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3210.0000 Food Stamps

This chapter presents policy regarding benefit issuance.

3210.0100 REPRESENTATIVES AND PAYEES (FS)

Individuals may designate a non-assistance group or assistance group member to make application and/or receive benefits on behalf of the assistance group.

3210.0101 Authorized Representative/Secondary Cardholder (FS)

When the payee, spouse, or a responsible assistance group member cannot apply for benefits they may be eligible for, an authorized representative may be designated to make application or carry out household responsibilities such as reporting changes or completing work registration on behalf of the assistance group. Food stamp authorized representatives may be designated by the primary payee of an assistance group as a secondary cardholder to receive an Electronic Benefits Transfer (EBT) card and to be able to access the primary payee's food stamp account.

Authorized representatives/secondary cardholders must be designated according to the following requirements:

1. the authorized representative/secondary cardholder must be designated in writing by the payee, spouse, or another responsible member of the assistance group;
2. the authorized representative/secondary cardholder should generally be designated prior to determining eligibility of the assistance group, however, the assistance group can also name an authorized representative/secondary cardholder at any time during the certification period;
3. the authorized representative/secondary cardholder must be an individual who is familiar with the current circumstances of the assistance group; and
4. if it becomes obvious that the authorized representative/secondary cardholder is not aware of the current assistance group circumstances, the eligibility specialist must record this information and immediately request in writing that the assistance group designate another authorized representative/secondary cardholder.

The authorized representative/secondary cardholder may be:

1. authorized on the application;
2. designated in writing using the form CF-ES 3010, Authorized Representative Form; or
3. designated for the interview only or the interview, receipt, and use of food stamps.

Designations of authorized representatives/secondary cardholders are valid for the current certification period only.

Payees of assistance groups who are not able to shop for themselves should be encouraged to designate a food stamp authorized representative as a secondary cardholder for benefit usage.

To ensure recipient understanding of the changes associated with EBT, the following must be discussed with recipients at application and at each review:

1. Recipients may continue to designate authorized representatives to apply and be interviewed on their behalf.
2. Recipients may continue to designate authorized representatives, when appropriate, to receive and use benefits in addition to the recipient's own benefit access.
3. Recipients may designate only one secondary cardholder per assistance group. FLORIDA accepts one secondary payee per payee type.

4. Food stamp authorized representatives will receive a separate EBT card with their name on it. They must select their own personal identification number (PIN).
5. The food stamp authorized representative will have access to all the food stamps in the EBT food account.
6. If a primary payee for both a cash and food stamp assistance group has the same person designated as both the food stamp authorized representative and cash alternate payee, that person will be issued two EBT cards; one to access the food stamp benefit account, and one to access the cash benefit account.
7. EBT benefits are not replaced if they are lost, stolen or misused, including misuse by an authorized representative. Refer to 3210.0217 for more information on stolen benefits.
8. The secondary cardholder's EBT cards are mailed to the primary cardholder.

Note: The applicant can authorize a representative on their application, but form CF-ES-3010 or a written request must be completed when designating the representative to respond on their behalf.

3210.0103 Designation at Time of Application (FS)

The designation of an authorized representative/secondary cardholder is normally made on the application at the time of application. If an application is made and signed by an authorized representative/secondary cardholder or a Primary Information Person (PIP) who is not an assistance group (AG) member, the designation for an authorized representative/secondary cardholder must be made by the payee, spouse, or a responsible AG member.

The designation must be made either on an authorization form or in a written format which gives the name, address and the designation desired. A SSN is not required. The form or written format must be signed by the payee or the spouse of the payee of the AG. An authorized representative/secondary cardholder may be designated at any time during the certification period.

3210.0104 Withdrawal of Authorization (FS)

The authorized representative/secondary cardholder authorization is valid only for the current certification period. The payee, spouse, or responsible assistance group member may withdraw the authorization at any time. Withdrawal of authorization will be made upon request in person, by telephone, or in writing. Requests made in person or by telephone must be documented on CLRC. Written requests will be placed in the case record.

3210.0105 Restrictions on Representatives (FS)

The following restrictions apply to authorized representatives/secondary cardholders:

1. ACCESS staff and food stamp retailers authorized to accept food stamps cannot act as authorized representatives/secondary cardholders unless no other individual is available to act on behalf of the individual;
 - a. written approval at each designation must be provided by the Region or Circuit Program Office, and
 - b. Region or Circuit Program Office approval must be documented.
2. individuals disqualified for fraud cannot act as authorized representatives/secondary cardholders during the period of disqualification, unless the disqualified individual is the only adult member of the assistance group able to act on the assistance group's behalf; and
3. providers of meals for the homeless may not act as authorized representatives for homeless individuals.

The Region or Circuit Program Office must make a determination as to whether these individuals are needed as authorized representatives/secondary cardholders.

3210.0106.01 Documentation and Control of Representatives (FS)

Representatives must be properly designated and authorization forms retained in the case record.

There is no limit placed on the number of individuals a representative/secondary cardholder may represent. When employers such as those employing seasonal farm workers or migrants are named as representatives or when a single representative has access to a large number of Electronic Benefits Transfer (EBT) cards, caution should be exercised to ensure the following:

1. that the payee or spouse freely requested the representative/secondary cardholder,
2. that the individual's situation is correctly represented,
3. that the representative/secondary cardholder is receiving the correct amount of benefits, and
4. that the representative/secondary cardholder is using the benefits properly.

3210.0106.02 Evidence of Misrepresentation (FS)

When evidence is obtained that an authorized representative/secondary cardholder has misrepresented an individual's circumstances and has knowingly provided false information or has improperly used food stamps, the representative may be disqualified from participating as an authorized representative/secondary cardholder. This disqualification may be for a period of up to one year.

A written notice must be sent to the individual(s) and the authorized representative/secondary cardholder 30 days prior to the date of disqualification. This notification will include:

1. the proposed action,
2. the reason for the action,
3. the individual's right to request a fair hearing,
4. the telephone number of the office, and
5. the name of the eligibility specialist to contact for more information.

Disqualification of representatives/secondary cardholders does not apply in the case of drug and alcoholic treatment centers and those group facilities which act as authorized representatives/secondary cardholders for their residents. In these instances, the facility is liable for any over-issuance which may occur.

3210.0107 Special Circumstances (FS)

Special provisions exist for authorized representatives/secondary cardholders for residents of drug or alcohol rehabilitation centers, residents of facilities for the blind and disabled, and residents of shelters for battered persons.

3210.0108 Drug/Alcohol Treatment Center Representative (FS)

The resident in the facility is prohibited from applying on his own behalf.

The employee of an organization or institution will apply on behalf of the resident, and is authorized to receive and spend the allotment received by its residents.

3210.0109 Blind/Disabled Group Home Representative (FS)

Residents in these facilities may apply on their own behalf or through an authorized representative/secondary cardholder. The group facility must ensure that each resident's food stamps are used for meals intended for that resident, regardless of whether the facility purchases

and prepares food consumed by eligible residents or if the residents purchase and prepare food for home consumption.

3210.0110 Use of Food Stamps by Facilities for Blind/Disabled (FS)

If the resident applies for food stamps and the facility is acting as the authorized representative/secondary cardholder, the facility may obtain and use the food stamps for food prepared by and/or served to the residents, or the facility may allow the resident to use all or any portion of the benefits on their own behalf.

If the resident is certified on his own behalf, the food stamps may be:

1. returned to the facility to be used to purchase food for meals served either communally or individually,
2. used by eligible residents to purchase and prepare food for their own consumption, or
3. used to purchase meals prepared and served by the facility.

3210.0111.01 Food Stamps Used in Shelter for Battered Persons (FS)

Food stamp benefits may be used by shelter residents in any one of the following ways:

1. shelter residents may use the food stamps to purchase meals prepared specifically for them at the shelter,
2. a shelter resident may designate the shelter as a secondary cardholder so that the shelter can purchase food for meals served to the resident, or
3. shelter residents may use the food stamps to purchase food for their own consumption.

3210.0111.02 Return of FS Benefits When Resident Leaves Facility (FS)

Once the individual leaves the facility, the facility is no longer allowed to act as that individual's authorized representative or secondary cardholder. This applies to both drug and alcohol treatment centers and group homes for the blind/disabled. Remove the facility's authorized representative on FLORIDA immediately, unless the facility needs the authorized representative's card to return unused benefits or a refund to the customer. Once the process to return the benefits or the refund is complete, remove the drug and alcohol treatment center or group home authorized representative as soon as possible.

Electronic Benefits Transfer (EBT) cards being held by the facility must be returned to the individual when they leave the facility. If the resident leaves without obtaining the EBT card, the center is to return the card to FIS Fidelity National Information Systems at the address below. These cards will have their status changed to "62" (card returned - other), which will deactivate the card(s). Should a resident later inquire about accessing their benefits, they should be referred to EBT Customer Service to request a replacement card.

Mailing address:

ACCESS EBT Card
P.O. Box 290
Milwaukee, WI. 53201-0290

At a minimum, the facility must return one-half of the benefit allotment to the individual regardless of what has been spent when the individual departs prior to the 16th of the month. If the facility did not spend any benefits on behalf of the individual, the facility must return the full value of any benefits already debited from the individual's current monthly allotment back into their EBT account at the time the individual leaves the facility.

The facility must not debit accounts under any circumstances after the individual has left the facility. For example: If there is a delay in the facility receiving the EBT card, and the individual has left the facility when the card arrives, the facility may not swipe the card for payment for meals eaten while the individual was at the facility. The facility must notify the Department when the individual leaves the facility. Benefits are returned to the individual's account by the facility performing a food stamp credit (or refund) transaction.

3210.0111.03 Liabilities and Penalties of Facilities (FS)

Facilities will be held responsible for any misrepresentation or fraud committed in the certification of facility residents. As an authorized representative or secondary cardholder, the facility must be knowledgeable about the individual's circumstances and should carefully review those circumstances with residents prior to applying on their behalf.

In addition, facilities will be held liable for all losses or misuse of food stamps held on behalf of residents and for any over-issuances which occur while the individual is a resident of the facility. A benefit recovery referral will be filed against the facility for any over-issuance of food stamps.

Note: Residents of blind/disabled living arrangements may apply for food stamps on their own behalf. If this occurs and the facility did not act as an authorized representative/secondary cardholder, the facility will not be penalized.

If there is reason to believe a facility has misappropriated or used food stamps for purchases that did not contribute to an entitled individual's meals, the Region or Circuit will promptly notify Headquarters, who will notify USDA. USDA may disqualify a facility as an authorized retail food store and may suspend the facility's authorized representative status for the same period.

If the facility loses its authorization from USDA (whereby the facility can no longer act as the authorized representative) or, if the facility loses its certification from USDA, the facility is no longer exempt as an institution. As a result, residents of the center are no longer eligible to participate.

3210.0112 Payee (FS)

The assistance group (AG) may select an adult living in the household to be the payee/head of the food stamp AG, provided all adults in the food stamp AG agree to the selection. The AG can select the payee/head of the food stamp AG at each application, recertification, or change in AG composition. If the food stamp AG does not name the payee/head of the food stamp AG, name the principal wage earner as the payee/head of the food stamp AG.

For purposes of failure to comply with work requirements or voluntary quit/reduction of hours of employment, the principal wage earner is the household member (including excluded members) who has the largest amount of earned income in the two months prior to the month of the noncompliance, quit, or reduction of hours. If there is no principal source of earned income, the individual selected at the last application, recertification, or household composition change is the payee/head of household.

The Department cannot require that the payee/head of the food stamp AG complete the interview or make application for benefits. A responsible member of the food stamp AG may make application and complete the interview.

The AG cannot name or change the AG member who is the payee/head the food stamp AG to avoid FSET requirements or penalties.

3210.0200 PAYMENTS (FS)

This section addresses benefit issuance and payments.

3210.0201 Electronic Benefits Transfer (EBT) (FS)

Food stamps will be automatically placed in the recipients' Electronic Benefits Transfer (EBT) account on a designated day for access at their convenience. There are separate accounts for food stamp and cash benefits, both accessible by one card.

The EBT card is the means by which participants (our recipients and their secondary payees) access their benefits. EBT cards are distributed by mail; therefore, it is extremely important that the correct and current mailing address be entered onto the FLORIDA system. Now, more than ever, it becomes necessary for address changes to be reported as soon as possible to prevent the EBT card from being returned due to an incorrect address, possibly delaying access to benefits.

Assistance group information is electronically transmitted from the FLORIDA system to the EBT Administrative System. The information passed through this interface will set up and maintain EBT accounts for FLORIDA assistance groups. The assistance category to be included from FLORIDA to EBT is FS.

