A *claimant* (see OAR 461-025-0305) has the right to a contested case hearing in the following situations upon the timely completion of a request for hearing:

(a) Except as provided in subsection (o) of this section, the Department has not approved or denied a request or application for public assistance within 45 days of the application.

(b) The Department has not acted timely on an application as follows:

(A) An application for **food stamps SNAP program benefits** --- within 30 days of the filing date.

(B) An application for a JOBS support service payment---within the time frames established in OAR 461-115-0190(3).

(c) The Department acts to deny, reduce, close, or suspend **food stamp SNAP program benefits**, a *grant of public assistance*, a *grant of aid*, a support service payment authorized in the JOBS program by OAR 461-190-0211, medical assistance, or child care benefits authorized under Division 160 or 165 of this chapter of rules in the ERDC or TANF child care programs. When used in this subsection, *grant of public assistance* and *grant of aid* mean the grant of cash assistance calculated according to the client's need.

(d) The Department claims that an earlier public assistance payment was an overpayment, or that an earlier issuance of **food stamp SNAP program benefits** was an overissuance.

(e) The *claimant* claims that the Department previously underissued public assistance or **food stamps SNAP program benefits** and the Department denies the claim.

(f) The household disputes its current level of **food stamp SNAP program benefits**.

(g) The *filing group* (see OAR 461-110-0370) is aggrieved by any action of the Department that affects the participation of the filing group in the *Food Stamp SNAP program*.

(h) The *claimant* asks for a hearing to determine if the waiver of an Intentional Program Violation hearing was signed under duress.

(i) The Department establishes or changes the client's premium for the Oregon Health Plan.
(j) In the Pre-TANF program, the Department denies payment for a basic living expense (see OAR 461-135-0475) or other support service payment in the JOBS program (see subsection (c) of this section).

(k) In the TA-DVS program, when OAR 461-135-1235 provides a right to a hearing.

(l) A service re-assessment of a client conducted in accordance with OAR Division 411-015 has resulted in a reduction or termination of Nursing Home nursing facility services, Home and Community Based or Waivered Services (defined at OAR 411-015-0005), Spousal Pay services (see OAR 411-030-0080), or Independent Choices services (see OAR Division 411-030 461-001-0030).

(m) The claimant's benefits are changed to vendor, protective, or two-party payments.

(n) Department has issued a notice seeking repayment under ORS 411.892 to an employer participating in the JOBS program.

(o) In the OSIP and OSIPM programs, when the Department has not approved or denied an application within the time frames established in OAR 461-115-0190.

(p) The right to a hearing is otherwise provided by statute or rule.

(2) A client is not entitled to a hearing on the question of the contents of a case plan (defined in OAR 461-190-0151) unless the right to hearing is specifically authorized by the Department's rules. For a dispute about an activity in the JOBS program, the client is entitled to use the Department's re-engagement process (see OAR 461-190-0231). In the TA-DVS program, a dispute about the contents of a TA-DVS case plan (see OAR 461-135-1205) is resolved through re-engagement if there is no right to a hearing under OAR 461-135-1235.

(3) A request for hearing is complete:

(a) In public assistance programs, when the Department's Administrative Hearing Request form (form DHS 443) is completed and signed by the claimant or the claimant's representative and is received by the Department.

(b) In the Food Stamp SNAP program when--

(A) The Department receives the claimant's oral or written statement that he or she wishes to appeal a decision affecting the claimant's food stamp SNAP program benefits to a higher authority; or

(B) The Department's Administrative Hearing Request form (form DHS 443) is completed and signed by the claimant or the claimant's representative and is received by the Department.
(c) In the case of a provider of child care, when a written request for hearing from the provider is received by the Department.

(4) In the event a request for hearing is not timely, the Department will determine whether the failure to timely file a request for hearing was beyond the reasonable control of the party and enter an order accordingly. The Department may refer an untimely request to the Office of Administrative Hearings for a hearing on the question of timeliness.

(5) In the event the claimant has no right to a contested case hearing on an issue, the Department may enter an order accordingly. The Department may refer a hearing request to the Office of Administrative Hearings for a hearing on the question of whether the claimant has the right to a contested case hearing.

(6) To be timely, a completed hearing request must be received by the Department not later than:

(a) Except as provided in subsection (b) of this section, the 45th day following the date of the decision notice (see OAR 461-001-0000) in public assistance and medical programs.

(b) The 90th day following the effective date of the reduction or termination of benefits in a public assistance program if the reduction or termination of aid is a result of a JOBS disqualification (see OAR 461-130-0330) or a penalty for failure to seek treatment for substance abuse or mental health (see OAR 461-135-0085).

(c) The 90th day following the date of the decision notice in the Food Stamp SNAP program, except:

(A) A filing group may submit a hearing request at any time within a certification period (see OAR 461-001-0000) to dispute its current level of benefits.

(B) A filing group may submit a hearing request within 90 days of the denial of a request for restoration of benefits if not more than twelve months has expired since the loss of benefits.

(d) The 30th day following the date of notice from the Oregon Department of Revenue in cases covered by ORS 293.250.

(e) In a case described in subsection (1)(h) of this rule, the request must be made within 90 days of the date the waiver was signed.

(7) In determining timeliness under section (6) of this rule, delay caused by circumstances beyond the control of the claimant is not counted.

(8) In computing the time periods provided by this rule, see OAR 461-025-0300(1).
In the REF and REFM programs, a client is not eligible for a contested case hearing when assistance is terminated because the eligibility time period imposed by OAR 461-135-0900 has been reached. If the issue is the date of entry into the United States the Department provides for prompt resolution of the issue by inspection of the individual's documentation issued by the US Citizenship and Immigration Services (USCIS) or by information obtained from USCIS, rather than by contested case hearing.

