of their rights to receive services, rights to appeal and right to file a complaint.
3. Notify the Child Care office in writing of a client's termination for contract care.
4. Maintain all relevant records for a period of 3 years as follows:

   a. Eligibility Case Files - Maintain complete documentation which supports eligibility decisions for each application for assistance for 3 years from the date the case is denied/terminated/closed or as defined in the MOA or contract. Eligibility records for children who have received subsidy benefits during the last 12 months must be on site at one location for auditing purposes.
   b. Child Attendance Records - Retain these records for 3 calendar years from the last date of attendance.
   c. Billing Records - Retain this record for 3 calendar years from the date upon which the bill is paid or rejected.

831 Subsidy Amount

The subsidy amount is derived from the Income Limits and Subsidy Percentage chart in MS 170 and is based on the household size and countable income.

The Contracted Slot Program is always paid from the Discretionary Category (see MS 102).

The Wraparound program is always paid from the At-Risk Funding Category (see MS 102).

Note: Households who have been assessed an IPV penalty are not eligible for 100% coverage until the penalty period has been exhausted. The Child Care staff must inform the Delegate Agency of an IPV penalty when the household is approved under contract care.

840 Requirements for Reimbursement

The Delegate Agency must submit Enrollment Attendance Verification (EAV) billings monthly to the Child Care office on or before the 5th business day of each month to ensure timely reimbursement. The EAV must:

- Include the service site/location's name, address, telephone number, and period of time covered; and
- The names of the children for which child care reimbursement is requested and the date and time of attendance; and
- Have each page of the EAV must be signed by an authorized person unless the delegate agency uses electronic means to record attendance.

Reimbursement will be allowed for the entire billing month for a child if:

- The child is eligible for the entire service period and,
- The child attends at least one day during the service period and,
- The Delegate Agency submits a reimbursement request for the child.

Example: If the Contracted Slot or Wraparound case is approved with an effective date of 05/01/2009 thru 04/30/2010, the 05/2009 service period can be reimbursed. However, if the case is approved with an effective date of 05/10/2009 thru 04/30/2010, the 05/2009 service period will not be reimbursed, as the child was not eligible the entire service period. Additionally, when a child turns 13 or no longer attends, the monthly service period will not be reimbursed, as the child was not eligible the entire monthly service period.

Note: A delegate agency will not be reimbursed above the approved budget in their MOA or contract.

841 Reimbursement

For each eligible child, the Delegate Agency's slots will be paid at the state approved rate, using the state maximum daily rate less the participant's co-payment responsibility.

For children 6 years of age through 12 years of age or children with special needs 13 years of age up to 19 years of age, full-time attendance is justified when attendance records validate at least 3 hours of attendance in a calendar day during the billing month.

For children less than 6 years of age full-time attendance is justified when attendance records validate at least 4 hours and 30 minutes of attendance in a calendar day during the billing month.

Attendance less than a full-time day will be paid at the approved part-time rate.

Delegate Agencies must be allowed flexibility in determining the amount of funds needed monthly. The funds must be requested monthly, but the amount billed depends on the needs of the agency. Delegate Agencies cannot request funds that will exceed the approved yearly MOA or contract amount.

Upon approval from the Child Care and Development Program, payment shall be made directly to Delegate Agency within thirty (30) business days of receipt of attendance billings.

850 Audits

A case may be selected to review the accuracy of subsidy benefits paid or authorized. Delegate Agencies are required to cooperate with the review process. The Delegate Agency's case files and attendance logs may be requested and compared to the EAVs submitted by the Delegate Agency. The Delegate Agency is required to cooperate with the review process. Refer to MS 152 regarding cooperation requirements.

Glossary

185% of Needs — TANF maximum income test.

Absent Parent — A child's parent who is not residing in the home, also known as, non-custodial parent (NCP).

ACE — Assistance with Child Care for the Employed

Active Overpayment — An overpayment which is open and being pursued and/or paid against.

Adequate Notice — Advance notice of an adverse action is provided to the household on proposed case actions. Note: Some actions do not require advance notification. See adverse action requirements for each program.

Advance Notice — Adequate notice of adverse action provided at least 10 days before taking an action on an ongoing or open case.