Account Setup records are transmitted to provide the EBT system with the demographic information needed to establish an EBT account, and create and mail an EBT card. Account Setup records are used to build customer accounts on the EBT system and provide information necessary for card issuance. Benefit authorization records tell the EBT system the value of each cardholder's benefits. Benefit Authorization records that cannot be matched to an EBT account remain in the Benefit Pending file for 90 days, after which they will be purged, if a corresponding account was not found. Benefit Authorization records for recurring benefits are not posted into the EBT account until the benefit availability date, but may be viewed in the Benefit Pending file until their benefit availability date arrives.

ACCOUNT SETUP RECORDS

The demographic records sent to the EBT system to establish accounts and create EBT cards are called "Account Setup Records" and "Benefit Records." Account setup records are composed of the following case/participant information:

1. FLORIDA Account Number - Case/Short List Member Number of the primary payee designated on AGPY. The case/short list member number is the state case identifier on the Client Search screen on the EBT system. Assistance groups with designated protective payees will have an additional suffix of "P" and designated legal guardians will have an additional suffix of "L" on the EBT system.
2. Primary/Alternate Indicator - FLORIDA system generated based on primary payee designation on AGPY or secondary payee information on AGAR.
3. Card Access Indicator - FLORIDA system generated based on the cardholder's designation to have access to food stamps only, Temporary Cash Assistance benefits only, or access to both.
4. Last Name - Primary payee information on AIID or secondary payee information on AGAR.
5. First Name - Primary payee information on AIID or secondary payee information on AGAR.
6. Middle Initial - Primary payee information on AIID or secondary payee information on AGAR.
7. Date of Birth - Primary payee information on AIID.
8. Social Security Number - Primary payee information on AIID.
9. Mailing Address - Primary payee information on AICI/AGAM (using current FLORIDA address hierarchy) or AGAR/AICI for legal guardians and protective payees depending on the mail address designation on AGAR.
10. City - Primary payee information on AICI/AGAM.
11. State - Primary payee information on AICI/AGAM.

12. Zip Code - Primary payee information on AICI/AGAM (zip + four characters).
13. Language Indicator - Primary payee information on AICI or secondary payee information from AGAR if member = 99.
14. Card Issuance Indicator - FLORIDA generated.
15. Drop Ship Indicator - INACTIVE (from DROP SHIP field on AGBI).
16. Issuance Service Site Number - Issuance Service Site designation on AGBI (5 digit county/site number).

BENEFIT AUTHORIZATION RECORDS

Once an account is established, then benefits may be added to the account. Benefit Authorization records contain the following data fields:

1. FLORIDA Account Number - Case/Short List Member Number of the primary payee designated on AGPY. The case/short list member number is the state case identifier on the Client Search screen on the EBT system. Protective payees will have an additional suffix of "P" and legal guardians will have an additional suffix of "L" on the EBT system.
2. Action Code - FLORIDA generated for benefit add or benefit void (intercept).
3. Category/Sequence - The category of assistance and assistance group sequence number from FLORIDA.
4. Credit/Debit Indicator - FLORIDA generated based on an internal action code.
5. Benefit Identifier - The unique benefit number assigned by FLORIDA for each benefit type and indicated on IQCH and IQFS (warrant number and food stamp benefit number) and the benefit period (MM/DD/YY).
6. Benefit Amount - The net benefit amount after recoupment as indicated on IQCH and IQFS.
7. Benefit Availability Date - The benefit availability date specified on the cash (TSCI) and food stamp (TFSQ) staggered issuance tables.
8. Benefit Month and Year - The benefit month and year indicated on IQCH and IQFS.
9. Issuance Service Site Number - Issuance Service Site designation on AGBI (five digit county/site number).

There are only two types of benefit records on the EBT system, benefit add and benefit void. Benefit add will add new benefits to an account. Benefit void is a benefit interception. Benefits cannot be deleted from nor "held" on the EBT system. If benefits were authorized in error, they must be intercepted prior to their benefit availability date and replaced with the correct benefits. If unable to intercept, the eligibility specialist should examine the case for over-issuance or under-issuance.

3210.0202 Staggered Issuance (FS)

Electronic Benefits Transfer (EBT) food stamps are issued over the first 28 calendar days of each month, including weekends and holidays. Assistance groups are assigned benefit availability dates based on the eighth and ninth digit of their FLORIDA case number. The FLORIDA system excludes expedited service approvals and new case approvals from the staggered issuance tables for the initial month of the certification period.

3210.0203.01 Expunged Status (FS)

Expunged accounts are accounts that have not been accessed or had a debit transaction performed in the preceding 365 days (one year).

When an account reaches expunged status any benefits contained in the account will begin to expunge individually as each benefit reaches 365 days of age from the date the last debit transaction was performed or from the date of deposit, if no debit transactions were performed against the benefit.

Due to expunged status accounts, an inquiry should be performed on all FLORIDA applications after a break in eligibility to determine if the person has an established account on the Electronic Benefits Transfer (EBT) system. If an account already exists in the EBT system for the person, the eligibility determination process should be completed in such a manner to direct any newly approved benefits to the account already on the EBT system. This is accomplished by approving the person using the same FLORIDA case/RFA number and short list member for the account already on the EBT system.

Note: Benefits deposited into expunged status accounts automatically reactivate the account. It is not necessary to manually reactivate an expunged account if a new benefit is being authorized for the account.

Exception: Very old accounts (pre 2003) may need to be manually reactivated using the account reactivation function on the EBT Administrative System if a new benefit deposit fails to reactivate the account.

3210.0203.02 EBT for Individuals Relocating to Another State (FS)

An individual can, but is not required to, use their Florida food stamps prior to relocating to another state.

Food stamp recipients that relocate may use their Electronic Benefits Transfer (EBT) food stamps at any retail store that displays the QUEST logo or at any local retailer that also does business in the state of Florida (e.g. – Albertson's, Food Lion, Publix, Winn-Dixie, Walgreens, K-Mart, etc.).

3210.0204 Aggregate Issuance (FS)

NONEXPEDITED APPLICATIONS

Assistance groups that meet certain eligibility criteria will receive both their initial month's prorated benefits and their first full month's benefits at the same time. This is called an aggregate issuance.

The eligibility criteria for aggregate issuance for non-expedited applications are:

1. the assistance group applied after the 15th calendar day of the month;
2. the assistance group has completed the application process and provided all required verification within 30 days following the date of application; and
3. the assistance group is eligible to receive benefits for the month of application and the following month.

Assistance groups whose initial month's benefit is less than \$10.00 (i.e., prorates to zero), are not entitled to receive a benefit for the initial month.

EXPEDITED APPLICATIONS

Assistance groups that are eligible for expedited services are entitled to receive aggregate issuance if they applied after the 15th day of the month. Assistance groups that are eligible for expedited services including those required to provide postponed verification are entitled to receive aggregate issuance of their initial month's benefit and the second month's full benefit within the five day expedited service time frame. Assistance groups that must provide postponed verification are not eligible to receive any benefits beyond the first two months of eligibility until they provide the verification(s) that was postponed or are certified under non-expedited criteria. Refer to 0610.0102 for expedited service criteria.

3210.0205 Recurring and Auxiliary Benefits (FS)

Around the 20th of each month FLORIDA executes the recurring benefit pulldown. This function creates the regular monthly benefits for the next month for each eligible assistance group. A monthly file is created and transmitted to the Electronic Benefits Transfer (EBT) system to post to the recipient's accounts in the benefit month.

Food stamps authorized for reasons other than the regular recurring monthly benefit are auxiliary benefits. Auxiliary benefits may be automatically generated by the FLORIDA system or created by the eligibility specialist.

FLORIDA creates auxiliary benefits for the initial month of application's prorated benefits, the month of application and any month prior to the recurring month.

The eligibility specialist may create auxiliary benefits for the following reasons:

1. casualty loss replacements;
2. supplements;
3. restoration of lost benefits;
4. special issuances when the system erroneously indicates that an assistance group has already received benefits for the month; or
5. benefits to be issued when an assistance group is formed from an existing assistance group due to a battered individual situation. Refer to 0810.0508.

All eligibility specialist generated auxiliaries must be authorized by the supervisor. The supervisor can approve, hold or cancel any auxiliary request. The eligibility specialist can cancel an auxiliary request prior to supervisory approval; however, once the auxiliary has been approved by the supervisor, it cannot be canceled. Auxiliaries that have been approved in error must be intercepted to prevent issuance.

3210.0206 Restoring Lost Benefits (FS)

The Department must restore lost benefits when a determination is made that benefits were lost because all or part of the assistance group's food stamps were denied, delayed, or terminated due to administrative error or due to identity theft.

Identity theft occurs when someone obtains the demographic information of another individual, uses the information to get an EBT or Medicaid card in the name of the other individual through an application approval or a replacement card, and receives (steals) the other individual's benefits. In situations of identity theft confirmed through an Inspector General or Public Benefits Integrity investigation and committed by an individual employed by the Department of Children and Families, restore the stolen benefits of an individual or household only if they were originally eligible for the benefits.

Benefits will be restored to the assistance group for not more than 12 months prior to whichever of the following occurred first:

1. the date the Department was notified by the assistance group or by another individual or agency in writing or orally of the possibility of lost benefits; or
2. the date the Department discovered that a loss of assistance group benefits occurred.

Benefits must be restored even if the assistance group is currently ineligible.

Exception: Benefits must be restored when over-recoupment has occurred, without regard of the 12 month time frame.

3210.0207 Payment of Benefits Wrongly Withheld (FS)

The Department will restore an assistance group's benefits which, were found by any judicial action to have been wrongfully withheld.

If the judicial action is the first action the individual has taken to obtain restoration of lost benefits, benefits will be restored for a period of not more than 12 months from the date the court action was initiated.

If the judicial action is a review of the Department's action, the benefits will be restored for a period of not more than 12 months from whichever of the following dates occurred first:

1. the date the Department receives a request for restoration, or
2. the date fair hearing action was initiated.

Benefits will not be restored for any period more than one year from when the Department is notified of, or discovers, the loss.

3210.0208 Errors Discovered by the Department (FS)

If the Department determines that a food stamp (FS) assistance group is entitled to restoration of lost benefits, the Department must:

1. take action to restore benefits,
2. inform the payee that an error was made that requires a restoration of benefits, and
3. indicate the amount to be restored.

If the amount of a prior over-issuance claim was deducted from the amount to be restored, the Department must provide an explanation of:

1. the way in which benefits will be restored, and
2. the payee's right to appeal through the fair hearing process if any aspect of the proposed lost benefit restoration is not acceptable.

3210.0209 Disputed Benefits (FS)

If an assistance group believes it is entitled to restoration of lost benefits, but the supervisor, after reviewing the case information, does not agree, the assistance group has 90 days from the date of the determination by the Department to request a fair hearing. The Department must restore lost benefits to the assistance group only if the fair hearing decision is favorable to the assistance group.

Benefits lost more than 12 months prior to the date the Department was initially informed of the assistance group's possible entitlement will not be restored.

If the assistance group disagrees with the amount to be restored as calculated by the Department or any other action taken by the Department to restore lost benefits, the assistance group may request a fair hearing within 90 days of the date the assistance group is notified of its entitlement.

If the fair hearing decision is favorable to the assistance group, the Department must restore any lost benefits in addition to those previously restored, in accordance with that decision.

3210.0210.01 Computing the Amount to be Restored (FS)

After correcting the error to prevent future losses and excluding those months for which benefits may have been lost prior to the 12 month time limit, the eligibility specialist must determine the months affected and calculate the amount to be restored.

3210.0210.02 Determining the Months Affected (FS)

If the assistance group (AG) was eligible but received an incorrect benefit, the loss of benefits must be calculated only for those months the AG participated.

If the loss was caused by an incorrect delay, denial, or termination of benefits, the months affected by the loss must be calculated as follows:

1. for loss due to erroneous denial, the month the loss initially occurred will be the month of application;
2. for an eligible AG filing a timely reapplication, the month following the expiration of its certification period will be the month of application;
3. for loss due to erroneous determination of client delay, the months for which benefits may have been lost due to the Department's delay must be calculated; and
4. for loss due to erroneous termination, the month the loss initially occurred will be the first month benefits were not received as a result of the erroneous action.

3210.0210.03 Calculation of Lost Benefits (FS)

The eligibility specialist must then calculate the loss for each month subsequent to the date the loss initially occurred until either the first month the error was corrected or the first month the assistance group is found ineligible.

