_____ **County** Case No. _____ Date _____

Work First Cash Assistance Application and Review Documentation Workbook

This is a workbook used to collect the information needed to determine eligibility for Work First Cash Assistance.

Does anyone in the household wish to apply for Medicaid? ☐ Yes ☐ No

Does anyone in the household have a disability to report? ☐ Yes ☐ No/Prefer not to report (***The reporting of a disability is strictly voluntary.***)

"Disability means, with respect to an individual: (1) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (2) a record of such impairment; or (3) being regarded as having such an" impairment" (Americans With Disabilities Act of 1990)

Does the individual need help to complete the application or interview process? ☐ Yes ☐ No

PROGRAM SCREENING (ALL ANSWERS MUST BE YES TO BE POTENTIALLY ELIGIBLE.)	
☐ Yes ☐ No	Is there a child in the home under age 18? Or if a recertification, is there a child in the home age 17 or is age 18 and will graduate from high school by age 19?
☐ Yes ☐ No	Is the applicant an adult who lives with the child (ren) and who meets the kinship rule?
☐ Yes ☐ No	Does the family reside in North Carolina and intend to remain or entered North Carolina seeking a job or with a job commitment?

Applicant Name: _____ Telephone No: _____

Address: _____

Mailing Address if different than above: _____

Directions to residence: _____

_____

☐ Form DSS-8227 (Immigrant Access Notice) provided and signed by the applicant.

☐ DSS- 10001, Language Services Agreement (For Limited English Proficiency (LEP) Customer) provided and signed by applicant.

NON-APPLICANT HOUSEHOLD MEMBERS ARE NOT REQUIRED TO PROVIDE A SOCIAL SECURITY NUMBER, IMMIGRANT OR CITIZENSHIP STATUS. CONTINUE TO ASSESS THE NON-APPLICANT BUDGET UNIT MEMBER FOR COUNTABLE RESOURCES SUCH AS INCOME AND ASSETS IN DETERMINING ELIGIBILITY.

The Department of Health and Human Services complies with Federal and State laws, which restrict the use and disclosure of information concerning applicants and recipients of public assistance and comply with applicable provisions of the Social Security Act concerning confidentiality. The Department of Health and Human Services does not discriminate against any person on the basis of race, color, national origin, sex, religion, age, political beliefs, or disability.

CASE HEAD/ PAYEE SECTION (WORK FIRST MANUAL SECTION 104)

	Name (Last, First, MI)	Gender	Marital Status	D.O.B.	Place of Birth	Race/Ethnicity	Language Preference

Parent's Name	Parent's Name	School (current enrollment)	Grade (current /highest completed)
		☐ Yes, Where _____ ☐ No	

Included in application? ☐ Yes ☐ No, explain	Citizenship/Immigrant Status (If included in application):	Individual ID. No.
	☐ U.S. CITIZEN ☐ QUALIFIED IMMIGRANT	

If included in the application, record the Citizenship/ Immigration Document(s) viewed:	Social Security Number, if included in application:
ID Verified ☐ Yes ☐ No Document viewed:	Kinship/Living With: Method of Verification

OTHER FAMILY UNIT MEMBERS (WORK FIRST MANUAL SECTION 104)

1	Name (Last, First, MI)	Gender	Marital Status	D.O.B.	Place of Birth	Race/Ethnicity	Language Preference

Parent's Name	Parent's Name	School (current enrollment)	Grade (current /highest completed)
		☐ Yes, Where _____ ☐ No	

Relationship to case head/payee	Included in application? ☐ Yes ☐ No, explain	Individual ID. No

If household member is included in the application, complete the following: ☐ U.S. CITIZEN ☐ Qualified Immigrant	Social Security Number, if included in application
ID Verified ☐ Yes ☐ No Document viewed:	Citizenship/Immigration Document(s) viewed:

2	Name (Last, First, MI)	Gender	Marital Status	D.O.B.	Place of Birth	Race/Ethnicity	Language Preference

Parent's Name	Parent's Name	School (current enrollment)	Grade (current /highest completed)
		☐ Yes, Where _____ ☐ No	

Relationship to case head/payee	Included in application? ☐ Yes ☐ No, explain	Individual ID. No.

If household member is included in the application, complete the following: ☐ U.S. CITIZEN ☐ QUALIFIED IMMIGRANT	Social Security Number, if included in application
ID Verified ☐ Yes ☐ No Document viewed:	Citizenship/ Immigration Document(s) viewed:

FAMILY UNIT MEMBERS CONT.