Adverse Action — Any Child Care Program action resulting in suspension, reduction, or termination of benefits. Denied cases do not require adverse action.

AFIA — Assets for Independence Act

AJS — Applicant Job Search

Annual Fee — A fee charged by the provider on an annual basis for each child in their care.

Annualize — To average income over a 12-month period.

Annuity — An amount payable yearly or at other regular intervals.

Appeal — An applicant /client's request for a case reviews regarding a Child Care case worker's negative action.

Applicant — An individual who applies for subsidy benefits.

Application — When receiving requests for assistance, the Child Care Program must accept any designated application form, which contains at least the applicant's name, address, and signature or the signature of a responsible household member or authorized representative. The applicant must answer all the questions on the application before the household can be approved.

Approval Date — The date the Child Care case manager signs the certificate authorizing subsidy benefits.

Assistance with Child Care for Employed (ACE) — Available to TANF recipients who become ineligible due to obtaining employment, increased hours, earnings, loss of earning disregards. ACE is available for 12 consecutive months following the last month in which they received a TANF cash grant (includes grants under $10).

Authorized Representative (AR) — Someone acting responsibly for a client in the various aspects of the application and/or reapplication process.

BCIS — Bureau of Citizenship and Immigration Services (formerly INS)

BIA — Bureau of Indian Affairs

Boarder — A person living in a Child Care household paying reasonable compensation for room and meals.

Cafeteria Plan — A term sometimes used to refer to flexible fringe benefit plans offered to employees by their employers.

Calendar Year — January 1 – December 31

Capital Assets — The accumulated possessions (property, goods, and products) used to produce income or other goods.

Capital Gain — The financial profit from sale or transfer of capital assets.

CCDF — Child Care Development Fund

CCMS — Child Care Management System

Centers for Medicare and Medicaid Services (CMMS) — CMMS rules govern the Medicaid programs.

Certification Period — The time period for which subsidy benefits have been approved.

CHAP (The Child Health Assurance Program) — Medicaid for children born after 9/30/83, meeting specific requirements (includes pregnant women).

Child Care Household — A group of persons who live in the same home, are related by blood, adoption or marriage and whose needs and income are included when determining eligibility for Child Care subsidy benefits.

Child Care Management System (CCMS) — The computer system used by the contractors to manage the child care program.

Child Care Program Contractors — The Children's Cabinet and Economic Opportunity Board.

Child Care Program Management Staff — The contracting agency staff above the case manager level.

Child Care Program Office — The contracting agency offices where eligibility is determined.

Child Care Program Staff — Any member of the Child Care Contracting Agency related to the Child Care Program.

Child Support Enforcement Program (CSEP) — CSEP in Nevada is responsible for the administration of and oversight of child support enforcement activity.

Client — An individual who receives benefits from the Child Care Program.

Closed Overpayment — An overpayment, which is paid in, full, excused by the court or permanently waived in its entirety by DWSS.

CMMS — Centers for Medicare and Medicaid Services

COLA — Cost of Living Adjustment

Collateral Contact — Person with no vested interest who the worker can contact to verify client information.

Component (Work) — A service, activity or program designed to assist TANF recipients to gain skills, training or work experience to increase their ability to obtain employment and achieve self-sufficiency.

Continued Benefits — Continuing or restoring benefits to the level authorized immediately before the notice of adverse action.

Cost of Living Adjustment (COLA) — An annual increase of benefits based upon the increase in the cost of living.

Current Verification — Verification issued within the previous thirty (30) days.

Custodial Parent — Parent who has physical and/or legal custody of child(ren).

DAA — Drug Addiction and Alcohol

DAG — Deputy Attorney General

Date of Discovery — The date Child Care Program staff obtains facts indicating an overpayment may exist.

DCFS — Division of Child and Family Services

Department of Health and Human Services (HHS) — HHS rules govern the TANF/ Employment and Training Programs.

Dependent Child — A child under the age of eighteen (18).

Deprivation — Loss of parental support caused by death, incapacity, or continued absence of one or both natural or adoptive parents. Deprivation also exists when one or both parents are Voc Rehab participants.

Derivative Citizenship — United States citizenship claimed by a person born outside of the U. S. to one or both U.S. citizen parents.