Documentation must establish the assistance group's eligibility for each month affected by the loss. If information is not available that verifies the assistance group's eligibility, the Department must advise the assistance group of the information that must be provided to determine eligibility for those months. For each month the assistance group cannot provide the necessary information to demonstrate its eligibility, the assistance group must be considered ineligible.

3210.0210.04 Determining Amount to be Restored (FS)

The amount of restoration of lost benefits due an assistance group is to be based on the issuance tables that were in effect at the time of the incorrect issuance. If the assistance group received a smaller benefit than it was eligible to receive, the difference between the actual and correct benefit equals the amount to be restored.

3210.0211 Lost Benefits - Intentional Program Violation (FS)

If the decision of disqualification for intentional program violation (IPV) is subsequently reversed, the individual is entitled to restoration of benefits lost during the period of disqualification not to exceed two months prior to the date of the Department's notification.

An individual would not be entitled to restoration of lost benefits for the period of disqualification based solely on the fact that a criminal conviction could not be obtained, unless the individual successfully challenged the disqualification period imposed by an administrative disqualification in a separate court action.

The amount to be restored must be determined by comparing the benefit the assistance group received with the benefit the assistance group would have received had the disqualified member been allowed to participate.

3210.0212 Method of Restoration (FS)

Regardless of current eligibility, the Department must restore lost benefits by issuing benefits equal to the amount of benefits that were lost minus any offsets when an outstanding benefit recovery claim exists.

For eligible assistance groups, the total amount to be restored must be issued in addition to the current benefit. For ineligible assistance groups, the amount to be restored must be issued in a lump sum.

The Department must honor reasonable requests by assistance groups to restore lost benefits in monthly installments, if, for example, the amount restored is more than it can use in a reasonable amount of time.

Whenever lost benefits are due an assistance group and the assistance group's composition has changed, lost benefits must be restored to the assistance group containing a majority of the individuals who were assistance group members at the time the loss occurred. If the Department cannot locate or determine the assistance group which contains the majority, benefits must be restored to the assistance group containing the payee at the time the loss occurred.

3210.0213.01 Replacement Issuances (FS)

Replacement issuances shall be provided to assistance groups when the assistance group reports that food purchased with their food stamps was destroyed in a household misfortune or disaster, such as fire, flood or hurricane.

A mechanical breakdown is not considered a disaster or household misfortune. It is not the intent of this policy to replace food losses every time an assistance group's electricity is off and the food in the refrigerator is spoiled.

Replacement issuances must not be provided to assistance groups when the Electronic Benefit Transfer (EBT) card is lost, stolen or misplaced after receipt. Benefits shall not be replaced if lost after receipt by any method other than a disaster or household misfortune. EBT issued benefits are not replaced if they are lost, stolen or misused, including misuse by an authorized representative. The primary payee/cardholder has sole responsibility for the security and safeguarding of the EBT card and PIN.

Replacement issuances are provided only if an assistance group timely reports the loss and provides a statement attesting to the loss of food purchased with food stamps. Losses may be reported verbally or in writing. The loss of food purchased with food stamps destroyed in a household misfortune is considered timely reported if it is reported to the Department within 10 days of the loss.

There is no limit on the number of replacements made for food purchased with food stamps which were destroyed in a household misfortune.

Replacement issuances are to be for the amount of the loss, up to the total amount of the benefit issued for the month. If multiple benefits were issued at the same time, the replacement must not exceed the total amount of the benefits issued.

3210.0213.02 Nonreceipt Affidavit/Replacement Authorization (FS)

A statement attesting to the assistance group's (AG's) loss in a household misfortune or disaster must be obtained prior to issuance of the replacement benefit. Form CF-ES 3515, Nonreceipt Affidavit/Replacement Authorization, can be used for this purpose. The form can either be mailed to the AG or completed in person at an ACCESS service center. The signed form must be returned to the Department within 10 days of the date of the report of the loss or no replacement will be made. If the 10th day falls on a weekend or holiday, it will be considered timely if received the next work day after the weekend or holiday. The supervisor must verify the information on the form for completeness and accuracy. The statement must then be signed by the supervisor and retained in the case file.

3210.0213.03 Time Limits for Making Replacements (FS)

Replacement issuances must be provided to assistance groups within 10 days after the report of non-delivery or loss or within two working days of receiving the signed affidavit (CF-ES 3515), whichever is later.

Replacement requests are to be denied if available documentation indicates that the assistance group's request appears to be fraudulent. The assistance group must be informed of its right to a fair hearing for denial or delay of replacement benefits. Replacements must not be made while the denial or delay is in the appeal process.

3210.0213.04 Special Requirements - Food Destroyed (FS)

Prior to replacing food purchased with food stamps that was destroyed in a household misfortune or disaster; the eligibility specialist must establish that the loss did in fact occur in a disaster situation such as fire, flood or hurricane. Verification of the misfortune or disaster will be made by collateral contact to a community agency such as the fire department, police department, Red Cross or by home visit.

The replacement will be made for the actual amount of the loss, not to exceed the amount of the original benefit issued.

3210.0217 Stolen Benefits (FS)

Stolen or misused Electronic Benefits Transfer (EBT) food stamps are not replaced unless there is evidence of negligence on the part of the Department or EBT Customer Service where the individual reported their card lost or stolen and immediate action was not taken to deactivate the card.

If a cardholder reports loss of benefits after they reported their card lost or stolen to EBT Customer Service or to the Department, please notify the EBT Project Office in Tallahassee for investigation.

Benefits are not replaced if they are stolen or misused by an authorized representative, alternate payee, legal guardian, protective payee or other person who was given access to the card and PIN by the primary payee.

Benefits are also not replaced if they are used prior to the individual notifying EBT Customer Service of the loss or theft of the card.

Theft and misuse of benefits is a criminal matter and the cardholder should be instructed to contact local law enforcement if this occurs.

3210.0300 IDENTIFICATION CARDS (FS)

This section addresses access to benefits.

3210.0301 Electronic Benefits Transfer Cards (FS)

An Electronic Benefits Transfer (EBT) card is issued to each assistance group to be able to access any food stamps they are eligible for. The EBT card must be presented upon request at authorized retailers. The cardholder must immediately report loss or theft of the EBT card, as liability for its misuse is solely the responsibility of the cardholder.

The primary payee or primary cardholder will receive an EBT card. If the primary payee receives both food stamp and cash benefits, their one card will access both accounts. Cards will also be issued to each secondary cardholder, one for any food stamp authorized representative and one for any cash alternate payee. If the food stamp authorized representative and the cash alternate payee are the same person, two cards will be issued, one for each of the account types.

The EBT cards are good as long as there is an account on the EBT system. Account status does not affect card status and card status does not affect account status. If an expunged account is reactivated, the card that was previously used to access the account will still be able to access the account as long as the card was not reported lost, stolen or damaged.

3220.0000 Temporary Cash Assistance

This chapter presents policy regarding benefit issuance.

3220.0100 REPRESENTATIVES AND PAYEES (TCA)

Individuals may designate a non-assistance group or assistance group member to make application and/or receive benefits on behalf of the assistance group.

3220.0101 Authorized Representative/Secondary Cardholder (TCA)

When the payee, spouse, or a responsible assistance group member cannot apply for benefits they may be eligible for, an authorized representative may be designated to make application on behalf of the assistance group. An authorized representative must be designated when food stamps and Temporary Cash Assistance (TCA) are continued for children under age 16 in a TCA food stamp assistance group penalized for noncompliance with work activities. Cash alternate payees may be designated by the primary payee of an assistance group as a secondary cardholder to receive an Electronic Benefits Transfer (EBT) card and to be able to access the primary payee's cash account.

Authorized representatives/secondary cardholders must be designated according to the following requirements:

1. the authorized representative/secondary cardholder must be designated in writing by the payee, spouse, or another responsible member of the assistance group;
2. the authorized representative/secondary cardholder should generally be designated prior to determining eligibility of the assistance group, however, the assistance group can also name an authorized representative/secondary cardholder at any time during the review period;
3. the authorized representative/secondary cardholder must be an individual who is familiar with the current circumstances of the assistance group; and
4. if it becomes obvious that the authorized representative/secondary cardholder is not aware of the current assistance group circumstances, the eligibility specialist must record this information and immediately request in writing that the assistance group designate another authorized representative/secondary cardholder.

The authorized representative/secondary cardholder may be:

1. authorized on the application;
2. designated in writing using the form CF-ES 3010, Authorized Representative Form; or
3. designated for the interview only or the interview, receipt, and use of cash benefits.

Designations of authorized representatives/secondary cardholders are valid for the current review period only.

Payees of assistance groups who are not able to shop for themselves should be encouraged to designate a cash alternate payee as a secondary cardholder for benefit usage.

To ensure recipient understanding of the changes associated with EBT, the following must be discussed with recipients at application and at each review:

1. Recipients may continue to designate authorized representatives to apply and be interviewed on their behalf.
2. Recipients may continue to designate cash alternate payees, when appropriate, to receive and use benefits in addition to the recipient's own benefit access.

3. Recipients may designate only one secondary cardholder per assistance group. FLORIDA accepts one secondary payee per payee type.
4. Cash alternate payees will receive a separate EBT card with their name on it. They must select their own personal identification number (PIN).
5. The cash alternate payee will have access to all the cash in the EBT cash account.
6. If a primary payee for both a cash and food stamp assistance group has the same person designated as both the food stamp authorized representative and cash alternate payee, that person will be issued two EBT cards; one to access the food stamp benefit account, and one to access the cash benefit account.
7. EBT benefits are not replaced if they are lost, stolen or misused, including misuse by a cash alternate payee. Refer to 3220.0217 for more information on stolen benefits.
8. The secondary cardholder's EBT cards are mailed to the primary cardholder.

Note: The applicant can authorize a representative on their application, but form CF-ES-3010 or a written request must be completed when designating the representative to respond on their behalf.

3220.0105 Restrictions on Representatives (TCA)

The following restrictions apply to authorized representatives/secondary cardholders:

1. ACCESS staff and food stamp retailers authorized to accept food stamps cannot act as authorized representatives/secondary cardholders unless no other individual is available to act on behalf of the individual;
 - a. written approval at each designation must be provided by the Region or Circuit Program Office, and
 - b. Region or Circuit Program Office approval must be documented;
2. individuals disqualified for fraud cannot act as authorized representatives/secondary cardholders during the period of disqualification, unless the disqualified individual is the only adult member of the assistance group able to act on the assistance group's behalf; and
3. providers of meals for the homeless may not act as authorized representatives for homeless individuals.

The Region or Circuit Program Office must make a determination as to whether these individuals are needed as authorized representatives/secondary cardholders.

3220.0112 Payee (TCA)

The payee is the caretaker relative with whom the child lives and who assumes primary responsibility for the daily care, supervision, and control of the child. Usually, this relative is the parent who lives in the home with the child on a continuing basis. When the parent fails to assume primary responsibility for the child's care due to causes such as physical illness or handicap, mental or emotional illness, personal instability, poor adjustment, or other personal problems, the specified relative in the home who does assume primary responsibility for the child must be the payee.

The payee is the primary cardholder for the Electronic Benefits Transfer (EBT) card.

The payee of a TCA benefit may not receive more than one TCA benefit at a time, regardless of the number or relationship of the children for whom responsible.

Exception: Relative payees may receive one or more TCA benefits for Relative Caregiver eligible children as well as a TCA benefit for other children who are not Relative Caregiver eligible.

3220.0113.01 Age of Payee (TCA)

Teen parents can be appointed as payee only if they meet one of the exceptions in Chapter 1400.

Specified relatives who are not the child's parent must be 18 or over to be payee, unless the specified relative is married or has had the "disability of non-age" removed by the Circuit Court.

3220.0113.02 Selection of Payee (TCA)

Legal custody of the child is not necessarily a factor in determining who will be the payee. The eligibility specialist must determine who is to be payee when more than one person claims responsibility for the child. The following policies apply to the assignment of payee when legal custody is an issue:

1. When the parent is only temporarily (less than 60 consecutive days) residing with the child and the caretaker relative, the caretaker relative must be payee unless the parent plans to immediately assume daily care, control, and supervision of the child.
2. When a specified relative has legal custody of the child and the parent and specified relative both reside with the child, the relative must be payee until the parent regains custody and assumes care and control of the child, or removes the child from the home.
3. When the individual who has legal custody of the child and the parent or specified relative who has physical possession of the child do not live together, the parent or specified relative with whom the child resides must be payee.
4. When a guardian is appointed by the court for the caretaker relative, the legal guardian must be payee rather than the caretaker relative.
5. When there is a legal guardian or a person holding power of attorney for the caretaker relative, two certified copies of the appointment papers must be obtained (one copy must be retained and one copy must be transmitted to the office of financial support).