3	Name (Last, First, MI)	Gender	Marital Status	D.O.B.	Place of Birth	Race/Ethnicity	Language Preference

Parent's Name	Parent's Name	School (current enrollment)	Grade (current /highest completed)
		☐ Yes, Where _____ ☐ No	

Relationship to case head/payee	Included in application? ☐ Yes ☐ No, explain	Individual ID. No.

If household member is included in the application, complete the following: ☐ U.S. CITIZEN ☐ QUALIFIED IMMIGRANT	Social Security Number, if included in application

ID Verified ☐ Yes ☐ No Document viewed:	Citizenship/Immigration Document(s) viewed:

4	Name (Last, First, MI)	Gender	Marital Status	D.O.B.	Place of Birth	Race/Ethnicity	Language Preference

Parent's Name	Parent's Name	School (current enrollment)	Grade (current /highest completed)
		☐ Yes, Where _____ ☐ No	

Relationship to case head/payee	Included in application? ☐ Yes ☐ No, explain	Individual ID. No.

If household member is included in the application, complete the following: ☐ U.S. CITIZEN ☐ QUALIFIED IMMIGRANT	Social Security Number, if included in application

ID Verified ☐ Yes ☐ No Document viewed:	Citizenship/ Immigration Document(s) viewed:

5	Name (Last, First, MI)	Gender	Marital Status	D.O.B.	Place of Birth	Race/Ethnicity	Language Preference

Parent's Name	Parent's Name	School (current enrollment)	Grade (current /highest completed)
		☐ Yes, Where _____ ☐ No	

Relationship to case head/payee	Included in application? ☐ Yes ☐ No, explain	Individual ID. No.

If household member is included in the application, complete the following: ☐ U.S. CITIZEN ☐ QUALIFIED IMMIGRANT	Social Security Number, if included in application

ID Verified ☐ Yes ☐ No Document viewed:	Citizenship/Immigration Document(s) viewed:

Check here: ☐ **if more people are in the household** (attach additional copies of this page, if needed)

OVS Check Completed: ☐ **Yes** ☐ **No If no, reason:** _____

BENEFITS FROM OTHER STATES

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

If yes, name: _____ Dates: _____ City/County/State: _____

Did he/she receive public assistance in the other state? ☐ Yes (check all that apply) ☐ No

☐ TANF (Federal: **Verify months of TANF assistance received**) ☐ Food & Nutrition Services ☐ Other _____

Agency Name: _____ Contact Person: _____ Telephone Number: _____

TEMPORARY ABSENCE

Anyone temporarily absent from the home? ☐ Yes (complete the questions below) ☐ No

Name	Date of Absence	Reason	Expected Return Date

If the family member is expected to be absent for **fewer than** 90 consecutive days, **include** in the application, unless the family member is receiving Work First or TANF assistance in another case. If absent for more than 90 days, see Work First Manual Section 112.

INDIVIDUAL CRIMINAL VIOLATIONS

Anyone in the home:

Trying to avoid a felony prosecution? ☐ Yes ☐ No Name(s): _____

Fleeing from law enforcement? ☐ Yes ☐ No Name(s): _____ _____

Trying to avoid jail after conviction of a felony? ☐ Yes ☐ No Name(s): _____

In violation of the conditions of probation or parole? ☐ Yes ☐ No Name(s): _____

Convicted of a drug-related felony committed on or after August 23, 1996? ☐ Yes ☐ No

Name(s): _____ **If yes**, was the conviction in North Carolina? ☐ Yes ☐ No

If convicted in North Carolina, what was the classification of the felony? Class: _____ **(classification of felony must be verified)**

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

CHILD SUPPORT SERVICES

Discuss the Child Support Services requirement and the right to claim good cause. (Work First Manual Section 116)

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

CHILD SUPPORT SERVICES CONT.

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

INCOME

(Refer to the Integrated Eligibility Manual Section 4000 and WF Manual Section 114)

Does anyone in the household have income from working? (Work study, sick pay, severance pay, vacation pay, working for a temporary agency, sheltered workshop, WIOA, or AmeriCorps VISTA.) ☐ Yes ☐ No If yes, complete the following:

1. Name: _____ Start Date: _____ Rate of Pay: _____

Employer: _____ Work Schedule/ Hrs. per Week: _____

Employer Address: _____ Telephone No.: _____

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

2. Name: _____ Start Date: _____ Rate of Pay: _____

Employer: _____ Work Schedule/ Hrs. per Week: _____

Employer Address: _____ Telephone No.: _____

Pay Received Month of Application		**Pay Received Last Month**	
Date	Amount (gross)	Date	Amount (gross)

List all jobs for the last 2 months for anyone in the household who currently is not working.