DETR — Division of Employment, Training and Rehabilitation

Disqualification — Individuals or households disqualified from program participation (ineligible).

Division of Welfare and Supportive Services — DWSS (formerly NSWD)

Diversion Payments — Diversion payments are financial assistance payments, designed to meet an immediate emergent need and prevent the family from requiring ongoing cash assistance in accordance with Nevada's or another state's policy provisions.

DoIT — Department of Information Technology

Domicile — A policy in TANF that requires a child to live with a relative who is within the required degree of relationship.

Drug Addiction and Alcohol — A provision included in the Social Security Act.

DWSS — Division of Welfare and Supportive Services (formerly NSWD)

E&T — DWSS Employment & Training

Earned Income — Income a client receives for a certain degree of activity or work.

Earned Income Tax Credits (EITC) — Payments from IRS to persons with tax dependents and gross monthly earnings at or below levels established by the IRS.

EBT — Electronic Benefit Transfer

ECS — DWSS Eligibility Certification Specialist (case manager)

EITC — Earned Income Tax Credits

Electronic Benefit Transfer (EBT) — EBT is an electronic system that allows a client to authorize transfer of their government benefits from a federal account to a retailer account to pay for products received. This account, which is accessed by a Food Stamp client with a pin number, is credited with the dollar amount of Food Stamp benefits.

Emancipated Minor — A person under age 18 who has been or is married. The marriage must not have been annulled. DWSS requires certain conditions be met before automatically applying emancipated status to a minor.

Employment and Training (E&T) Program — The program for employment assistance and work registration of TANF and Food Stamp clients.

Equity — The fair market value of an item minus all money owed on it and the cost associated with its sale or transfer.

ESD — Employment Security Division

Essential Person — The need for a particular member of a household to be in the home on a continuous basis because of the (certified) mental or physical impairment of another member.

ETS — DWSS Employment and Training Specialist

Fair Hearing — A meeting conducted by the Child Care Program Manager/ Administrator with any applicant or client who disagrees with and wishes to appeal some action taken on his/her Child Care case.

Fair Market Value (FMV) — Amount of money an item would bring if sold in the current local market.

FAME — Acronym for Food Stamp, AFDC, Medicaid and Employment and Training programs. AFDC is now called the TANF program.

Family Preservation Program (FPP) — TANF assistance for children with profound or severe mental retardation or children under age 6 with developmental delays.

FEMA — Federal Emergency Management Agency

First Cousin Once Removed — A person's first cousin once removed is either his (1) first cousin's child, or (2) parent's first cousin.

First Excess — A payment sent to a TANF recipient by CSEP. When CSEP receives a child support collection on the current monthly obligation and that exceeds the TANF grant plus the disregard, the excess is sent to the client.

Fiscal Year — July 1 – June 30 (State), Oct 1-Sept 30 (Federal)

Fixed Income — Income, which does not vary.

Fluctuating Income — Income in which the amount varies because of an increase or decrease in hours worked, rate of pay, or inclusion of a bonus.

FPP — Family Preservation Program

FSS — Family Services Specialist

Good Cause — A term used to indicate that a client had an acceptable reason for not complying with a program requirement.

Grant in Jeopardy of Ineligibility — CSEP reports a case that is potentially ineligible for the TANF grant because CSEP received child support collection on the current monthly obligation and it equals or exceeds the TANF grant plus the disregard.

HCFA — Health Care Financing Agency, now known as Centers for Medicare and Medicaid Services (CMMS)

Head of Household — The person who signs an application for assistance and assumes responsibility for the child care household.

Health Care Financing Agency (HCFA) — Now known as Centers for Medicare and Medicaid Services (CMMS). CMMS rules govern the Medicaid programs.

HEAP — Home Energy Assistance Program

HHS — Department of Health and Human Services

Home Energy Assistance Program (HEAP) — This program pays benefits twice yearly to help eligible persons pay utility costs.

Housing and Urban Development (HUD) — Federal housing agency providing funds to assist needy families/elderly/disabled individuals with housing/shelter costs/ mortgages (e.g., the family pays a percentage of the rent/mortgage based on income).