3220.0113.03 Nonrelative as Payee (TCA)

A nonrelative may be payee in the following situations:

1. when a payee is sanctioned, a nonrelative may be the protective payee (protective payees may remain payee per policy provided in passage 3220.0114.01); and
2. when an emergency situation arises in an active case preventing the relative payee from caring for the child, a nonrelative may be payee to avoid placing the child in foster care or to provide time to make other arrangements for the child's care (an emergency nonrelative payee may be payee only for 90 days).

3220.0114.01 Protective Payee (TCA)

The protective payee is an individual approved by the eligibility specialist to receive benefits on behalf of the assistance group (AG) when the payee is penalized due to failure to meet work requirements and requests TCA for children under age 16.

The individual selected to act as protective payee must be a responsible person, who evidences concern for the well-being of the AG. It is the protective payee's responsibility to ensure that benefits are used for the AG.

3220.0114.02 When Protective Payee Must be Selected (TCA)

An individual must be selected to act as protective payee when the parent or caretaker relative fails to comply with work activity requirements without good cause or is disqualified for TCA fraud.

The other instance when a protective payee must be selected is for any case containing a teen parent.

For penalties due to noncompliance with work activities and disqualified for TCA fraud, the payee of the penalized AG is responsible for assisting the eligibility specialist with the selection of the protective payee. In the event it is not possible to designate a qualified protective payee or authorized representative/secondary cardholder, TCA payments cannot be issued.

Staff will discontinue the protective payee selection process for work penalties when any one of the following conditions exists:

1. A hearing is requested,
2. The individual becomes exempt for TCA work activities, or
3. The individual demonstrates compliance as determined by Regional Workforce Board (RWB) /contract provider.

For disqualification penalties due to TCA fraud, staff will not select a protective payee for a two parent TCA household when only one parent has been disqualified. Designate the non-disqualified parent as the payee of the benefit. Staff must discontinue the protective payee requirement for the children's benefit once the individual has served their TCA disqualification penalty.

3220.0114.03 Who Can Be Protective Payee (TCA)

An individual may receive benefits in his own right and be protective payee for another AG. The protective payee will not receive remuneration for services rendered in this capacity, either by the AG or by the Department of Children and Families.

The following individuals may be considered for protective payee:

1. An adult relative (includes a family member whose needs are not included in the AG);
2. An adult friend/neighbor;
3. A member of the clergy; or
4. A member of a community service group, social agency, or volunteer agency.

The following individuals are not considered suitable protective payees:

1. An individual in a sanctioned AG,
2. Landlords, grocers, and other vendors who give services to the AG;
3. Department of Children and Families employees who are directly responsible for determining eligibility for TCA or food stamps for the AG;and
4. An individual disqualified for TCA fraud.

3220.0114.04 Role and Responsibility of the Protective Payee (TCA)

The eligibility specialist must explain to the protective payee the following roles and responsibilities. The protective payee:

1. must agree to see that the benefit is used expressly for the benefit of the members of the AG by supervising the use of the benefit or directly spending the benefit on behalf of the AG, including paying the recipient's portion of subsidized child care;
2. must agree to be accountable to the Department of Children and Families for expenditures of the funds;
3. must sign a new Protective Payee Agreement every 12 months;
4. must understand how the benefit is budgeted and whose needs are included in the AG;
5. must understand the law on Misuse of Child Support Funds and the protective payee's liability under this law; and

6. may voluntarily withdraw from the agreement at any time.

The following policies apply to protective payees:

1. It is the protective payee's responsibility to report any changes in the status of the AG to the eligibility specialist. This does not negate the responsibility of the parent or relative to report changes as they occur.
2. It is not the protective payee's responsibility to participate in the eligibility review process. The parent or relative must complete the required forms and be interviewed. The protective payee may be requested to supply information needed by the eligibility specialist to complete the process.

3220.0200 PAYMENTS (TCA)

This section addresses benefit issuance and payments.

3220.0201 Electronic Benefits Transfer (EBT) (TCA)

Cash benefits will be automatically placed in a recipients' Electronic Benefits Transfer (EBT) account on a designated day for access at their convenience. There are separate accounts for food stamp and cash benefits, both accessible by one card.

The EBT card is the means by which participants (our recipients and their secondary payees) access their benefits. EBT cards are distributed by mail; therefore, it is extremely important that the correct and current mailing address be entered onto the FLORIDA system. Now, more than ever, it becomes necessary for address changes to be reported as soon as possible to prevent the EBT card from being returned due to an incorrect address, possibly delaying access to benefits.

Assistance group information is electronically transmitted from the FLORIDA system to the EBT Administrative System. The information passed through this interface will set up and maintain EBT accounts for FLORIDA assistance groups. The assistance categories to be included from FLORIDA to EBT are TCA (ADCR, ADCU, ADCI).

Account Setup records are transmitted to provide the EBT system with the demographic information needed to establish an EBT account, and create and mail an EBT card. Account Setup records are used to build customer accounts on the EBT system and provide information necessary for card issuance. Benefit authorization records tell the EBT system the value of each cardholder's benefits. Benefit Authorization records that cannot be matched to an EBT account remain in the Benefit Pending file for 90 days, after which they will be purged, if a corresponding account was not found. Benefit Authorization records for recurring benefits are not posted into the EBT account until the benefit availability date, but may be viewed in the Benefit Pending file until their benefit availability date arrives.

ACCOUNT SETUP RECORDS

The demographic records sent to the EBT system to establish accounts and create EBT cards are called "Account Setup Records" and "Benefit Records." Account setup records are composed of the following case/participant information:

1. FLORIDA Account Number - Case/Short List Member Number of the primary payee designated on AGPY. The case/short list member number is the state case identifier on the Client Search screen on the EBT system. Assistance groups with designated

- protective payees will have an additional suffix of "P" and designated legal guardians will have an additional suffix of "L" on the EBT system.
2. Primary/Alternate Indicator - FLORIDA system generated based on primary payee designation on AGPY or secondary payee information on AGAR.
 3. Card Access Indicator - FLORIDA system generated based on the cardholder's designation to have access to food stamps only, Temporary Cash Assistance benefits only, or access to both.
 4. Last Name - Primary payee information on AIID or secondary payee information on AGAR.
 5. First Name - Primary payee information on AIID or secondary payee information on AGAR.
 6. Middle Initial - Primary payee information on AIID or secondary payee information on AGAR.
 7. Date of Birth - Primary payee information on AIID.
 8. Social Security Number - Primary payee information on AIID.
 9. Mailing Address - Primary payee information on AICI/AGAM (using current FLORIDA address hierarchy) or AGAR/AICI for legal guardians and protective payees depending on the mail address designation on AGAR.
 10. City - Primary payee information on AICI/AGAM.
 11. State - Primary payee information on AICI/AGAM.
 12. Zip Code - Primary payee information on AICI/AGAM (zip + four characters).
 13. Language Indicator - Primary payee information on AICI or secondary payee information from AGAR if member = 99.
 14. Card Issuance Indicator - FLORIDA generated.
 15. Drop Ship Indicator - INACTIVE (from DROP SHIP field on AGBI).
 16. Issuance Service Site Number - Issuance Service Site designation on AGBI (five digit county/site number).

BENEFIT AUTHORIZATION RECORDS

Once an account is established, then benefits may be added to the account. Benefit Authorization records contain the following data fields:

1. FLORIDA Account Number - Case/Short List Member Number of the primary payee designated on AGPY. The case/short list member number is the state case identifier on the Client Search screen on the EBT system. Protective payees will have an additional suffix of "P" and legal guardians will have an additional suffix of "L" on the EBT system.
2. Action Code - FLORIDA generated for benefit add or benefit void (intercept).
3. Category/Sequence - The category of assistance and assistance group sequence number from FLORIDA.
4. Credit/Debit Indicator - FLORIDA generated based on an internal action code.
5. Benefit Identifier - The unique benefit number assigned by FLORIDA for each benefit type and indicated on IQCH and IQFS (warrant number and food stamp benefit number) and the benefit period (MM/DD/YY).
6. Benefit Amount - The net benefit amount after recoupment as indicated on IQCH and IQFS.
7. Benefit Availability Date - The benefit availability date specified on the cash (TSCI) and food stamp (TFSQ) staggered issuance tables.
8. Benefit Month and Year - The benefit month and year indicated on IQCH and IQFS.
9. Issuance Service Site Number - Issuance Service Site designation on AGBI (5 digit county/site number).

There are only two types of benefit records on the EBT system, benefit add and benefit void. Benefit add will add new benefits to an account. Benefit void is a benefit interception. Benefits cannot be deleted from nor "held" on the EBT system. If benefits were authorized in error, they must be intercepted prior to their benefit availability date and replaced with the correct benefits. If

unable to intercept, the eligibility specialist should examine the case for over-issuance or under-issuance.

3220.0202 Staggered Issuance (TCA)

EBT cash benefits are issued over the first three business days of each month based on the eighth and ninth FLORIDA case number digits.

3220.0203.01 Expunged Status (TCA)

Expunged accounts are accounts that have not been accessed or had a debit transaction performed in the preceding 365 days (one year).

When an account reaches expunged status any benefits contained in the account will begin to expunge individually as each benefit reaches 365 days of age from the date the last debit transaction was performed or from the date of deposit, if no debit transactions were performed against the benefit.

Due to expunged status accounts, an inquiry should be performed on all FLORIDA applications after a break in eligibility to determine if the person has an established account on the Electronic Benefits Transfer (EBT) system. If an account already exists in the EBT system for the person, the eligibility determination process should be completed in such a manner to direct any newly approved benefits to the account already on the EBT system. This is accomplished by approving the person using the same FLORIDA case/RFA number and short list member for the account already on the EBT system.

Note: Benefits deposited into expunged status accounts automatically reactivate the account. It is not necessary to manually reactivate an expunged account if a new benefit is being authorized for the account.

Exception: Very old accounts (pre 2003) may need to be manually reactivated using the account reactivation function on the EBT Administrative System if a new benefit deposit fails to reactivate the account.

3220.0203.02 EBT for Individuals Relocating to Another State (TCA)

An individual can, but is not required to, withdraw their Temporary Cash Assistance (TCA) benefits prior to relocating to another state.

The Electronic Benefits Transfer (EBT) card can be used for any TCA recipient at any Automated Teller Machine (ATM) that displays the "STAR" or "QUEST" logos or from a QUEST retailer that allows cash withdrawals.

3220.0206 Restoring Lost Benefits (TCA)

The Department must restore lost benefits when a determination is made that benefits were lost because all or part of the assistance group's cash assistance were denied, delayed, or terminated due to administrative error or due to identity theft.

Identity theft occurs when someone obtains the demographic information of another individual, uses the information to get an EBT or Medicaid card in the name of the other individual through an application approval or a replacement card, and receives (steals) the other individual's benefits. In situations of identity theft confirmed through an Inspector General or Public Benefits Integrity investigation and committed by an individual employed by the Department of Children and Families, restore the stolen benefits of an individual or household only if they were originally eligible for the benefits.

Benefits will be restored to the assistance group for not more than 12 months prior to whichever of the following occurred first:

1. the date the Department was notified by the assistance group or by another individual or agency in writing or orally of the possibility of lost benefits; or
2. the date the Department discovered that a loss of assistance group benefits occurred.

Benefits must be restored even if the assistance group is currently ineligible.

Exception: Benefits must be restored when over-recoupment has occurred, without regard of the 12-month time frame.

3220.0214.02 Recurring Benefits (TCA)

Around the 20th of each month FLORIDA executes the monthly recurring benefit pulldown. This function creates the regular monthly benefits for the next month for each eligible assistance group. A monthly file is created and transmitted to the Electronic Benefits Transfer (EBT) system to post to the recipient's accounts in the benefit month.

3220.0214.03 Auxiliary Benefits (TCA)

Benefits authorized for reasons other than the recurring monthly benefit are auxiliary benefits. Auxiliary benefits are automatically generated by the FLORIDA system or manually created by the eligibility specialist.

FLORIDA creates auxiliary benefits for:

1. initial month(s) prorated benefits, and
2. restoration of benefits to pre-hearings level after a reduction or cancellation of benefits and a fair hearing is requested.