Program Acronyms and Overview

(1) Acronyms are frequently used when referring to a program. There is an acronym for each umbrella program (for instance, OSIP) and acronyms for each subprogram (for instance, OSIP-AB, OSIP-AD, and OSIP-OAA).

(2) When no program acronym appears in a rule in Chapter 461 of these rules, the rule with no program acronym applies to all programs listed in this rule. If a rule does not apply to all programs, the rule uses program acronyms to identify the programs to which the rule applies.

(3) Wherever an umbrella acronym appears, that means the rule covers all the subprograms under that code (for instance, OSIP means OSIP-AB, OSIP-AD, and OSIP-OAA).

(4) ADC; Aid to Dependent Children. Financial aid to low-income families when children are deprived of parental support because of continued absence, death, incapacity, or unemployment. When used alone, ADC refers to all ADC programs. Use of the acronym, ADC, which stands for Aid to Dependent Children, and use of the phrase, Aid to Dependent Children, refer to the state's Temporary Assistance for Needy Families Program, and its acronym, TANF. The following codes are used for ADC subprograms:

   (a) ADC-BAS; Aid to Dependent Children - Basic (includes eligibility based on continued absence, death, incapacity, or unemployment). ADC with deprivation based on unemployment is also denoted by ADC-BAS/UN.

   (b) EA; Aid to Dependent Children - Emergency Assistance. Emergency cash to families without the resources to meet emergent needs.

(5) ADCM; Aid to Dependent Children Medical. Medical aid to low-income families when children are deprived of parental support, as for ADC. Use of the acronym ADCM, which stands for Aid to Dependent Children Medical, and use of the phrase Aid to Dependent Children Medical refer to EXT, MAA, MAF, and SAC programs. When used alone, ADCM refers to all ADC-related medical programs. The following codes are used for ADCM subprograms:

   (a) ADCM-BAS; Aid to Dependent Children Medical - Basic.

   (b) ADCM-EXT; Aid to Dependent Children Medical - Extended. ADCM-EXT provides extended medical benefits to families after their ADC benefits end.

   (c) ADCM-SAC; Aid to Dependent Children Medical - Substitute or Adoptive Care. ADCM-SAC gives medical coverage to children in substitute or adoptive care.

(6) The Assessment Program (see the Pre-TANF program in this rule).
(7) BCCM; Breast and Cervical Cancer Medical program.

(8) CAWEM; Citizen/Alien-Waived Emergent Medical. Medicaid coverage of emergent medical needs for clients who are not eligible for other medical programs solely because they do not meet citizenship and alien status requirements.

(9) CEC; Continuous Eligibility for OHP-CHP. Title XXI medical assistance for a pregnant non-CAWEM child found eligible for the OHP-CHP program who, for a reason other than moving out of state or becoming a recipient of private major medical health insurance, otherwise would lose her eligibility. The pregnant individual is deemed eligible for OHP-CHP through the last day of the month in which the pregnancy ends.

(10) CEM; Continuous Eligibility for Medicaid. Title XIX medical assistance for a non-CAWEM child found eligible for Medicaid who loses his or her eligibility for a reason other than turning 19 years of age or moving out of state. The child is deemed eligible for Medicaid for the remainder of the 12 month eligibility period.

(11) DFSP DSNAP; Disaster Food Stamp Supplemental Nutrition Assistance Program. Following a presidential declaration of a major disaster in Oregon, DFSP DSNAP provides emergency food stamps DSNAP program benefits to victims. OAR 461-135-0491 to 461-135-0497 cover DFSP DSNAP eligibility and benefits.

(12) ERDC or ERDC-BAS; Employment Related Day Care-Basic. Helps low-income working families pay the cost of child care.

(13) EXT; Extended Medical Assistance. The Extended Medical Assistance program provides medical assistance for a period of time after a family loses its eligibility for the MAA, MAF, or Pre-TANF program due to an increase in their child support or earned income.

(14) FS; Food Stamps. Helps low-income households maintain proper nutrition by giving them the means to purchase food. Any reference to Food Stamps or FS also includes the Supplemental Nutrition Assistance Program or SNAP.

(15) GA; General Assistance. Cash assistance to low-income individuals with disabilities who do not have dependent children.

(16) GAM; General Assistance Medical. Medical assistance to clients who are eligible for the GA program but have not been found eligible for OSIPM benefits.

(17) HSP; Housing Stabilization Program. A program that helps low-income families obtain stable housing. The program is operated through the Housing and Community Services Department through community-based, service-provider agencies. The Department's rules for the program (OAR 461-135-1305 to 461-135-1335) were repealed July 1, 2001.
JOBS; Job Opportunity and Basic Skills. An employment program for REF, REFM, and TANF clients. JOBS helps these clients attain self-sufficiency through training and employment. The program is part of Welfare Reform.

JOBS Plus. Provides subsidized jobs rather than FS SNAP or TANF benefits. For TANF clients, JOBS Plus is a component of the JOBS Program; for FS clients and noncustodial parents of children receiving TANF, it is a separate employment program. Eligibility for TANF clients, FS SNAP clients, and noncustodial parents of children receiving TANF is determined by the Department. Eligibility for UI recipients is determined by the Oregon State Employment Department. When used alone, JOBS Plus includes only clients whose JOBS Plus program participation is through the Department of Human Services. JOBS Plus administered through the Oregon State Employment Department is known in chapter 461 of the Oregon Administrative Rules as Oregon Employment Department UI JOBS Plus. The following acronyms are used for specific categories:

(a) ADC-PLS; Clients eligible for JOBS Plus based on TANF.
(b) FS-PLS SNAP-PLS; Clients eligible for JOBS Plus based on FS SNAP.
(c) NCP-PLS; Noncustodial parents of children receiving TANF.