HUD — Housing and Urban Development

IDA — Individual Development Account

IFG — Individual and Family Grant Program

Illegal Non-citizen Alien — A non-citizen living in the United States without proper approval from the Bureau of Citizenship and Immigration Services (BCIS) and who has received a final order of deportation.

IM — Informational Memorandum

Immigrant — Defined by the Bureau of Citizenship and Immigration Service (BCIS) as an alien who is abandoning their residence in a foreign country to live in the United States as a permanent or temporary legal resident.

INCAP (Incapacitated) — Individuals temporarily unable through illness/injury to make decisions, be in attendance at interview, or sign documents. Also applies to an individual determined to be incapacitated/disabled to work by a certified physician, the Nevada Medicaid Office, Social Security, Administration, Veteran's Administration, Voc Rehab or any other agency utilizing Social Security criteria.

Incompetent — An individual who has been declared permanently or on a long-term basis to be incapable of making legally binding decisions due to physical/mental illness injury. Statements from certified physicians, Social Workers, Voc Rehab counselors, Social Security Administration, Veterans Administration, etc., court orders, and observation are means of verifying incompetence. This term also applies to minor children unable to make legally binding decisions until they are an adult.

Individual Development Account (IDA) — The use of Individual Development Accounts (IDAs) are intended to improve the economic independence and stability of individuals and families and to promote and support the transition to economic self-sufficiency. Federal funds match the amount of earnings of low-income working individuals and families. IDA savings are to be used for a first home purchase, post secondary educational expenses, or business capitalization.

The Social Security Act provides for the use of State Family Assistance Grant funds, such as, Temporary Assistance for Needy Families (TANF) and Welfare-to-Work (WtW) funds to be used to establish IDAs for low-income working individuals and families. The Assets for Independence Act (AFIA) provides for IDAs under Head Start, Low Income Home Energy Assistance (LIHEA) and Community Services. IDAs have been established under WtW and Community Services. DWSS is currently evaluating the use of TANF funds for IDAs.

Informational Memorandum (IM) — Contains informational items of which contractors should be apprised.

In-kind Contribution — Any gain or benefit to a person which is not in the form of money payable directly to the client such as clothing, public housing, or food.

INS — Immigration and Naturalization Service (changed to BCIS)

Institution of Higher Education — One, which usually requires a high school diploma or equivalency, certificate such as GED to enter. (E.g., business, technical, trade, beauty or vocational school, or enrolled in regular curriculum at a college or university that offers degree programs regardless of whether a high school diploma is required. This includes correspondence and off-campus home-study enrollment.)

Intentional Program Violation (IPV) — Purposeful or willful misstatement of information by a client to receive more benefits than they are entitled to.

Investigations and Recovery (I&R) — DWSS unit responsible for investigations, recovery of overpayments, prosecution and Medicaid Estate Recovery (MER).

IRS — Internal Revenue Service

Job Search — Applicants are required to make inquires to at least ten (10) prospective employers per week for no more than 4 weeks at a time.

Job Training Partnership Act (JTPA) — Job Training Partnership Act is a federal program offering job training. JTPA replaced the CETA program. The Workforce Investment Act of 1998 replaces the JTPA program.

JTPA — Job Training Partnership Act

Kinship Care Recipient — An adult present in the home whose needs are not included in the TANF grant, who supervises and cares for the TANF child(ren), and meets relationship requirements, is age 62 or older, has legal custody of the child(ren), and passed a background/fingerprint check.

Legal Guardian/Caretaker — An adult, not the natural/adoptive parent, who has legal custody documented through the court system for the children in their care.

Legal Parents — Mother, by having given birth to the child or by proof of adoption; father, by proof of adoption, legal document, court adjudication, or his acknowledgment of paternity.

Legal Requirements — The non-financial eligibility requirements for a Child Care program child such as age, relationship, domicile, and citizenship.

Legally Obligated Child Support — Court ordered or legally recorded document requiring the payments of child support to be made in the form of cash, medical, or to a third party. The official document indicates who the support is paid to and for, the frequency, and the amount of payment.

LIHEA — Low Income Home Energy Assistance

Local Workforce Investment Board (LWIB) — The LWIB, formerly known as the Private Industry Council (PIC), manages the selection and monitoring of service providers for WtW services.