The eligibility specialist manually generates auxiliary benefits when:

1. initial month(s) prorated benefits for new individuals have been added to an existing assistance group,
2. supplemental benefits have been added for changes that resulted in increased benefits when the monthly recurring pull down has occurred and the AG is entitled to increased benefits for months prior to the next recurring month (includes interim changes, benefit adjustments from changes in policy and agency errors),
3. state collection of child support begins and timely action is not taken to remove the direct paid support income from the budget,
4. a recurring benefit results in underpayment,
5. an assistance group is determined retroactively eligible for a higher benefit as a result of a fair hearing decision,
6. an assistance group's recurring benefit was issued in an incorrect payee's name, and TCA benefits can still be canceled, or
7. a replacement for a canceled benefit.

Prior to manually creating an auxiliary benefit, the eligibility specialist must do the following:

1. Check IQCH to determine if an auxiliary payment has already been issued for the same reason and for the same period to avoid duplication of benefits.
2. Check IQCH when there is an indication in the case record that cancellation or interception of a benefit occurred in the same month(s) for which the auxiliary benefit is being created. Determine if the assistance group remains eligible for the benefit.

All eligibility specialist generated auxiliary benefit information must be documented on CLRC (running record comments screen), including the reason for the auxiliary benefit. All eligibility

specialist generated auxiliary benefits must be authorized by the supervisor. Cash auxiliary benefits may be canceled by the eligibility specialist before approval by the supervisor. Once approved, they cannot be canceled. Cash auxiliary benefits cannot be intercepted.

3220.0215.02 Intercepted Benefits (TCA)

Benefits are intercepted for reduction or cancellation when the required action occurs after the recurring benefit pulldown deadline. Intercepts on the system are requested on the SFHD screen. The eligibility specialist may intercept recurring cash benefits up through the day prior to the benefit availability date. Cash auxiliary benefits may be intercepted on the day they are created.

3220.0215.03 Reissued Benefits (TCA)

Situations occur where a cash benefit must be reissued to the assistance group. These situations are:

1. The recurring cash benefit was canceled and the assistance group remains eligible for the benefit.
2. The recurring cash benefit was issued to the assistance group in the name of an incorrect payee and was cashed by the incorrectly named payee.

The disposition of the original cash benefit must always be determined prior to the creation and authorization of the reissued benefits. Reissued benefits are authorized for the same amount of the original benefit.

3220.0215.09 Benefits Outstanding More Than One Year (TCA)

Cash benefits that have not been accessed or had a debit transaction performed in the preceding 365 (one year) days will be expunged (removed) from the Electronic Benefits Transfer (EBT) system. Recipients are entitled to receive a cash benefit up to one year from the last day of the month in which the benefit was issued. An expunged cash benefit may be restored by the auxiliary process if the payee requests the benefit by the last day of the month in which the benefit was expunged. Do not restore expunged benefits that are more than one year old.

3220.0217 Stolen Benefits (TCA)

Stolen or misused Electronic Benefits Transfer (EBT) cash benefits are not replaced unless there is evidence of negligence on the part of the Department or EBT Customer Service where the individual reported their card lost or stolen and immediate action was not taken to deactivate the card.

If a cardholder reports loss of benefits after they reported their card lost or stolen to EBT Customer Service or to the Department, please notify the EBT Project Office in Tallahassee for investigation.

Benefits are not replaced if they are stolen or misused by an authorized representative, alternate payee, legal guardian, protective payee or other person who was given access to the card and PIN by the primary payee.

Benefits are also not replaced if they are used prior to the individual notifying EBT Customer Service of the loss or theft of the card.

Theft and misuse of benefits is a criminal matter and the cardholder should be instructed to contact local law enforcement if this occurs.

3220.0300 IDENTIFICATION CARDS (TCA)

This section addresses access to benefits.

3220.0301 Electronic Benefits Transfer Cards (TCA)

An Electronic Benefits Transfer (EBT) card is issued to each assistance group to be able to access any cash benefits they are eligible for. The EBT card must be presented upon request at authorized retailers. The cardholder must immediately report loss or theft of the EBT card, as liability for its misuse is solely the responsibility of the cardholder.

The primary payee or primary cardholder will receive an EBT card. If the primary payee receives both food stamp and cash benefits, their one card will access both accounts. Cards will also be issued to each secondary cardholder, one for any food stamp authorized representative and one for any cash alternate payee. If the food stamp authorized representative and the cash alternate payee are the same person, two cards will be issued, one for each of the account types.

The EBT cards are good as long as there is an account on the EBT system. Account status does not affect card status and card status does not affect account status. If an expunged account is reactivated, the card that was previously used to access the account will still be able to access the account as long as the card was not reported lost, stolen or damaged.

3230.0000 Family-Related Medicaid

This chapter presents policy regarding benefit issuance.

3230.0100 REPRESENTATIVES AND PAYEES (MFAM)

Individuals may designate a non-assistance group or assistance group member to make application and/or receive benefits on behalf of the assistance group.

3230.0102 Designated Representative (MFAM)

When the applicant/recipient, their spouse, legal guardian, Power of Attorney, or a responsible member of the assistance group cannot apply for benefits they may be eligible for, a designated representative may be authorized to make application on behalf of the assistance group.

Designated representatives must be authorized according to the following requirements:

1. the designated representative must be authorized in writing by the applicant/recipient, their spouse, legal guardian, Power of Attorney, or another responsible member of the assistance group;
2. the designated representative is commonly authorized prior to determining eligibility of the assistance group, however, the assistance group can also name the representative at any time during the review period;
3. the designated representative must be an individual who is familiar with the current circumstances of the assistance group; and
4. if it becomes obvious that the designated representative is not aware of the current assistance group circumstances, the eligibility specialist must record this information and immediately request in writing that the assistance group authorized another representative.

The designated representative may be:

1. authorized on the application, or
2. on any written and signed statement from the applicant/recipient.

Recipients may continue to authorize designated representatives to apply and be interviewed on their behalf.

3230.0116 Self-Designated Representative (MFAM)

In instances where the individual does not select a specific person as designated representative, the eligibility specialist must determine if the self-designated representative is the most appropriate person to fulfill this responsibility. An organization cannot self-designate, but an individual employee of an organization may continue to self-designate. If the individual employee of an organization self-designates, the preferred method is to complete the CF-ES 2505 form. If this is done, only that employee may communicate with the Department and not any other employee of the organization.

The eligibility specialist must determine who has knowledge of the individual's affairs. If a self-appointed designated representative has little or no knowledge of an individual's finances, the eligibility specialist must record a complete explanation of efforts made to obtain a knowledgeable designated representative.

The following guide presents an order of preference for selection of the designated representative:

1. legal guardian,
2. power of attorney,
3. relatives,
4. friends, and
5. agency representative/nursing home staff (other than nursing home administrator).

3230.0117 Who May Not Act as Designated Representative (MFAM)

The following persons may not act as the designated representative:

1. a DCF employee responsible for making the eligibility determination for the assistance group, or that employee's immediate supervisor, or
2. a nursing home administrator (including administrators of ICF/MRs and State Hospitals), or anyone in a position to act as nursing home administrator, except in instances where the administrator is the individual's legal guardian.

3230.0118 Liability of the Designated Representative (MFAM)

The designated representative is liable for prosecution for perjury and/or fraud if the designated representative knowingly withholds information or knowingly gives false information about the assistance group. The eligibility specialist is responsible for advising the designated representative that by signing the application/eligibility form, the designated representative indicates a clear understanding of these responsibilities, and has provided information to the best of the designated representative's knowledge about the individual's situation.

3230.0300 IDENTIFICATION CARDS (MFAM)

This section addresses access to benefits.

3230.0302 Medicaid Identification Card (MFAM)

The Medicaid Identification Card (MIC) is a computer generated form and is the authorization by which the individual secures Medicaid benefits. MICs are also produced weekly for new assistance groups being added to FLORIDA.

3230.0303 Proof of Medicaid (MFAM)

When an individual requests proof of Medicaid eligibility, the eligibility specialist will first verify Medicaid eligibility through FLORIDA and the Florida Medicaid Management Information System (FMMIS). If eligible, the individual will generate proof of their Medicaid eligibility coverage by accessing their online MyACCESS Account. The eligibility specialist can generate a Medicaid Identification Card through FLORIDA.

3230.0400 THIRD PARTY PAYMENTS AND BILLING (MFAM)

This section addresses policy on third party payments and billing.

3230.0401 Third Party Payments (MFAM)

To be eligible for Medicaid, the individual must assign to the state the individual's right to any third party payment for medical care. When Medicaid benefits are being authorized for a child residing with a nonrelative, any payments for medical care must be legally assigned to the state. The individual or the child's parent, caretaker, or the designated facility official must cooperate with the state in obtaining third party payments. This includes but is not limited to:

1. insurance policies,
2. court ordered medical support, and
3. irrevocable trusts which provide for medical expenses.

Under Florida law, this assignment is automatic by receiving Medicaid. The individual acknowledges it when signing the application.

3230.0402 Reimbursement (MFAM)

If an individual receives medical care that is not covered by Medicaid, the state does not have the right to third party payment for that care.

If an individual receives medical care that is paid or will be paid by Medicaid, any third party payment received by the Medicaid provider is to be reimbursed to the state up to the amount paid by Medicaid.

If an individual receives direct reimbursement for medical care paid by Medicaid, the individual is required to reimburse the state. This is done by endorsing the check from the insurance company to Agency for Health Care Administration or by sending a check or money order to Agency for Health Care Administration.

3230.0403 Eligibility Specialist Given Reimbursement (MFAM)

Support for administration of other federally funded programs (food stamps, social services, etc.).

If the individual gives the reimbursement to the eligibility specialist, the eligibility specialist must submit the reimbursement to:

ACS Recovery Services
P.O. Box 12188
Tallahassee, FL 32317-2188, and

Attach a cover memo that includes the following information: the individual's name, Medicaid identification number, and hospital admission date or date of service(s) if outpatient case.

3230.0407 Billing (MFAM)

Before Medicaid will pay claims for the first day of eligibility, the provider must have proof that the assistance group is not responsible for the claim.

This section describes how to notify providers of bills that are potentially reimbursable by Medicaid.

3230.0407.01 Billing Authorization (MFAM)

In Medically Needy cases, expenses incurred on the day the Share of Cost is met and are used in full to meet the Share of Cost are not eligible to be paid by Medicaid. Any bills incurred on the date the Share of Cost is met that are not used in full to meet the SOC are eligible for reimbursement by Medicaid.

The eligibility specialist must complete a Billing Authorization Form for each provider who provided services on the day the SOC was met and whose bill was not used in full to meet the Share of Cost and send the form to the applicable provider(s).

3230.0407.02 Medicaid Claims Payment (MFAM)

Medicaid pays claims for covered services within prescribed program limits. A provider who chooses to participate in the Medicaid Program must submit the claim. A Medicaid provider does not have to bill Medicaid; however, if he chooses to bill Medicaid, he must accept the Medicaid payment as payment in full.

Providers must submit clean claims to Medicaid within 365 days of the date of service. A clean claim is an original, correctly completed claim that is ready to process. Medicaid claims over 365 days old may be paid if an eligibility or technical (systems) error was made on the case by DCF.

3230.0500 Certified Application Counselors (MFAM)

Staff and volunteers of state-designated organizations may act as application assisters, authorized to provide assistance to applicants and recipients with the application and redetermination process. Certified Application Counselors (CAC) are trained in the Medicaid eligibility policies and adhere to all rules and regulations relating to safeguarding and confidentiality of customer information.

The assistance provided by CACs include: providing information on Medicaid programs, helping individuals complete an application/redetermination, assisting the individuals to provide required documentation, submitting documents to the Department, making inquiries as to the status of the applications and redeterminations, assisting individuals with responding to Department requests.

3240.0000 SSI-Related Medicaid, State Funded Programs

This chapter presents policy regarding benefit issuance.

3240.0100 REPRESENTATIVES AND PAYEES (MSSSI, SFP)

Individuals may designate a non-assistance group or assistance group member to make application and/or receive benefits on behalf of the assistance group.

3240.0115 Designated Representative (MSSSI, SFP)

A designated representative is someone who assumes responsibility for acting on behalf of the individual or assistance group by providing information for the eligibility determination.

Designated representatives must be authorized according to the following requirements:

1. the designated representative must be authorized in writing by the applicant/recipient, their spouse, legal guardian, Power of Attorney, or another responsible member of the assistance group;
2. the designated representative is commonly authorized prior to determining eligibility of the assistance group, however, the assistance group can also name the representative at any time during the review period;
3. the designated representative must be an individual who is familiar with the current circumstances of the assistance group; and
4. if it becomes obvious that the designated representative is not aware of the current assistance group circumstances, the eligibility specialist must record this information and immediately request in writing that the assistance group authorized another representative.