LIS; Low-Income Subsidy. The Low-Income Subsidy program is a federal assistance program for Medicare clients who are eligible for extra help meeting their Medicare Part D prescription drug costs.

MAA; Medical Assistance Assumed. The Medical Assistance Assumed program provides medical assistance to people who are eligible for the Pre-TANF program or ongoing TANF benefits.

MAF; Medical Assistance to Families. The Medical Assistance to Families program provides medical assistance to people who are ineligible for MAA but are eligible for Medicaid using ADC program standards and methodologies that were in effect as of July 16, 1996.

OFSET. The Oregon Food Stamp Employment Transition Program, which helps FS SNAP program benefit recipients find employment. This program is mandatory for some FS SNAP program benefit recipients.

OHP; Oregon Health Plan. The Oregon Health Plan Program provides medical assistance to many low-income individuals and families. The program includes five categories of people who may qualify for benefits. The acronyms for these categories are:

(a) OHP-OPU; Adults. OHP coverage for adults who qualify under the 100 percent income standard. A person eligible under OHP-OPU is referred to as a health plan new/noncategorical (HPN) client.
(b) OHP-OPC; Children. OHP coverage for children who qualify under the 100 percent income standard.

(c) OHP-OP6; Children Under 6. OHP coverage for children under age 6 who qualify under the 133 percent income standard.

(d) OHP-OPP; Pregnant Females and their newborn children. OHP coverage for pregnant females who qualify under the 185 percent income standard and their newborn children.

(e) OHP-CHP; Persons Under 19. OHP coverage for persons under age 19 who qualify under the 185 percent income standard for medical assistance authorized by the Children's Health Insurance Program (CHIP) provision of the 1997 Balanced Budget Act.

(2325) OSIP; Oregon Supplemental Income Program. Cash supplements and special need payments to persons who are blind, disabled, or 65 years of age or older. When used alone, OSIP refers to all OSIP programs. The following acronyms are used for OSIP subprograms:

(a) OSIP-AB; Oregon Supplemental Income Program - Aid to the Blind.

(b) OSIP-AD; Oregon Supplemental Income Program - Aid to the Disabled.

(c) OSIP-EPD; Oregon Supplemental Income Program - Employed Persons with Disabilities program. This program provides Medicaid coverage for employed persons with disabilities with adjusted income less than 250 percent of the Federal Poverty Level.

(d) OSIP-OAA; Oregon Supplemental Income Program - Old Age Assistance.

(2426) OSIPM; Oregon Supplemental Income Program Medical. Medical coverage for elderly and disabled individuals. When used alone, OSIPM refers to all OSIP-related medical programs. The following codes are used for OSIPM subprograms:

(a) OSIPM-AB; Oregon Supplemental Income Program Medical - Aid to the Blind.

(b) OSIPM-AD; Oregon Supplemental Income Program Medical - Aid to the Disabled.

(c) OSIPM-EPD; Oregon Supplemental Income Program Medical - Employed Persons with Disabilities program. This program provides Medicaid coverage for employed persons with disabilities with adjusted income less than 250 percent of the Federal Poverty Level.
(d) OSIPM-OAA; Oregon Supplemental Income Program Medical - Old Age Assistance.

(e) OSIPM-IC; Oregon Supplemental Income Program Medical - Independent Choices

(2527) The Post-TANF program provides a monthly transitional payment to employed clients who are no longer eligible for the Pre-TANF or TANF programs due to earnings, and meet the other eligibility requirements.

(2628) The Pre-TANF program is an up-front assessment and resource-search program for TANF applicant families. The intent of the program is to assess the individual's employment potential; determine any barriers to employment or family stability; develop an individualized case plan that promotes family stability and financial independence; help individuals find employment or other alternatives; and provide basic living expenses immediately to families in need.

(2729) QMB; Qualified Medicare Beneficiaries. Programs providing payment of Medicare premiums and one program also providing additional medical coverage for Medicare recipients. Each of these programs also is considered to be a Medicare Savings Program (MSP). When used alone in a rule, QMB refers to all MSP. The following codes are used for QMB subprograms:

(a) QMB-BAS; Qualified Medicare Beneficiaries - Basic. The basic QMB program.

(b) QMB-DW; Qualified Medicare Beneficiaries - Disabled Worker. Payment of the Medicare Part A premium for people under age 65 who have lost eligibility for Social Security disability benefits because they have become substantially gainfully employed.

(c) QMB-SMB; Qualified Medicare Beneficiaries - Specified Limited Medicare Beneficiary. Payment of the Medicare Part B premium only. There are no medical benefits available through QMB-SMB.

(d) QMB-SMF; Qualified Medicare Beneficiaries - Qualified Individuals. Payment of the Medicare Part B premium only. There are no medical benefits available through QMB-SMF. This program has a 100-percent federal match, but also has an allocation that, if reached, results in the closure of the program.

(2830) REF; Refugee Assistance. Cash assistance to low-income refugee singles or married couples without children.

(2931) REFM or REFM-BAS; Refugee Assistance Medical - Basic. Medical coverage for low-income refugees.
(3032) The Repatriate Program helps Americans resettle in the United States if they have left a foreign land because of an emergency situation.

(3133) SAC; Medical Coverage for Children in Substitute or Adoptive Care.

(3234) Senior Prescription Drug Assistance Program; provides that people 65 years of age or older can purchase prescription drugs at the Medicaid price.

(3335) SFDNP; Senior Farm Direct Nutrition Program. Food vouchers for low income seniors. Funded by a grant from the United States Department of Agriculture.

(3436) SFPSS; State Family Pre-SSI/SSDI Program. A voluntary program providing cash assistance and case management services to families when at least one TANF eligible adult in the household has an impairment (see OAR 461-125-0260) and is or will be applying for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI).