Lump Sum Payment — A financial settlement, which often involves funds, accumulated over an extended period of time.

LWE — Limited Work Experience

MAABD — Medical Assistance for the Aged, Blind and Disabled

Major Parent — The natural/adoptive parent of a minor parent.

Managing Conservator — A person designated by a court to have daily legal responsibility for a child.

Medicaid — State-paid insurance for eligible TANF grant members, Medical Assistance Program (MAP) recipients, and SSI recipients.

Medicaid Card — A certificate issued monthly to eligible TANF/TANF related medical categories/CHAP categories and individuals eligible for SSI/Medicaid.

Medical Support — The non-custodial parent may be ordered to obtain health insurance for their children who receive TANF/Medicaid when it is available at a reasonable cost. Available at a reasonable cost is usually defined as being available through the employer. The medical support may be court-ordered as a cash payment. If the children are on assistance, Medicaid will intercept the payments to offset Medicaid expenditures. Direct cash medical support is budgetable income.

MHDS — Mental Health and Developmental Services

Migrant Farm Worker — Farm workers who are presently employed away from their permanent residence or home base.

Minor Child — A person under the age of 18 years old.

Minor Parent — An individual who is under the age of 18, has never been married, and is pregnant or the natural parent of a dependent child.

Monthly Obligation — The amount of the child support payment, which the non-custodial (absent parent) parent has been ordered to pay each month.

NCP (Non-Custodial Parent) — A parent absent from the home or the parent without custody.

Needy Caretaker (NCT) — An adult whose needs are included in a TANF grant because they are within the required degree of relationship and are financially eligible according to TANF policy (e.g., grandmother, aunt, uncle, etc.) Note: Two adult relatives (e.g., aunt/uncle/grandmother/grandfather) cannot be included as needy unless they have dependent children of their own and meet TANF deprivation requirements.

NEON — New Employees of Nevada

NESD — Nevada Employment Security Department (ESD).

Nevada QUEST Card — Nevada's EBT card. It is a plastic debit card with the QUEST logo and PAN on the front. A magnetic strip on the back allows the client access to their account when connected with a four-digit secret PIN.

New Employees of Nevada (NEON) — TANF recipients who must participate with DWSS Employment & Training Unit.

NNCT — Non-Needy Caretaker

NOCO/NONCOOP — Acronym for non-cooperation with a program requirement or specific request.

NOD — Notice of Decision sent to advise the Child Care household of a case decision.

NOMADS — Nevada Operations of Multi-Automated Data Systems

Non-Needy Caretaker (NNCT) — An adult present in the home whose needs are not included in the TANF grant, who supervises and cares for the TANF child(ren), and meets relationship requirements.

NSWD — Nevada State Welfare Division (changed to DWSS)

NVRD — Nevada Vocational Rehabilitation Department (Voc Rehab)

OBRA — Acronym for Omnibus Budget Reconciliation Act. A child receiving Medicaid for one year from the date of their birth.

OJT — On-the-job training

Overpayment — The amount of benefits issued in excess of what should have been issued. Benefits made on behalf of the client to which they were not entitled and they must repay.

P&P — Policy and Procedure Inquiry form

Parent — Natural/Adoptive parent of a child.

PASS (Plans for Achieving Self-Sufficiency) — A program administered by Social Security Administration/Mental Health and Rehabilitation (MHR).

PCN (Primary Care Network) — Medicaid enrolled health plan provider.

Personal Account Number (PAN) — A 16-digit number embossed on the front of each Nevada Quest Card, and subsequently connected to a client's individual EBT account when the card is issued.

Personal Identification Number (PIN) — A four-digit secret alphanumeric code that the client selects to access their electronic benefits account.

PL — Public Law

Point of Sale (POS) Device — A device that a client "swipes" their card through which allows it to be electronically read. This device is used by participating retailers and allows a client to purchase food items.

Policy and Procedure Inquiry — Form used to request guidance/clarification regarding policy and/or procedure. This form is sent to the Chief of Child Care and Development for his response.

Policy Transmittal (PT) — Memorandum used for disseminating policy guidance and/or clarification to the contractors prior to its inclusion in the Child Care Policy Manual.