The designated representative may be:

1. authorized on the application, or
2. on any written and signed statement from the applicant/recipient.

The individual can select the designated representative, or if the individual is incapable of selecting a representative, the designated representative may be self-appointed. An organization cannot self-designate, but an individual employee of an organization may continue to self-designate. If the individual employee of an organization self-designates, the preferred method is to complete the CF-ES 2505 form. If this is done, only that employee may communicate with the Department and not any other employee of the organization. If the individual does not designate the designated representative, the eligibility specialist must record the reason.

A designated representative must be selected when the individual has been declared legally incompetent and cannot legally act on his own behalf. If the individual has a legal guardian, the legal guardian must act on the individual's behalf as the designated representative. If the legal guardian will not cooperate or cannot be located, someone else may act as designated representative. When someone other than the legal guardian is the designated representative, a written notice must be sent to the legal guardian advising the legal guardian that a designated representative has been appointed. A copy of the written notice must be filed in the case record.

The individual may select a designated representative at any time. The individual does not have to be functionally or legally incompetent to have a designated representative.

3240.0116 Self-Designated Representative (MSSSI, SFP)

In instances where the individual does not select a specific person as designated representative, the eligibility specialist must determine if the self-designated representative is the most appropriate person to fulfill this responsibility. An organization cannot self-designate, but an individual employee of an organization may continue to self-designate. If the individual employee of an organization self-designates, the preferred method is to complete the CF-ES 2505 form. If this is done, only that employee may communicate with the Department and not any other employee of the organization.

The eligibility specialist must determine who has knowledge of the individual's affairs. If a self-appointed designated representative has little or no knowledge of an individual's finances, the eligibility specialist must record a complete explanation of efforts made to obtain a knowledgeable designated representative.

The following guide presents an order of preference for selection of the designated representative:

1. legal guardian,
2. power of attorney,
3. relatives,
4. friends, and
5. agency representative/nursing home staff (other than nursing home administrator).

3240.0117 Who May Not Act as Designated Representative (MSSSI, SFP)

The following persons may not act as the designated representative:

1. a DCF employee responsible for making the eligibility determination for the assistance group, or that employee's immediate supervisor, or
2. a nursing home administrator (including administrators of ICF/MRs and State Hospitals), or anyone in a position to act as nursing home administrator, except in instances where the administrator is the individual's legal guardian.

3240.0118 Liability of the Designated Representative (MSSSI, SFP)

The designated representative is liable for prosecution for perjury and/or fraud if the designated representative knowingly withholds information or knowingly gives false information about the assistance group. The eligibility specialist is responsible for advising the designated representative that by signing the application/eligibility form, the designated representative indicates a clear understanding of these responsibilities, and has provided information to the best of the designated representative's knowledge about the individual's situation.

3240.0119 Designation of OSS/PNAS Beneficiary (MSSSI, SFP)

An OSS/PNAS individual must designate a beneficiary to receive the OSS/PNAS warrant which may not have been endorsed and cashed prior to the death of the individual. The Designation of Beneficiary Form must be completed by the individual or his guardian prior to approval of an OSS/PNAS application. The individual should be reminded of his debt to the Special Living Arrangement provider when choosing the beneficiary.

At each eligibility review, the case recording must reflect discussion with the individual or PIP, the case name, and the current address of the designated beneficiary. If a valid beneficiary designation does not exist for a deceased individual, the court must be petitioned to name a beneficiary. The court order must be submitted to ASFMD (Statewide Financial Support Services).

3240.0120.01 OSS/PNAS Representative Payee (MSSI, SFP)

Occasionally OSS/PNAS individuals are unable to act on their own behalf because of physical and/or mental limitations. DCF recognizes that these individuals would not be capable of making decisions essential to insure that their basic needs would be met, that is, food, shelter, clothing, and medical care, nor would these same individuals be able to handle their financial affairs. Therefore, DCF allows for a representative payee to use the OSS/PNAS benefits received in the best interest of the incapable beneficiary.

The selection process should be initiated by the eligibility specialist when the need for a representative payee becomes known. The need for a payee may be evidenced by the individual not utilizing the OSS payment to meet their basic needs, that is, clothing and medical care, and not paying their caretaker. If applicable, the individual and counselor should be given the opportunity and be encouraged to participate in the selection process.

In those situations where a responsible person wishes to be appointed legal guardian and is so appointed by a court, that individual must be made the OSS representative payee.

In those situations where the OSS individual has a legal guardian, the guardian must be the representative payee. If the guardian cannot be located or does not appear to be concerned with the welfare of the individual, court action should be taken to remove the guardian and request the appointment of a successor guardian.

3240.0120.02 OSS/PNAS Payee Selection Criteria (MSSI, SFP)

An OSS/PNAS representative payee must meet the following selection criteria:

1. must reside in the same locality as the OSS individual (for PNAS, may reside in different locality); and
2. will not receive remuneration for services rendered in this capacity, either by the OSS individual or DCF.

The following individuals may be considered:

1. a relative;
2. a responsible individual assistance group member 18 or older who shows concern for the well-being of the individual;
3. a friend;
4. a neighbor;
5. a member of the clergy;
6. a member of a community service group, social agency or volunteer agency; or
7. a Special Living Arrangement Provider.

3240.0120.03 Role and Responsibilities of Payee (MSSI, SFP)

A responsible person who shows concern for the well being of the individual will be selected as payee. The OSS/PNAS check will be made out in the payee's name, and this payee will be responsible to see that the funds are used strictly for the benefit of the individual. The payee may either supervise the individual's use of the money, or spend the money for the direct benefit of the individual.

It is the payee's responsibility to report any changes in the status of the individual to DCF. This in no way negates the responsibility of the individual or counselor to report changes to the eligibility specialist.

3240.0121 OSS/PNAS Power of Attorney (MSSSI, SFP)

When it is not possible for the representative payee to be appointed as legal guardian, the OSS individual may give "power of attorney" to another individual to administer their financial affairs.

When court action is not possible to remove a guardian and appoint a successor guardian, and the individual has not given power of attorney to an individual, a responsible person who wishes to be the individual's representative payee may do so. However, the individual must first give written notice to the legal guardian (copy in case record), followed by a reasonable period of time for a response before assuming the responsibility of representative payee. An individual who wishes to become and is selected to be the representative payee must agree to and sign the OSS Representative Payee Agreement.

3240.0200 PAYMENTS (MSSSI, SFP)

This section addresses benefit issuance and payments.

3240.0214 Cash Benefit Payments and Warrants (MSSSI, SFP)

A warrant is a program benefit in the form of a cash payment. Warrants are issued from the State Comptroller's office to eligible recipients in the form of a state check. Warrants are issued for recipients' monthly recurring benefits and for auxiliary benefits. The warrant life for these warrants is 12 months.

For MSSSI, this policy applies to OSS and PNAS only.

3240.0216.01 OSS/PNAS Warrants (MSSSI, SFP)

It may be necessary to authorize auxiliary payments to provide correct payment to an individual at the time of application approval or for ongoing payment. Auxiliary payments are authorized through submission of the Authorization of Auxiliary Payment to ASFMD. There are three types of Auxiliary Payments which may be authorized:

1. issuance,
2. reissuance, and
3. supplementation.

3240.0216.02 OSS/PNAS Issuance (MSSSI, SFP)

A warrant must be issued when the following occurs:

1. to authorize payment for a current and/or prior month(s) when an individual is determined ineligible for ongoing payment;
2. to authorize payments posthumously;
3. for cases closed due to document and computer processing errors and eligibility specialist errors in eligibility determination;
4. when an individual has been determined eligible for OSS and payment authorized for a specific month, but for some reason the individual's name did not appear on the payroll for that month; or
5. when the appeal of a rejection or cancellation is granted with retroactive payments, provided eligibility for the retroactive payment is determined.

If an individual is being approved and payment must be authorized for more than two months during the application process, a warrant must be issued. The first two months of retroactive payments can be authorized on the Supplemental Payment System at the time of approval.

3240.0216.03 OSS/PNAS Reissuance (MSSSI, SFP)

Action should be taken to reissue a warrant when the following circumstances occur:

1. when a warrant has been issued on a payroll under a particular SSN, but is in the wrong name and is intercepted or returned for some reason and canceled; and
2. when a warrant has been issued on a payroll under a particular SSN in an incorrect name and has been cashed.

3240.0216.04 OSS/PNAS Supplementation (MSSI, SFP)

When a warrant has been authorized and appears on the payroll for a particular month, but the eligibility specialist has determined after the established date for changes that the individual was eligible for a larger benefit, action should be taken to supplement a warrant.

Correction of underpayment may not be made for any month prior to the month in which the factor causing underpayment was reported to, or becomes known, to DCF. DCF is not responsible for underpayment resulting from individual error or error on the part of the Institutional/Special Living Arrangement Provider.

For OSS, correction of underpayment for active cases is done by completion of a "D" action SPS document. For OSS cases that are not currently active, underpayment is corrected by submitting a supplement payment, using the Authorization for Special Circumstance Payment (CF-ES Form 2004.)

In ICP, correction of underpayment to the LTC provider is made to the provider through the institutional billing process.

3240.0216.06 Interception of OSS/PNAS Warrants (MSSI, SFP)

A warrant may be intercepted to reduce or cancel payment, provided adequate written notice is given.

Interceptions are to be made by telephone call to the Office of Statewide Accounts and Receivables (ASFMD) until noon on the SPS interception deadline date. If more than five interceptions are being requested at one time, the transceiver equipment must be used in place of the telephone. The effective date on the SPS must be the first day of the month for which the warrant is intercepted when the case is being canceled.

3240.0216.07 Forwarding OSS/PNAS Warrants (MSSI, SFP)

The individual, the authorized representative, representative payee, or Service Worker is responsible for advising the eligibility specialist of changes of address.

The eligibility specialist is responsible for updating the SPS document by the next payroll deadline to change the address. OSS and PNAS warrants are not forwarded. If the change of address is not processed prior to the production of the SPS payroll, the eligibility specialist must call ASFMD prior to noon on the SPS interception deadline to provide the new address.

When the individual fails to receive an OSS warrant because of the individual's failure to notify DCF of a change of address, the eligibility specialist must explore how the individual managed without the warrant, as well as the individual's eligibility for the warrant. Discussion with the individual and other responsible persons must include a reminder of the individual's responsibility to report all changes, including changes of address, promptly.

3240.0300 IDENTIFICATION CARDS (MSSI)

This section addresses access to benefits.

3240.0302 Medicaid Identification Card (MSSI)

The Medicaid Identification Card (MIC) is a gold, plastic, permanent card and is the authorization by which the individual secures Medicaid benefits. MICs are also produced weekly for new assistance groups being added to FLORIDA.

3240.0303 Proof of Medicaid (MSSI)

When an individual requests proof of Medicaid eligibility, the eligibility specialist will first verify Medicaid eligibility through FLORIDA and the Florida Medicaid Management Information System (FMMIS). If eligible, the individual will generate proof of their Medicaid eligibility coverage by accessing their online MyACCESS Account. The eligibility specialist can generate a Medicaid Identification Card through FLORIDA.

3240.0400 THIRD PARTY PAYMENTS AND BILLING (MSSI)

This section addresses policy on third party payments and billing.

3240.0401 Third Party Payments (MSSI)

To be eligible for Medicaid, the individual must assign to the state the individual's right to any third party payment for medical care. When Medicaid benefits are being authorized for a child residing with a nonrelative, any payments for medical care must be legally assigned to the state. The individual or the child's parent, caretaker, or the designated facility official must cooperate with the state in obtaining third party payments. This includes but is not limited to insurance policies, court ordered medical support, and irrevocable trusts which provide for medical expenses.

Under Florida law, this assignment is automatic by receiving Medicaid. The individual acknowledges it when signing the application.

3240.0402 Reimbursement (MSSI)

If an individual receives medical care that is not covered by Medicaid, the state does not have the right to third party payment for that care.

If an individual receives medical care that is paid or will be paid by Medicaid, any third party payment received by the Medicaid provider is to be reimbursed to the state up to the amount paid by Medicaid.

If an individual receives direct reimbursement for medical care paid by Medicaid, the individual is required to reimburse the state. This is done by endorsing the check from the insurance company to Agency for Health Care Administration or by sending a check or money order to Agency for Health Care Administration.

3240.0403 Eligibility Specialist Given Reimbursement (MSSI)

If the individual gives the reimbursement to the eligibility specialist, the eligibility specialist must submit the reimbursement to:

ACS Recovery Services
P.O. Box 12188
Tallahassee, FL 32317-2188; and

Attach a cover memo that includes the following information: the individual's name, Medicaid identification number, and hospital admission date or date of service(s) if outpatient case.