(3537) SNAP; Supplemental Nutrition Assistance Program. Helps low-income households maintain proper nutrition by giving them the means to purchase food. SNAP used to be known as FS or Food Stamps, any reference to SNAP also includes FS and Food Stamps.

(3538) TA-DVS; Temporary Assistance for Domestic Violence Survivors. Addresses the needs of clients threatened by domestic violence.

(3639) TANF; Temporary Assistance for Needy Families. Cash assistance for families when children in those families are deprived of parental support because of continued absence, death, incapacity, or unemployment. Cash assistance used to be known as ADC.

Stats. Implemented: ORS 411.060, 411.816, 412.014, 412.049, 414.042, 414.342
461-105-0006
Business Continuity Provisions

THIS IS A NEW RULE

(1) The use of this rule by any CAF branch office (see OAR 461-001-0000) requires the approval for that site by --

(a) The Deputy Assistant Director for CAF Field Services or the designee of this official; and

(b) The Administrator of the Office of Self Sufficiency Programs or the designee of this official.

(2) The Department will only approve the use of this rule after considering the feasibility of avoiding the use of the rule by moving enough employees who are able to perform the needed tasks to the sites that have too few employees.

(3) For purposes of this rule:

(a) "Business continuity disruption" refers to an emergency event or a work stoppage that causes the absence of most of the employees in at least one branch office for an expected time period of sufficient duration that compliance with applicable administrative rules in Chapter 461 is not feasible. A "business continuity disruption" continues until a sufficient number of employees return to work to permit compliance at the branch office with the administrative rules in Chapter 461.

(b) "Emergent need".

(A) In the ERDC program, the term "emergent need" refers to an individual who requires child care in order to work and who will lose this child care unless the application is processed promptly.

(B) In the SNAP program, the term "emergent need" refers to an individual who qualifies for expedited services under OAR 461-135-0575.

(C) In the medical assistance programs:

(i) The term "emergent need" refers to an individual reporting either of the following:

(I) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention or medication may reasonably be expected to result in placing the health of the patient in serious jeopardy, serious impairment to bodily
functions, or serious dysfunction of any bodily organ or part.

(II) A need for prompt processing of an application to secure provider services for mental health, substance abuse, or long-term care.

(ii) An individual does not need to document the "emergent need".

(D) In the REF and TANF programs, the term "emergent need" refers to a household that meets the requirements of one of the following subparagraphs:

(i) Countable income less than $150 a month, and liquid resources that do not exceed $100.

(ii) Gross income and resources that combined are less than the total of the household's monthly rent or mortgage, plus its utilities.

(iii) Liquid resources (see subsection (c) of this section) that do not exceed $100 as well as being a destitute household of migrant and seasonal farmworkers (see OAR 461-001-0015) with little or no income at the time of application.

(E) In the TA-DVS program, the term "emergent need" refers to an individual with an immediate safety need.

(c) "Liquid resources" refers to cash on hand, a checking or savings account, a savings certificate, and a lump sum payment.

(4) During a business continuity disruption, a branch office issues DSNAP benefits as provided in OAR 461-135-0491 to 461-135-0497 if the branch office is in a location authorized by the Food and Nutrition Service (FNS) during a disaster benefit period. This rule does not otherwise apply to the DSNAP program.

(5) Notwithstanding any other administrative rule in Chapter 461, during a business continuity disruption under the authorization required in section (1) of this rule, a CAF branch office may use any or all of the following special provisions:

(a) Application process.

(A) Individuals qualifying as emergent need.

(i) In the ERDC, medical assistance, REF, and TANF programs, acceptance or processing by the Department of applications may be limited to individuals in emergent need.
(ii) In the SNAP program, processing of applications for new clients may be limited to individuals in emergent need.

(iii) In the TA-DVS program, waive the requirement to jointly staff an application for TA-DVS benefits under OAR 461-135-1230(3).

(B) Application process for individuals without an emergent need.

(i) In the ERDC, REF, and TANF programs, each branch office using this provision may document a request for benefits by maintaining a dated list of the names of these new clients as well as social security numbers (if available). The Department will use these lists to establish the date of request for those clients who request assistance during the business continuity disruption and complete the application within 30 days after the conclusion of the business continuity disruption or by the deadline that applies under another program rule, whichever occurs later.

(ii) In the SNAP program, for a new client, each branch office using this provision may document a filing date by maintaining a file of completed filing pages (DHS 415Y or DHS 539F). The Department will schedule and conduct interviews with each client after the conclusion of the business continuity disruption.

(iii) In the medical assistance programs, each branch office should establish a date of request using OAR 461-115-0030.

(iv) In the TA-DVS program, the Department may document a request for benefits by maintaining a dated list of the names of the applicants as well as social security numbers (if available). The Department will use this list to establish a date of request for those clients who request assistance during the business continuity disruption. The Department will schedule and conduct interviews with each client within two business days after the conclusion of the business continuity disruption or when an immediate safety need arises, whichever occurs sooner.

(b) Benefit levels. In the ERDC, REF, SFPSS, and TANF programs:

(A) Except as provided for REF in OAR 461-135-0900(4), a client, including a client in the monthly reporting system (MRS) or in the Simplified Reporting System (SRS), may continue to receive benefits at the level in effect the day before the special provisions of this rule applied to the branch office.
(B) In the ERDC, SFPSS, and TANF programs, the Department may authorize a branch office to automatically extend certification periods for the duration of the business continuity disruption.

(C) Payments for support services (see OAR 461-001-0025) listed in a case plan (see OAR 461-001-0025) may continue at the level in effect the day before the special provisions of this rule applied to the branch office. The Department approves or denies any new request for a support services payment on a case by case basis.