POS — Point of Sale

Post-medical (PM) Four Months, Aid Code PM — Medicaid insurance coverage extended for a maximum of four months after denial of TANF cases denied because of child support income.

Prepaid Burial Insurance — Insurance that pays for a specific funeral arrangement. Also known as pre-need plan or prepaid funeral agreement.

Processing Time Limits — Number of days the worker has to complete a particular action.

Program Violations/Sanctions — Penalties associated with noncompliance with a Child Care program requirement or disqualification from Child Care program participation.

Prospective Budgeting — A way to determine eligibility and benefits using the best estimate of the household's current and future circumstances and income.

Prudent Person Principle — Reasonable decision made by staff based on the best information available and common sense in a particular situation.

PRWORA — Personal Responsibility and Work Opportunity Reconciliation Act of 1996. This act was signed by President Clinton on August 22, 1996.

PT — Policy Transmittal

Public Law (PL) — Laws enacted by specific congressional acts.

Purpose of Care — An approved activity that does not allow for the parent/caretaker to care for the child(ren). Approved activities are employment, training, educational classes, seeking employment, temporary disability or NEON related requirements.

Qualified Relative — Grandparent, great-grandparent, uncle, aunt and adult siblings not living in the same household as the dependent child receiving subsidy benefits.

Quality Control (QC) — A group of people who conduct and complete state mandated reviews and report their findings to policy setting officials. This unit also participates in training activities and corrective action to ensure program integrity is maintained for the programs administered by the DWSS.

Questionable Information — Information that is contradictory or incomplete.

Real Property — Land and any improvements on it.

Recipient — An individual who receives services from the Child Care Program

Reconciliation — Refers to the process of ensuring that all transactions have been processed accurately and validated.

Recoupment — To withhold part of a client's current benefit because of a previous overpayment.

Registration Fee — A fee charged by the provider when a child enrolls at their facility.

Reimbursement — Repayment for a specific item or service.

Reinstatement — Process of reinstating cases that were denied/terminated.

Repayment Agreement — A signed agreement between the client and either the provider and/or Child Care Program stating the client will repay any obligation outstanding or benefit for which the client was not entitled.

Resident Seasonal Farm Worker — Farm workers who do not leave their permanent residence to work in agriculture or a related industry.

Resources — Both liquid and non-liquid assets a client can convert to meet his immediate needs.

Retirement, Survivors and Disability Insurance (RSDI) — Social Security benefits issued to persons who are eligible for retirement, disability or survivor benefits due to the death of a parent and/or spouse.

Retroactive Benefit — An initial benefit issued for a month approved after the benefit period has passed.

Review — An optional case evaluative review by the case worker, supervisor, manager, or Investigations based on reported/unreported changes and other client circumstances.

Royalty — A payment to an individual for permitting another to use or market his property (such as mineral rights, patents, or copyrights).

RSDI — Retirement, Survivors and Disability Insurance

RSVP — Retired Senior Volunteer Program

Sanction — A reduction in or ineligibility for benefits because of failure to cooperate with a Child Care program requirement.

SAVE — Systematic Alien Verification for Entitlements

SBA — Small Business Administration

Second Excess — A child support payment sent to a TANF recipient by CSEP. When CSEP receives a child support collection that exceeds the monthly obligation, the excess is applied toward child support arrears. This amount is sent to the client if all past months' unreimbursed TANF have been paid off, and child support arrears are still owed to the client.

Self-employment Income — Income available from one's own business, trade, or profession rather than from an employer.

Service Agreement — The service agreement explains to the client and/or provider their responsibilities to the Child Care Program and associated penalties which can occur for failure to uphold the agreement. The service agreement with the applicant/client is reviewed and signed at each application and/or redetermination. The caseworker must confirm these obligations have been read/understood by the applicant/client.

Sibling — Blood-related or adoptive brother or sister.

Signature — The first initial and last name or the entire first and last name. If the client is unable to write, they may use an “X” as their signature/mark.

SLA — Supported Living Arrangement

Sneede v. Kizer — Special Medicaid category provided to persons ineligible for TANF and there is income or resources of a family member who is not a parent or spouse. Sneede v. Kizer also applies to CHAP and Transitional Medicaid cases.