3240.0404 Private Insurance (MSSI)

Payments from private insurance for services recognized in the DCF rate for the facility are handled through the third party recovery process.

If the individual has any private insurance which covers institutional care, the eligibility specialist must:

1. complete the appropriate FLORIDA screens (AFMD, AFMC), and
2. forward a copy of the screen to the facility to apprise the facility of the availability of third party coverage for institutional services.

All types of insurance coverage must be entered on the screen, but only when institutional care coverage is present is a copy forwarded to the facility.

The Third Party Recovery Unit must ensure that third party sources are billed and that the facility refunds any payments due Medicaid that are received from these sources.

3240.0405 Medicare (MSSI)

The facility will keep the Medicare payment for care in skilled nursing facilities, if the Medicare rate is higher than the Medicaid rate. No vendor payment will be made during the Medicare coverage period.

Medicaid can, however, participate in the payment of the coinsurance, if the Medicaid rate is higher than the Medicare rate. Medicare payments will be handled through the third party recovery process. The eligibility specialist will not be involved in this process in any way. A vendor payment can be made during the Medicare coverage period in this situation. The facility is to retain the Medicare payment during the full Medicare coverage period. During the first 20 days of full Medicare coverage, no Medicaid vendor payment will be made as the Medicare payment is considered payment in full.

For Medicare payments for psychiatric care in state mental hospitals, the facility is to refund Medicare payments through the third party recovery process or refer to the Medicaid Fiscal Agent through the adjustment void process. The eligibility specialist is not involved in any way with Medicare payments. A vendor payment can be made to State Mental Hospitals during the Medicare coverage period.

3240.0406 Contributions to Facility (MSSI)

AHCA is responsible for the administrative code and policy pertaining to voluntary general contributions received by a nursing home.

The eligibility specialist must question the individual or designated representative regarding the presence of contributions during the application and eligibility review process. The eligibility specialist must be alert to information received from other sources, such as quality control or audit reports, about the presence of contributions.

If there is a general, signed contributions notice on file with DCF, the voluntary general contributions do not affect Medicaid payment to the facility.

If there is no current, signed contribution notice on file, the contributions are third party payments and must be refunded by the facility to Medicaid Third Party Recovery. The eligibility specialist must notify Medicaid Third Party Recovery of the presence of contributions which are to be refunded.

3240.0407 Billing (MSSI)

Before Medicaid will pay claims for the first day of eligibility, the provider must have proof that the assistance group is not responsible for the claim.

This section describes how to notify providers of bills that are potentially reimbursable by Medicaid.

3240.0407.01 Billing Authorization (MSSI)

In Medically Needy cases, expenses incurred on the day the Share of Cost is met which are used in full to meet the Share of Cost are not eligible to be paid by Medicaid. Any bills incurred on the date the Share of Cost is met that are not used in full to meet the SOC are eligible for reimbursement by Medicaid.

The eligibility specialist must complete a Billing Authorization Form for each provider who provided services on the day the SOC was met and whose bill was not used in full to meet the Share of Cost and send the form to the applicable provider(s).

3240.0407.02 Medicaid Claims Payment (MSSI)

Medicaid pays claims for covered services within prescribed program limits. The claim must be submitted by a provider who chooses to participate in the Medicaid Program. A Medicaid provider does not have to bill Medicaid; however, if he chooses to bill Medicaid, he must accept the Medicaid payment as payment in full.

Providers must submit clean claims to Medicaid within 365 days of the date of service. A clean claim is an original, correctly completed claim that is ready to process. Medicaid claims over 365 days old may be paid if an eligibility or technical (systems) error was made on the case by DCF.

3250.0000 Child In Care

This chapter presents policy regarding benefit issuance.

3250.0100 REPRESENTATIVES AND PAYEES (CIC)

The Family Safety/Community Based Care (FS/CBC) counselor, private agency counselor or DJJ representative is the PIP for all CIC cases and is responsible for filing an application on behalf of the child in care.

3250.0300 IDENTIFICATION CARDS (CIC)

This section addresses access to benefits.

3250.0302 Medicaid Identification Card (CIC)

The Medicaid Identification Card (MIC) is a computer generated form and is the authorization by which the individual secures Medicaid benefits. MICs are also produced weekly for new assistance groups being added to FLORIDA.

3250.0303 Proof of Medicaid (CIC)

When an individual requests proof of Medicaid eligibility, the eligibility specialist will first verify Medicaid eligibility through FLORIDA and the Florida Medicaid Management Information System (FMMIS). If eligible, the individual will generate proof of their Medicaid eligibility coverage by accessing their online MyACCESS Account. The eligibility specialist can generate a Medicaid Identification Card through FLORIDA.

3250.0400 THIRD PARTY PAYMENTS (CIC)

This section addresses policy on third party payments.

3250.0401 Third Party Payments (CIC)

To be eligible for Medicaid, the individual must assign to the state the individual's right to any third party payment for medical care. When Medicaid benefits are being authorized for a child residing with a nonrelative, any payments for medical care must be legally assigned to the state. The individual or the child's parent, caretaker, or the designated facility official must cooperate with the state in obtaining third party payments. This includes but is not limited to:

1. insurance policies,
2. court ordered medical support, and
3. irrevocable trusts which provide for medical expenses.

Under Florida law, this assignment is automatic by receiving Medicaid. The individual acknowledges it when signing the application.

3250.0402 Reimbursement (CIC)

If an individual receives medical care that is not covered by Medicaid, the state does not have the right to third party payment for that care.

If an individual receives medical care that is paid or will be paid by Medicaid, any third party payment received by the Medicaid provider is to be reimbursed to the state up to the amount paid by Medicaid.

If an individual receives direct reimbursement for medical care paid by Medicaid, the individual is required to reimburse the state. This is done by endorsing the check from the insurance company to Agency for Health Care Administration or by sending a check or money order to Agency for Health Care Administration.

3250.0403 Eligibility Specialist Given Reimbursement (CIC)

If the individual gives the reimbursement to the eligibility specialist, the eligibility specialist must submit the reimbursement to:

ACS Recovery Services
P.O. Box 12188
Tallahassee, FL 32317-2188; and

Attach a cover memo that includes the following information: the individual's name, Medicaid identification number, and hospital admission date or date of service(s) if outpatient case.

3260.0000 Refugee Assistance Program

This chapter presents policy regarding benefit issuance.

3260.0100 REPRESENTATIVES AND PAYEES (RAP)

Individuals may designate a non-assistance group or assistance group member to make application and/or receive benefits on behalf of the assistance group.

3260.0101 Authorized Representative/Secondary Cardholder (RAP)

When the payee, spouse, or a responsible assistance group member cannot apply for benefits they may be eligible for, an authorized representative may be designated to make application on behalf of the assistance group. An authorized representative must be designated when food stamps and cash are continued for children under age 16 in a cash food stamp assistance group penalized for noncompliance with cash work activities. Cash alternate payees may be designated by the primary payee of an assistance group as a secondary cardholder to receive an Electronic Benefits Transfer (EBT) card and to be able to access the primary payee's cash account.

Authorized representatives/secondary cardholders must be designated according to the following requirements:

1. the authorized representative/secondary cardholder must be designated in writing by the payee, spouse, or another responsible member of the assistance group;
2. the authorized representative/secondary cardholder should generally be designated prior to determining eligibility of the assistance group, however, the assistance group can also name an authorized representative/secondary cardholder at any time during the review period;
3. the authorized representative/secondary cardholder must be an individual who is familiar with the current circumstances of the assistance group; and
4. if it becomes obvious that the authorized representative/secondary cardholder is not aware of the current assistance group circumstances, the eligibility specialist must record this information and immediately request in writing that the assistance group designate another authorized representative/secondary cardholder.

The authorized representative/secondary cardholder may be:

1. authorized on the application;
2. designated in writing using the form CF-ES 3010, Authorized Representative Form; or
3. designated for the interview only or the interview, receipt, and use of cash benefits.

Designations of authorized representatives/secondary cardholders are valid for the current review period only.

Payees of assistance groups who are not able to shop for themselves should be encouraged to designate a cash alternate payee as a secondary cardholder for benefit usage.

To ensure recipient understanding of the changes associated with EBT, the following must be discussed with recipients at application and at each review:

1. Recipients may continue to designate authorized representatives to apply and be interviewed on their behalf.
2. Recipients may continue to designate cash alternate payees, when appropriate, to receive and use benefits in addition to the recipient's own benefit access.

3. Recipients may designate only one secondary cardholder per assistance group. FLORIDA accepts one secondary payee per payee type.
4. Cash alternate payees will receive a separate EBT card with their name on it. They must select their own personal identification number (PIN).
5. The cash alternate payee will have access to all the cash in the EBT cash account.
6. If a primary payee for both a cash and food stamp assistance group has the same person designated as both the food stamp authorized representative and cash alternate payee, that person will be issued two EBT cards; one to access the food stamp benefit account, and one to access the cash benefit account.
7. EBT benefits are not replaced if they are lost, stolen or misused, including misuse by a cash alternate payee. Refer to 3260.0217 for more information on stolen benefits.
8. The secondary cardholder's EBT cards are mailed to the primary cardholder.

Note: The applicant can authorize a representative on their application, but form CF-ES-3010 or a written request must be completed when designating the representative to respond on their behalf.

3260.0105 Restrictions on Representatives (RAP)

The following restrictions apply to authorized representatives/secondary cardholders:

1. ACCESS staff and food stamp retailers authorized to accept food stamps cannot act as authorized representatives/secondary cardholders unless no other individual is available to act on behalf of the individual;
 - a. written approval at each designation must be provided by the Region or Circuit Program Office, and
 - b. Region or Circuit Program Office approval must be documented;
2. individuals disqualified for fraud cannot act as authorized representatives/secondary cardholders during the period of disqualification, unless the disqualified individual is the only adult member of the assistance group able to act on the assistance group's behalf; and
3. providers of meals for the homeless may not act as authorized representatives for homeless individuals.

The Region or Circuit Program Office must make a determination as to whether these individuals are needed as authorized representatives/secondary cardholders.

3260.0112 Payee (RAP)

The RAP payee is the responsible adult (18 or older) who makes application on behalf of the assistance group. The sponsor may not be the payee for the assistance group unless approval has been granted by Headquarters. The request for Headquarters approval must clearly explain why the sponsor is the only individual available to be payee.

The payee is the primary cardholder for the Electronic Benefits Transfer (EBT) card.

3260.0200 PAYMENTS (RAP)

This section addresses benefit issuance and payments.

3260.0201 Electronic Benefits Transfer (EBT) (RAP)

Cash benefits will be automatically placed in a recipients' Electronic Benefits Transfer (EBT) account on designated day for access at their convenience. There are separate accounts for food stamp and cash benefits, both accessible by one card.

The EBT card is the means by which participants (our recipients and their secondary payees) access their benefits. EBT cards are distributed by mail; therefore, it is extremely important that the correct and current mailing address be entered onto the FLORIDA system. Now, more than ever, it becomes necessary for address changes to be reported as soon as possible to prevent the EBT card from being returned due to an incorrect address, possibly delaying access to benefits.

Assistance group information is electronically transmitted from the FLORIDA system to the EBT Administrative System. The information passed through this interface will set up and maintain EBT accounts for FLORIDA assistance groups. The assistance category to be included from FLORIDA to EBT is RAP.

Account Setup records are transmitted to provide the EBT system with the demographic information needed to establish an EBT account, and create and mail an EBT card. Account Setup records are used to build customer accounts on the EBT system and provide information necessary for card issuance. Benefit authorization records tell the EBT system the value of each cardholder's benefits. Benefit Authorization records that cannot be matched to an EBT account remain in the Benefit Pending file for 90 days, after which they will be purged, if a corresponding account was not found. Benefit Authorization records for recurring benefits are not posted into the EBT account until the benefit availability date, but may be viewed in the Benefit Pending file until their benefit availability date arrives.