(D) In the REF and TANF programs, for an emergent need household, the Department may issue a temporary benefit in the following amounts:

(i) $200 for a single individual.

(ii) $100 for each additional individual to a maximum payment of $900.

(E) In the TA-DVS program, payments will be made to address immediate safety needs.

(c) Processing changes for current recipients. Except in the SNAP program, a branch office may suspend the processing of changes during the business continuity disruption.

(d) Redetermination of benefits issued in accordance with this rule; payments for supplemental benefits and establishment of overpayments. For each client who receives a benefit under the provisions of this rule, after the business continuity disruption ends:

(A) The Department will determine the correct benefit amount and either provide a supplemental payment or assess an overpayment as appropriate.

(B) In the SNAP program, the Department will make the determination about supplemental payments under paragraph (A) of this subsection within 10 days of the end of the business continuity disruption.

(e) In the SNAP program, in addition to the other processes described in this rule, the policies under this subsection may be implemented upon authorization by the Food and Nutrition Service (FNS). The Department notifies each affected branch office of the authorization and its effective dates prior to implementation.

(A) For a telephone request for a SNAP program application, the filing date (see OAR 461-115-0040) is the same as the date of request (see OAR 461-115-0030).
(B) A SNAP program applicant may receive a telephone interview without a Department determination that a *branch office* visit is a hardship to the applicant.

(C) An applicant requesting a SNAP program application via the telephone, meeting the expedited service criteria under OAR 461-115-0690, and whom the *branch office* must be able to identify may be interviewed and may provide an oral signature via the telephone after affirming all of the provided information is true and correct.

(i) If eligible for SNAP program benefits, the applicant is certified until the last day of the following month.

(ii) The applicant must sign and return a completed SNAP program application along with any requested verifications to the local *branch office* within 30 days.

(D) SNAP program benefits may be maintained at the current level and extended for two additional months when the Department receives FNS approval within any month described in the following situations:

(i) The last month of a *certification period* (see OAR 461-001-0000).

(ii) The month an Interim Change Report is due.

(iii) The month a Transitional Benefit Alternative period ends.

(iv) The month a Monthly Change Report is due.

(E) A client must report changes described in OAR 461-170-0011 by the last day of the month following the month in which the change occurred.

(6) Notwithstanding any other administrative rule in Chapter 461, during a *business continuity disruption* with the approval of the Manager of Field Services for the Seniors and People with Disabilities Division (SPD) or the designee of this official:

(a) A *branch office* may limit acceptance or processing of applications for long-term services to individuals in *emergent need* who do not yet have a placement or are at risk of losing their current one.

(b) An SPD or AAA office may apply any exception in this rule for SNAP and Medicaid programs to the extent authorized.

Stats. Implemented: ORS 411.060, 411.816, 412.014, 412.049, 414.042
Household Group

(1) The household group consists of the individuals who live together with or without benefit of a dwelling. For homeless people, the household group consists of the individuals who consider themselves living together.

(2) A separate household group is established for all the individuals who live in a dwelling. A separate dwelling is not recognized for the purpose of determining the members of a household group unless the living space has--separate from other dwellings--an access to the outside that does not pass through another dwelling, a sleeping area, a bathroom, and a kitchen facility.

(3) For all programs except the FS SNAP program, a separate household group is established for individuals who live in the same dwelling as another household group, if all the following are true:

(a) There is a landlord-tenant relationship between the two groups in which the tenant is billed by the landlord at fair market value (see OAR 461-001-0000) for housing.

(b) The tenant lives independently from the landlord.

(c) The tenant:

   (A) Has and uses sleeping, bathroom, and kitchen facilities separate from the landlord; or

   (B) Shares bathroom or kitchen facilities with the landlord, but the facilities are in a commercial establishment that provides room or board or both for compensation at fair market value.

(4) Individuals who live with more than one household group during a calendar month are members of the household group in which they spend more than half of their time, except as follows:

(a) In the ERDC program, if a child (see OAR 461-001-0000) lives with different caretakers during the month, the child is considered a member of both household groups.

(b) In the FS program:

   (A) The individual is a member of the household group that provides the individual more than half of his or her 21 weekly meals. If the individual is a child, the child is a member of the household group credited with providing the child more than half of his or her 21 weekly meals. A
household group is credited with providing breakfast and lunch for each
day the child departs that group's home for school, even if the child eats no
breakfast or lunch at that home.

(B) During the month in which a resident of a domestic violence shelter (see
OAR 461-001-0000) enters the shelter, the resident may be included both
in the household he or she left and in a household group in the shelter.

(e) In the MAA, MAF, and TANF programs:

(A) If a parent (see OAR 461-001-0000) sleeps at least 30 percent of the time
during the calendar month in the home of the dependent child (see OAR
461-001-0000), the parent is in the same household group as the
dependent child.

(B) A dependent child is included in the group with the caretaker relative (see
OAR 461-001-0000), who usually has the major responsibility for care
and control of the dependent child, if the dependent child lives with two
household groups in the same calendar month for at least one of the
following reasons:

(i) Education.

(ii) The usual caretaker relative is gone from the household for part of
the month because of illness.

(iii) A family emergency.

(c) In the SNAP program:

(A) The individual is a member of the household group that provides the
individual more than half of his or her 21 weekly meals. If the
individual is a child, the child is a member of the household group
credited with providing the child more than half of his or her 21
weekly meals. A household group is credited with providing breakfast
and lunch for each day the child departs that group's home for school,
even if the child eats no breakfast or lunch at that home.

(B) During the month in which a resident of a domestic violence shelter
(see OAR 461-001-0000) enters the shelter, the resident may be
included both in the household he or she left and in a household group
in the shelter.