Name	Employer	Dates Worked	Date of Final Pay

Complete the following if anyone in the household has **self-employment income, rental income, roomer income, or boarder income**. (Collect at least two months' information. Additional months may be needed for a representative projection of expected income.)

Name: _____ Type of Business/income: _____

Month	Income	Expenses	Adjusted Gross
1.			
2.			

Unearned Income

Does anyone in the household receive any of the following?

		Source of Income	Person Receiving Income	Freq.	Date Received	Avg. Mo. Amount
Yes ☐	No ☐	Work First Cash Assistance /TANF/Tribal TANF				
Yes ☐	No ☐	Financial Contributions Contributor:				
Yes ☐	No ☐	Child Support/Alimony/Work Release Direct - Clerk of Court – IV-D State/County: _____				
Yes ☐	No ☐	Social Security Claim #				
Yes ☐	No ☐	Supplemental Security Income (SSI) Claim #				
Yes ☐	No ☐	Military Allotment				
Yes ☐	No ☐	Veteran's Benefits: Compensation/Pension/ A & A Portion VA File #				
Yes ☐	No ☐	Unemployment Compensation				

Yes	No	Source of Income	Person Receiving Income	Freq.	Date Received	Avg. Mo. Amount
☐	☐	Worker's Compensation				
☐	☐	Pension/Retirement/Civil Service Annuity				
☐	☐	Railroad Retirement				
☐	☐	Private Disability (See WF114, III.)				
☐	☐	Interest/Dividends				
☐	☐	Educational Grants, Scholarships				
☐	☐	Income from Trust Fund/Promissory Note				
☐	☐	Foster Care Payment/County Supplement				
☐	☐	Other				

RESOURCES

Does anyone in the household have any of the following? ☐ Yes ☐ No If yes, check (✓) all that apply.

(Refer to Work First Manual Section 115)

Yes	Resource	List all owners	Stated Value	Access (A J RT I)	Verified Value (3rd party verification if questionable)
☐	**Cash**				
☐	**Bank Account** Checking Savings Bank Name:				
☐	**IRA's, CD's, Money Market, Mutual Funds** Bank: Account #:				
☐	**Stocks** Broker: Stock Name: # Shares: **Bonds** Issuer: **U.S. Savings Bonds** Face Value: Series #:				
☐	**Other**				

A: Accessible to Owner
J: Jointly Owned
RT: Resulting Trust
I: Inaccessible (Document reason)

Total Resources (Limit: $3,000) 0.00

If the family has excess resources, they may rebut/reduce the value of the resource. Does the applicant wish to rebut/reduce the value of a resource? ☐ Yes ☐ No If yes, reason: _____

(Refer to Work First Manual Section 115)

COLLATERAL CONTACT

Name, address, and phone number of a person who does not live with the family or is not related to anyone in the household. In the event the ONLY potential collateral is a relative, document circumstances. Contact the collateral to verify the household situation.

Name: _____

Address: _____

_____

Phone: _____

Discrepancies: _____

_____

Method of Verification: ☐ Telephone Call ☐ DSS-6961

Did this collateral verify household size, composition, and residence? ☐ Yes ☐ No **If no, obtain secondary collateral**

ADDITIONAL INFORMATION

1. Does the family pay rent/mortgage? ☐ Yes ☐ No Amt/freq._____ Rental/Mortgage Co. _____
2. Does anyone receive HUD/Section 8 assistance or a rent subsidy? ☐ Yes ☐ No

   If yes, how much is the family responsible for each month? $ _____Payable to: _____
3. Does anyone receive child care subsidy? ☐ Yes ☐ No

   If yes, determine the source. ☐ Federal (non-TANF funds) ☐ Tribal/State ☐ TANF/Work First

   How much is the subsidy payment for each child in care?

   Child's Name: _____ Payment Amount: $ _____ Frequency: _____

   Child's Name: _____ Payment Amount: $ _____ Frequency: _____

   Child's Name: _____ Payment Amount: $ _____ Frequency: _____
4. Is anyone on the application a member of a federally recognized tribe? ☐ Yes ☐ No **If yes, complete the following**:

Name	Tribe	Enrollment card
1.		☐ Yes ☐ No
2.		☐ Yes ☐ No
3.		☐ Yes ☐ No
4.		☐ Yes ☐ No

ADDITIONAL SERVICES

Discuss and offer to refer the family members to the following services/programs. Document all referrals in case record and include copies of referral form, if applicable. If possible, document as to referral outcome and services received, if any, by the family.