ACCOUNT SETUP RECORDS

The demographic records sent to the EBT system to establish accounts and create EBT cards are called "Account Setup Records" and "Benefit Records." Account setup records are composed of the following case/participant information:

1. FLORIDA Account Number - Case/Short List Member Number of the primary payee designated on AGPY. The case/short list member number is the state case identifier on the Client Search screen on the EBT system. Assistance groups with designated protective payees will have an additional suffix of "P" and designated legal guardians will have an additional suffix of "L" on the EBT system.
2. Primary/Alternate Indicator - FLORIDA system generated based on primary payee designation on AGPY or secondary payee information on AGAR.
3. Card Access Indicator - FLORIDA system generated based on the cardholder's designation to have access to food stamps only, Temporary Cash Assistance benefits only, or access to both.
4. Last Name - Primary payee information on AIID or secondary payee information on AGAR.
5. First Name - Primary payee information on AIID or secondary payee information on AGAR.
6. Middle Initial - Primary payee information on AIID or secondary payee information on AGAR.
7. Date of Birth - Primary payee information on AIID.
8. Social Security Number - Primary payee information on AIID.
9. Mailing Address - Primary payee information on AICI/AGAM (using current FLORIDA address hierarchy) or AGAR/AICI for legal guardians and protective payees depending on the mail address designation on AGAR.
10. City - Primary payee information on AICI/AGAM.
11. State - Primary payee information on AICI/AGAM.
12. Zip Code - Primary payee information on AICI/AGAM (zip + four characters).
13. Language Indicator - Primary payee information on AICI or secondary payee information from AGAR if member = 99.
14. Card Issuance Indicator - FLORIDA generated.

15. Drop Ship Indicator - INACTIVE (from DROP SHIP field on AGBI).
16. Issuance Service Site Number - Issuance Service Site designation on AGBI (5 digit county/site number).

BENEFIT AUTHORIZATION RECORDS

Once an account is established, then benefits may be added to the account. Benefit Authorization records contain the following data fields:

1. FLORIDA Account Number - Case/Short List Member Number of the primary payee designated on AGPY. The case/short list member number is the state case identifier on the Client Search screen on the EBT system. Protective payees will have an additional suffix of "P" and legal guardians will have an additional suffix of "L" on the EBT system.
2. Action Code - FLORIDA generated for benefit add or benefit void (intercept).
3. Category/Sequence - The category of assistance and assistance group sequence number from FLORIDA.
4. Credit/Debit Indicator - FLORIDA generated based on an internal action code.
5. Benefit Identifier - The unique benefit number assigned by FLORIDA for each benefit type and indicated on IQCH and IQFS (warrant number and food stamp benefit number) and the benefit period (MM/DD/YY).
6. Benefit Amount - The net benefit amount after recoupment as indicated on IQCH and IQFS.
7. Benefit Availability Date - The benefit availability date specified on the cash (TSCI) and food stamp (TFSQ) staggered issuance tables.
8. Benefit Month and Year - The benefit month and year indicated on IQCH and IQFS.
9. Issuance Service Site Number - Issuance Service Site designation on AGBI (5 digit county/site number).

There are only two types of benefit records on the EBT system, benefit add and benefit void. Benefit add will add new benefits to an account. Benefit void is a benefit interception. Benefits cannot be deleted from nor "held" on the EBT system. If benefits were authorized in error, they must be intercepted prior to their benefit availability date and replaced with the correct benefits. If unable to intercept, the eligibility specialist should examine the case for over-issuance or underissuance.

3260.0202 Staggered Issuance (RAP)

EBT cash benefits are issued over the first three business days of each month based on the eighth and ninth FLORIDA case number digits.

3260.0203.01 Expunged Status (RAP)

Expunged accounts are accounts that have not been accessed or had a debit transaction performed in the preceding 365 days (one year).

When an account reaches expunged status any benefits contained in the account will begin to expunge individually as each benefit reaches 365 days of age from the date the last debit transaction was performed or from the date of deposit, if no debit transactions were performed against the benefit.

Due to expunged status accounts, an inquiry should be performed on all FLORIDA applications after a break in eligibility to determine if the person has an established account on the Electronic Benefits Transfer (EBT) system. If an account already exists in the EBT system for the person, the eligibility determination process should be completed in such a manner to direct any newly approved benefits to the account already on the EBT system. This is accomplished by approving the person using the same FLORIDA case/RFA number and short list member for the account already on the EBT system.

Note: Benefits deposited into expunged status accounts automatically reactivate the account. It is not necessary to manually reactivate an expunged account if a new benefit is being authorized for the account.

Exception: Very old accounts (pre 2003) may need to be manually reactivated using the account reactivation function on the EBT Administrative System if a new benefit deposit fails to reactivate the account.

3260.0203.02 EBT for Individuals Relocating to Another State (RAP)

An individual can, but is not required to, withdraw their Refugee Assistance Program (RAP) benefits prior to relocating to another state.

The Electronic Benefits Transfer (EBT) card can be used for any RAP recipient at any Automated Teller Machine (ATM) that displays the "STAR" or "QUEST" logos or from a QUEST retailer that allows cash withdrawals.

3260.0206 Restoring Lost Benefits (RAP)

The Department must restore lost benefits when a determination is made that benefits were lost because all or part of the assistance group's cash assistance were denied, delayed, or terminated due to administrative error or due to identity theft.

Identity theft occurs when someone obtains the demographic information of another individual, uses the information to get an EBT or Medicaid card in the name of the other individual through an application approval or a replacement card, and receives (steals) the other individual's benefits. In situations of identity theft confirmed through an Inspector General or Public Benefits Integrity investigation and committed by an individual employed by the Department of Children and Families, restore the stolen benefits of an individual or household only if they were originally eligible for the benefits.

Benefits will be restored to the assistance group for not more than 12 months prior to whichever of the following occurred first:

1. the date the Department was notified by the assistance group or by another individual or agency in writing or orally of the possibility of lost benefits; or
2. the date the Department discovered that a loss of assistance group benefits occurred.

Benefits must be restored even if the assistance group is currently ineligible.

Exception: Benefits must be restored when over-recoupment has occurred, without regard of the 12-month time frame.

3260.0214.02 Recurring Benefits (RAP)

Around the 20th of each month FLORIDA executes the monthly recurring benefit pulldown. This function creates the regular monthly benefits for the next month for each eligible assistance group. A monthly file is created and transmitted to the Electronic Benefits Transfer (EBT) system to post to the recipient's accounts in the benefit month.

3260.0214.03 Auxiliary Benefits (RAP)

Benefits authorized for reasons other than the recurring monthly benefit are auxiliary benefits. Auxiliary benefits are automatically generated by the FLORIDA system or manually created by the eligibility specialist.

FLORIDA creates auxiliary benefits for:

1. initial month(s) prorated benefits, and

2. restoration of benefits to pre-hearings level after a reduction or cancellation of benefits and a fair hearing is requested.

The eligibility specialist manually generates auxiliary benefits when:

1. initial month(s) prorated benefits for new individuals have been added to an existing assistance group,
2. supplemental benefits have been added for changes that resulted in increased benefits when the monthly recurring pull-down has occurred and the AG is entitled to increased benefits for months prior to the next recurring month (includes interim changes, benefit adjustments from changes in policy and agency errors),
3. state collection of child support begins and timely action is not taken to remove the direct paid support income from the budget,
4. a recurring benefit results in underpayment,
5. an assistance group is determined retroactively eligible for a higher benefit as a result of a fair hearing decision,
6. an assistance group's recurring benefit was issued in an incorrect payee's name, and
Note: TCA benefits can still be canceled.
7. a replacement for a canceled benefit.

Prior to manually creating an auxiliary benefit, the eligibility specialist must do the following:

1. Check IQCH to determine if an auxiliary payment has already been issued for the same reason and for the same period to avoid duplication of benefits.
2. Check IQCH when there is an indication in the case record that cancellation or interception of a benefit occurred in the same month(s) for which the auxiliary benefit is being created. Determine if the assistance group remains eligible for the benefit.

All eligibility specialist generated auxiliary benefit information must be documented on CLRC (running record comments screen), including the reason for the auxiliary benefit. All eligibility specialist generated auxiliary benefits must be authorized by the supervisor. Cash auxiliary benefits may be canceled by the eligibility specialist before approval by the supervisor. Once approved, they cannot be canceled. Cash auxiliary benefits cannot be intercepted.

3260.0215.02 Intercepted Benefits (RAP)

Benefits are intercepted for reduction or cancellation when the required action occurs after the recurring benefit pull down deadline. Intercepts on the system are requested on the SFHD screen. The eligibility specialist may intercept recurring cash benefits up through the day prior to the benefit availability date. Cash auxiliary benefits can be intercepted on the day they are created.

3260.0215.03 Reissued Benefits (RAP)

Situations occur where a cash benefit must be reissued to the assistance group. These situations are:

1. The recurring cash benefit was canceled and the assistance group remains eligible for the benefit.
2. The recurring cash benefit was issued to the assistance group in the name of an incorrect payee and was cashed by the incorrectly named payee.

The disposition of the original cash benefit must always be determined prior to the creation and authorization of the reissued benefits. Reissued benefits are authorized for the same amount of the original benefit.

3260.0215.09 Benefits Outstanding More Than One Year (RAP)

Cash benefits that have not been accessed or had a debit transaction performed in the preceding 365 (one year) days will be expunged (removed) from the Electronic Benefits Transfer (EBT) system. Recipients are entitled to receive a cash benefit up to one year from the last day of the month in which the benefit was issued. An expunged cash benefit may be restored by the auxiliary process if the payee requests the benefit by the last day of the month in which the benefit was expunged. Do not restore expunged benefits that are more than one year old.

3260.0217 Stolen Benefits (RAP)

Stolen or misused Electronic Benefits Transfer (EBT) cash benefits are not replaced unless there is evidence of negligence on the part of the Department or EBT Customer Service where the individual reported their card lost or stolen and immediate action was not taken to deactivate the card.

If a cardholder reports loss of benefits after they reported their card lost or stolen to EBT Customer Service or to the Department, please notify the EBT Project Office in Tallahassee for investigation.

Benefits are not replaced if they are stolen or misused by an authorized representative, alternate payee, legal guardian, protective payee or other person who was given access to the card and PIN by the primary payee.

Benefits are also not replaced if they are used prior to the individual notifying EBT Customer Service of the loss or theft of the card.

Theft and misuse of benefits is a criminal matter and the cardholder should be instructed to contact local law enforcement if this occurs.

3260.0300 IDENTIFICATION CARDS (RAP)

This section addresses access to benefits.

3260.0301 Electronic Benefits Transfer Cards (RAP)

An Electronic Benefits Transfer (EBT) card is issued to each assistance group to be able to access any cash benefits they are eligible for. The EBT card must be presented upon request at authorized retailers. The cardholder must immediately report loss or theft of the EBT card, as liability for its misuse is solely the responsibility of the cardholder.

The primary payee or primary cardholder will receive an EBT card. If the primary payee receives both food stamp and cash benefits, their one card will access both accounts. Cards will also be issued to each secondary cardholder, one for any food stamp authorized representative and one for any cash alternate payee. If the food stamp authorized representative and the cash alternate payee are the same person, two cards will be issued, one for each of the account types.

The EBT cards are good as long as there is an account on the EBT system. Account status does not affect card status and card status does not affect account status. If an expunged account is reactivated, the card that was previously used to access the account will still be able to access the account as long as the card was not reported lost, stolen or damaged.

3260.0400 THIRD PARTY PAYMENTS (RAP)

This section addresses policy on third party payments.

3260.0401 Third Party Payments (RAP)

To be eligible for Medicaid, the individual must assign to the state the individual's right to any third party payment for medical care. When Medicaid benefits are being authorized for a child residing with a nonrelative, any payments for medical care must be legally assigned to the state. The individual or the child's parent, caretaker, or the designated facility official must cooperate with the state in obtaining third party payments. This includes but is not limited to:

1. insurance policies,
2. court ordered medical support, and
3. irrevocable trusts which provide for medical expenses.

Under Florida law, this assignment is automatic by receiving Medicaid. The individual acknowledges it when signing the application.

3260.0402 Reimbursement (RAP)

If an individual receives medical care that is not covered by Medicaid, the state does not have the right to third party payment for that care.

If an individual receives medical care that is paid or will be paid by Medicaid, any third party payment received by the Medicaid provider is to be reimbursed to the state up to the amount paid by Medicaid.

If an individual receives direct reimbursement for medical care paid by Medicaid, the individual is required to reimburse the state. This is done by endorsing the check from the insurance company to Agency for Health Care Administration or by sending a check or money order to Agency for Health Care Administration.

3260.0403 Eligibility Specialist Given Reimbursement (RAP)

If the individual gives the reimbursement to the eligibility specialist, the eligibility specialist must

Submit the reimbursement to:

ACS Recovery Services
P.O. Box 12188
Tallahassee, FL 32317-2188; and

Attach a cover memo that includes the following information: the individual's name, Medicaid identification number, and hospital admission date or date of service(s) if outpatient case.