(5) In the OSIPM program, individuals receiving waivered care or nursing facility care are
each an individual household group.
(6) In the QMB program, the household group consists of the client and the client's *spouse* (see OAR 461-001-0000), even if the *spouse* does not meet all nonfinancial eligibility requirements.

(7) The individuals in the household group who apply for benefits are called applicants. The household group and applicants form the basis for determining who is in the remaining eligibility groups.

(8) Individuals absent from the household for 30 days or more are no longer part of the household, except for the following:

(a) In all programs except the *FS SNAP* program, individuals in a general hospital for 30 days or more remain in the household group unless they go into long-term care. In the *FS SNAP* program, these individuals are no longer in the household group.

(b) In the *CEC, CEM, ERDC, EXT, MAA, MAF, OHP, REF, REFM, SAC, and TANF* programs:

(A) A *caretaker relative* who is absent for up to 90 days while in a residential alcohol or drug treatment facility is in the household group.

(B) A *child* who is absent for 30 days or more is in the household group if the *child* is:

(i) Absent for illness (unless the *child* is in a long-term care Title XIX facility), social service, or educational reasons;

(ii) In foster care, but expected to return to the household within the next 30 days; or

(iii) For OHP only, in a residential alcohol or drug treatment facility. If the household of the *child* is ineligible because of income, the *child* is a separate household.

(c) In the ERDC and OHP programs, an individual who is absent because of education, training, or employment, including long-haul truck driving, fishing, and active duty in the U.S. armed forces.

(d) In the MAA, MAF, REF, REFM, and TANF programs, a *parent* who is absent for 30 days or more is in the household group if:

(A) The *parent* is absent because of education, training or employment -- including absence while working or looking for work outside the area of their residence, such as long-haul truck driving, fishing and active duty in the U.S. armed forces; and
(B) The other parent remains in the home.

(9) In the OSIP-EPD and OSIPM-EPD programs, the household group consists only of the individual applying for or receiving benefits.

Stats. Implemented: ORS 411.060, 411.070, 411.816, 412.049, 414.042, 418.100
In the Food Stamp SNAP program:

(1) Except as provided in this rule, the filing group is composed of members of a household group (see OAR 461-110-0210) who customarily purchase and prepare meals together.

(2) Except as provided in sections (3) and (8) of this rule, the following individuals, if in the same household group, must be in the same filing group, even if they do not customarily purchase and prepare meals together:
   - Each spouse (see OAR 461-001-0000).
   - A parent (see OAR 461-001-0000) and his or her child under age 22 living with the parent.
   - A household group member and child under age 18 who lives with and is under parental control of that household group member. For the purposes of this subsection, parental control means the adult is responsible for the care, control, and supervision of the child or the child is financially dependent on the adult.

(3) Notwithstanding sections (1) and (2) of this rule:
   - An individual is excluded from the filing group if, during the month the group applied for food stamps SNAP program benefits, the individual received food stamp benefits or SSI benefits through the state of California that included food stamp SNAP program benefits. This exclusion applies only in the initial month and, if necessary to meet notice requirements, in the month following the initial month. This exclusion does not apply to an individual who was the head of household in the prior household.
   - An individual is excluded from the filing group if during the initial month the group applied for SNAP program benefits the individual received SNAP program benefits in another household and was not the head of household in the prior household.
   - An elderly (see OAR 461-001-0015) individual and his or her spouse may be considered a separate filing group from others with whom the elderly individual purchases and prepares meals, if:
     - The elderly individual is unable to purchase or prepare food because of a permanent and severe disabling condition; and
(B) The combined income of the other members of the *household group* does not exceed the following limit:

<table>
<thead>
<tr>
<th>Other Household Members</th>
<th>Monthly Countable Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$1,490</td>
</tr>
<tr>
<td>2</td>
<td>2,004</td>
</tr>
<tr>
<td>3</td>
<td>2,518</td>
</tr>
<tr>
<td>4</td>
<td>3,033</td>
</tr>
<tr>
<td>5</td>
<td>3,547</td>
</tr>
<tr>
<td>6</td>
<td>4,061</td>
</tr>
<tr>
<td>7</td>
<td>4,575</td>
</tr>
<tr>
<td>8</td>
<td>5,089</td>
</tr>
<tr>
<td>Each additional person</td>
<td>515</td>
</tr>
</tbody>
</table>

(4) A paid live-in attendant and the attendant's minor child may choose not to be in the filing group with the recipient of the services provided, unless required by section (2) of this rule to be in the same filing group.

(5) An individual in foster care, the individual's *spouse*, and each child under age 22 living with the individual are not eligible to participate in the FS SNAP program independently of the care or service provider's filing group, but may be included in the provider's filing group if the provider applies for benefits.

(6) Notwithstanding section (2) of this rule, the following *household group* members may form a separate filing group from other members of the *household group*:

(a) A resident of an alcohol or drug treatment and rehabilitation program certified by the Department for which an employee of the facility is the authorized representative (see OAR 461-135-0550). A resident's spouse in the same facility may be in a separate filing group, but a child of a resident must be in the same filing group as the resident.

(b) A resident in *group living* (see OAR 461-001-0015).

(c) A resident of a public or private non-profit *homeless* or *domestic violence shelter* (see OAR 461-135-0510).

(d) An individual who is a resident of federally subsidized housing for the *elderly*, an individual with a disability, or blind recipient of benefits under Title I, II, X, XIV, or XVI of the Social Security Act.

(7) A member of the *household group* who pays the filing group for room and board (lodger) is treated as follows:
(a) A lodger cannot participate in the **FS SNAP** program independently of the
*household group* when the lodger pays a reasonable amount for room and board.
A reasonable amount is:

(A) An amount that equals or exceeds the Thrifty Food Plan for the individual
and anyone in that individual's filing group (see OAR 461-155-0190(2)), if
more than two meals per day are provided; or

(B) An amount that equals or exceeds two-thirds of the Thrifty Food Plan for
the individual and anyone in the individual's filing group, if two or fewer
meals per day are provided.