Service Explained		Referral Yes	Referral No
☐	**Child Care –** Assistance in arranging and/or paying for child care for children under age 13 or disabled children.	☐	☐
☐	**Head Start (if offered in county) -** Federal preschool program that promotes the school readiness of children ages birth to 5 from low-income families.	☐	☐
☐	**Medicaid-**Medicaid serves low-income parents, children, seniors, and people with disabilities.	☐	☐
☐	**Women's Infants and Children Program (WIC)-** assists with buying food if a member of the household is pregnant or has a child under 5 years of age in the home. ☐ Currently receiving WIC	☐	☐
☐	**Maternity Support Services-** also known as the "Baby Love Program," promotes healthy pregnancies and positive birth outcomes. These services are available to Medicaid-eligible pregnant women during and after pregnancy (60-day postpartum period).	☐	☐
☐	**WIOA-** Assists individuals, including youth and those with significant barriers to employment, obtain employment and training.	☐	☐
☐	**Vocational Rehabilitation** - Assistance for individuals with disabilities for medical treatment, rehabilitation, training, education, and job placement.	☐	☐
☐	**Voter Registration** – If are you not registered to vote where you live now, would you like to apply to register to vote here today? **If yes**, offer to assist with completion of the form. Once form is completed and signed, transmit to local board of elections. **Provide voter registration application to <u>all</u> applicants and recipients. (**Refer to WF Manual 104 VI)	**Yes** ☐	**No** ☐

BENEFIT DIVERSION (IF OFFERED BY THE COUNTY AGENCY)

Is Benefit Diversion appropriate for this applicant? ☐ YES ☐ NO

☐ Benefit Diversion Accepted Amount Approved **$**_____ **months covered** _____

☐ Benefit Diversion Agreement (DSS-8657) Completed

☐ **Benefit Diversion Offer Declined (Reason):** _____

Cash Assistance Issuance Methods (Check method selected by applicant/recipient)

☐ EBT (Explain usage restrictions and provide EBT Brochure and EBT FAQ .)

☐ Direct Deposit (If new or changed information, provide Direct Deposit Authorization Form, DSS-5023.

☐ Protective Payee: ☐ New ☐ Change ☐ No longer required

(Complete DSS-1665, Work First Family Assistance Protective Payee Agreement, if changed or new.) Refer **to the Work First Manual to determine if a Protective Payee is mandatory.**

CERTIFICATIONS

Check (✓) that each of the following was explained and applicable notice/form provided to applicant/recipient.

- ☐ DSS-20009 Rights and Responsibilities
- ☐ AUDIT/DAST screening was completed for applicable adult(s) (DSS-8218)
- ☐ MRA Core Requirements (DSS-6963A) was signed by each adult
- ☐ DSS-6966 (Notification of the Family Violence Option)
- ☐ DSS-8221 (Work Requirements if Child Care Not Available)
- ☐ DSS- 5334 (Notice of Requirement to Cooperate and Right to Claim Good Cause for Refusal to Cooperate in Child Support Enforcement)
- ☐ Job Quit Penalty
- ☐ Learning Needs Screening Tool Waiver & Consent Agreement Completed (DSS-5330)
- ☐ Learning Needs Screening Tool completed, if applicable. (DSS-5327)
- ☐ Voter registration opportunity and voter registration application

---

I, _____, understand that by signing this form, I am stating:
(applicant/recipient printed name)

- ✓ I understand the penalties for giving false information, and I have told the truth on this form.
- ✓ I know my rights and what I must do to get assistance.
- ✓ I agree to give information about what I have said.
- ✓ I agree to report changes to the social/human services agency.
- ✓ I agree to let the social/human services agency get proof of what I have said from any person or another agency.
- ✓ I know the social/human services agency keeps private anything said about my situation.
- ✓ I will not access the cash assistance on my EBT card or use my cash assistance in any liquor store, gambling or gaming establishment or any establishment that provides adult oriented entertainment.
- ✓ I know if I do not sign this form, I will not get assistance.

Applicant/Recipient Signature: _____ Date: _____

Witness Signature: (if signed with an "X") _____ Date: _____

Interviewer's Signature: _____ Date: _____

Other Case Information

Months used on the Time Limits: _____ of 24 State ____ of 60 Federal ____ of 60 State

Family Cap Child ☐ Yes ☐ No If yes, child's name: _____

Minor Parent ☐ Yes ☐ No If yes, minor parent's name: _____

Case Decision

☐ Approved ☐ Pending/Reason: _____

☐ Denied ☐ Withdrawn Reason: _____

_____

_____ _____

Processor's Printed Name and Signature Date