SNWIB (Southern Nevada Workforce Investment Board) — The southern WtW agency which manages the selection and monitoring of service providers for WtW services.

SSI — Supplemental Security Income

Standard of Need/Needs Standard — Basic needs of TANF families represented by a figure predetermined by the State of Nevada according to the number of persons in the assistance household group. This figure represents food, clothing, housing, utilities, and incidentals. Incidentals include such things as transportation (other than job training or medical transportation), telephone, laundry, medical supplies not paid by Medicaid, home remedies, recreation, and household equipment.

Step Grandparent — The spouse of a blood-related grandparent.

Stepparent — Spouse of the natural/adoptive parent, not blood-related.

Subsidized Housing (SH) — Housing which is subsidized allowing the TANF/CHAP household reduced rent/mortgage payments.

Supplemental Benefit — Additional benefits for any month in which the household has received initial benefits.

Supplemental Payment — A payment made in addition to the regular monthly payment.

Supplemental Security Income (SSI) — A needs-tested program administered by the Social Security Administration providing monthly income to aged, blind, and disabled individuals, including children.

Suspended Overpayment — An overpayment which recovery steps have been either unsuccessful due to loss of contact, loss of income (expenses exceed income), or temporarily waived by DWSS.

Systematic Alien Verification for Entitlements (SAVES) — A database DWSS employees can access to determine the citizenship status of a non-citizen.

TANF (Temporary Assistance for Needy Families), Aid Code AF — The block grant which states receive to fund their public assistance program. TANF replaces Aid to Families with Dependent Children (AFDC). A Welfare check or warrant.

TANF-related Medicaid, Aid Code AM — A category of medical assistance for families meeting certain TANF criteria which may be received with or without associated TANF (cash) benefits.

Ten-Ten-Ten Concept — Concept used to determine the earliest month a change could be effective for Child Care benefits when determining the first month of an overpayment. The client has 10 days to report the change; the case manager has 10 days to take action on the change; and the advance notice of adverse action expires in 10 days. Quality Control uses this concept in determining an error on unreported changes or untimely case actions.

Term Life Insurance — Life insurance with no cash or loan value.

Terminated Overpayment — An overpayment, which has exceeded its legal time, limit for collection.

Third Party — Person or organization outside the child care household.

Transitional Medicaid, Aid Code TR — Medicaid insurance coverage extended for a maximum of 12 months after termination of certain TANF cases because of new or increased earnings, or loss of earned income disregards.

Transitional Medicaid (TR) Quarterly Reporting — To continue eligibility, the transitional Medicaid client must report earnings, child care expenses, and household composition changes in the 4th, 7th, and 10th months of the transitional Medicaid 12-month period.

Tribal Marriage — Marriages conducted under the provisions of the laws established by each tribe. These marriages are legally recognized in Nevada.

Trust — Property held by one person for the benefit of another. All trusts are referred to the State Child Care Coordinator to be forwarded to the Deputy Attorney General (DAG).

UIB — Unemployment Insurance Benefits

Unable to Locate (UTL) — Sometimes used in case record documentation or by the post office when returning mail for a client.

Underpayment — When the client is issued additional benefits because the original benefit was less than they were entitled to.

Unearned Income — Payments received without performing work-related activities, including benefits from other programs.

Universal Life — Life insurance which may or may not have a cash surrender value.

Vendor Payments — Payment made directly to the client's creditor or person providing the service by a person or organization outside the household.

Verification — Documentation that substantiates household eligibility requirements.

Vested Interest — A situation or circumstance to which a person has a strong personal commitment.

VISTA — Volunteers in Service to America

Voc Rehab — Department of Vocational Rehabilitation.

Waiver of Continued Benefits — A client option to allow the worker to process an adverse action during the client's appeal process.

Welfare-to-Work (WtW) — Provides transitional employment services for the hardest-to-employ (HTE) welfare recipients and non-custodial parents to assist in moving them into unsubsidized employment.

Whole Life Insurance — Life insurance that has a cash surrender value. Loans may be taken out against whole life policies.

WIA — Workforce Investment Act of 1998

Work Registration — Food Stamp eligibility requirement that all nonexempt household members be registered for employment. DWSS considers all applicable individuals to be work registered who are required to meet work requirements.