(b) A lodger may participate in the **FS SNAP** program independently of the
*household group* when the lodger pays less than a reasonable amount for room
and board.

(8) The following *household group* members are excluded from the filing group:

(a) A resident of a commercial boarding house.

(b) An ineligible student, as defined in OAR 461-135-0570.

(9) A household member may be in two filing groups if the member:

(a) Is a resident of a *domestic violence shelter* (see OAR 461-001-0000) or *safe home*
(see OAR 461-001-0000); and

(b) Recently left the household containing the individual abuser.

Stat. Auth.: ORS 411.816
Stats. Implemented: ORS 411.816, 411.825
In the REF and REFM programs:

(1) An individual is not included in the filing group who does not meet the requirements of OAR 461-135-0900(2) regarding alien status or OAR 461-135-0900(4) regarding length of time in the United States.

(2) The filing group consists of only the individuals described in at least one of the following three subsections:

(a) A single adult who has no *spouse* (see OAR 461-001-0000) or *dependent child* (see OAR 461-001-0000) in the *household group* (see OAR 461-110-0210).

(b) A married couple who is in the same *household group* and who has—no *dependent child*.

   (A) No children;

   (B) Only children who are age 18 or over; or

   (C) No children under the age of 18 in the *household group*.

(c) A TANF *program* filing group (see OAR 461-110-0330) that is ineligible for TANF *program benefits*.

(2) A separate REF and REFM program filing group may be formed within a *household group* consisting of only the newly arriving refugees, if:

(a) The newly arrived refugee is rejoining a *spouse* (see OAR 461-001-0000) or a *parent* (see OAR 461-001-0000) of a common child in the *household group*;

(b) The previously arrived *spouse or parent* of a common child is working and over TANF program income limits; and

(c) There is at least one adult in the new filing group.

(3) A separate REF and REFM program filing group may be formed within a *household group* consisting of only the newly arriving refugees, if the *spouse* of the refugee does not meet the requirements of OAR 461-135-0900(2).

Stat. Auth.: 411.060, 411.070
Stats. Implemented: 411.060, 411.070
For all programs covered by Chapter 461 of the Oregon Administrative Rules, the client or someone authorized to act on behalf of the client must contact the Department or use another appropriate method to request benefits (see OAR 461-115-0150). The request may be oral or in writing. The request starts the application process.

The date of request is one of the following:

(a) In the EA, ERDC-BAS, GA, OSIP, REF, and TANF programs and for support service payments in the JOBS program authorized by OAR 461-190-0211, the date of request is the day the request for benefits is received by the Department.

(b) In the FS SNAP program, this section does not apply. See OAR 461-115-0040.

(c) In the GAM, MAA, MAF, OHP, OSIPM, REFM, and SAC programs, the date of request is determined as follows:

(A) For a new applicant,:

(i) The day the request for medical benefits is received by a Department representative, except as described in subparagraphs (ii) and (iii) of this paragraph.

(ii) If the request for medical benefits is received by a Department representative no later than the next business day after medical services are received, the date of request is the day these medical services were received.

(iii) An individual's request to be placed on the OHP Standard Reservation List (see OAR 461-135-1125) does not establish a date of request for medical benefits.

(B) For a current recipient, the date of request is one of the following:

(i) The date the client reports a change requiring a redetermination of eligibility.

(ii) The date the Department initiates a review, except that the automatic mailing of an application does not constitute a Department-initiated review.

(iii) The date the client establishes a date of request by contacting the Department orally or in writing or by submitting an application.
(C) For an OHP Standard Reservation List Applicant (see OAR 461-135-1125), the date of request is the date the Department mails the OHP 7210R Application (see OAR 461-135-1125).

(d) In the SFPSS program:

(A) Except as provided in paragraph (B) of this subsection, the date of request is the day the client signs the program's Interim Assistance Agreement.

(B) The date of request for support service payments is the day the request for benefits is received by the Department.

Stats. Implemented: ORS 411.060, 411.070, 411.816, 412.014, 412.049, 414.042, 2009 Or. Laws ch. 867
When An Application Must Be Filed

(1) A client must file an application, or may amend a completed application, as a prerequisite to receiving benefits as follows:

(1) (a) A client may apply for the TA-DVS program as provided in OAR 461-135-1220.

(2) (b) In all programs other than except the TA-DVS program:

(a) (A) Except as provided otherwise in sections (3), (4), (5), and (6) of this rule, a client wishing to apply for program benefits must submit a complete application on a form approved by the Department.

(b) (B) An application is complete if all of the following requirements are met:

(A) (i) All information necessary to determine the individual's eligibility and benefit amount is provided on the application for each individual in the filing group.

(B) (ii) The applicant, even if homeless, provides a mailing address.

(C) (iii) The application is signed. An individual required but unable to sign the application may sign with a mark, witnessed by another individual.

(D) (iv) The application is received by the Department, except an electronic application (see OAR 461-001-0000) meets the requirements of this paragraph only when submitted to and received by the Department with an electronic signature.

(32) A new application is not required in the following situations:

(a) In the Food Stamp SNAP program, when a single application can be used both to determine a client is ineligible in the month of application and to determine the client is eligible the next month. This can be done when--

(A) Anticipated changes make the filing group (see OAR 461-110-0370) eligible the second month; or

(B) The filing group provides verification between 30 and 60 days following the filing date (see OAR 461-115-0040), under OAR 461-180-0080.

(b) In all programs except the Food Stamp SNAP program, when a single application can be used both to determine a client is ineligible on the date of request (see OAR 461-115-0030) and to determine the client is eligible when anticipated changes make the filing group eligible within 45 days from the date of request.
(c) When the case is closed and reopened during the same calendar month.

(d) When benefits were suspended for one month because of the level of income, and the case is reopened the month following the month of suspension.

(e) When reinstating medical benefits for a pregnant woman covered by OAR 461-135-0950.

(f) When the Department determines a child under the age of 19 years with a date of request from July 1, 2009 through December 31, 2009 is not eligible for EXT, MAA, MAF, OHP, OSIPM, QMB, or SAC program benefits for a reason other than failure to complete the application requirements under OAR 461-115-0020, and the Department chooses to redetermine the child's eligibility for EXT, MAA, MAF, OHP, OSIPM, QMB, and SAC program benefits under the administrative rules in effect on October 1, 2009 and January 1, 2010.

(43) When a client establishes a new date of request (see OAR 461-115-0030) prior to the end of the month following the month of case closure, unless the Department determines a new application is required, a new application is not required in the following situations:

(a) In the OSIPM program, when the client's case closed due to failure to make a liability payment required under OAR 461-160-0610.

(b) In the OSIPM-EPD program, when the client's case closed due to failure to make a participant fee payment required under OAR 461-160-0800.

(54) A new application is required to add a newborn child to a benefit group (see OAR 461-110-0750) according to the following requirements:

(a) For the REF and TANF programs:

   (A) A new application is not required if the child is listed on the application as "unborn" and there is sufficient information about the child to establish its eligibility.

   (B) A new application is required if the child is not included on the application as "unborn."

(b) In the EXT, MAA, MAF, OHP, and REFM programs, no additional application is required to add the child to the benefit group of the child's mother. The child may be added to a benefit group other than the benefit group of the child's mother if eligibility can be determined without submission of a new application.

(c) In the ERDC and FS SNAP programs, an application is not required to add the child to the benefit group.
(d) In all programs other than ERDC, EXT, FS, MAA, MAF, OHP, REF, REFM, SNAP, and TANF, an application is required.

(65) Except for OHP-OPU applicants who must use the OHP 7210R Application (see OAR 461-135-1125), a new application is required to add an individual, other than a newborn child, to a benefit group according to the following requirements:

(a) In the ERDC and FS SNAP programs, a new application is not required.

(b) In the EXT, MAA, MAF, OHP, REFM, SAC, and TANF programs, an individual may be added by amending a current application if the information is sufficient to determine eligibility; otherwise a new application is required.

(c) In all programs other than the ERDC, EXT, FS, MAA, MAF, OHP, REFM, SAC, SNAP, and TANF programs, a new application is required.

(76) A client whose TANF grant is closing may request ERDC orally or in writing.

(87) For all programs except the EXT, FS, MAA, MAF, and OHP programs, Except for an applicant for the SNAP program, a client may change between programs administered by the Department using the current application if the following conditions are met:

(a) The client makes an oral or written request for the change.

(b) The Department has sufficient evidence to determine eligibility and benefit level for the new program without a new application.

(c) The program change can be effected while the client is eligible for the first program.

(98) Except for OHP-OPU applicants who must use the OHP 7210R Application (see OAR 461-135-1125), a new application is not required in the EXT, MAA, MAF, OHP, OSIP, OSIPM, and QMB programs, a new application is not required to redetermine eligibility for the same program or to change between these programs if the following conditions are met:

(a) The client is currently receiving benefits from one of these programs; and

(b) The Department has sufficient evidence to redetermine eligibility for the same program or determine eligibility for the new program without a new application or by amending the current application.

Stats. Implemented: ORS 411.060, 411.070, 411.117, 411.816, 412.049, 414.042
Who Must Sign the Application and Complete the Application Process

(1) In the ERDC, MAA, MAF, REF, REFM, and TANF programs, the following people must sign the application and complete the application process:

(a) In the MAA, MAF, REF, REFM, and TANF programs:

(A) Each parental caretaker relative must sign the application.

(B) A non-parental caretaker relative must sign the application, subject to the following specific requirements:

(i) If the non-parental caretaker relative applies for benefits with the dependent child and lives with a spouse, both the non-parental caretaker relative and the spouse must sign the application.

(ii) A non-parental caretaker relative who applies only for children must sign the application, but the non-parental caretaker relative's spouse is not required to sign the application.

(iii) If the non-parental caretaker relative changes, the new non-parental caretaker relative must sign a current application.

(b) In the ERDC program, a caretaker must sign.

(2) In the EA program:

(a) A caretaker relative must sign the application and complete the application process for a dependent child under age 18. If the child is not living with a caretaker relative, another adult may act on behalf of the child.

(b) If the caretaker relative lives with a spouse, both must sign the application.

(c) A dependent child age 18 who applies must sign the application and complete the application process.

(3) In the Food Stamp program, the primary person, the spouse of the primary person, or another adult member of the filing group must sign the application and complete the application process.

(4) In the GA, GAM, and QMB programs, an adult requesting assistance and the adult's spouse, if they live together, must complete the application process and sign the application.
(54) In the OHP program, the primary person, the spouse of the primary person, and other adult members of the filing group who are age 19 or over must sign the application and complete the application process.

(65) In the OSIP and OSIPM programs, an adult requesting assistance and the adult's spouse, if they live together, must sign the application and complete the application process, if able. If the client and the spouse are unable to sign the application and complete the application process, this can be done by the authorized representative. If the applicant dies prior to the determination of eligibility for OSIPM, the application may be processed if the Department receives the required verification.

(6) In the SNAP program, the primary person, the spouse of the primary person, or another adult member of the filing group must sign the application and complete the application process.

(7) A person required to sign the application but unable to sign may sign with a mark, witnessed by an employee of the field office.

Stat. Auth.: 411.060, 411.816, 418.100 412.049, 414.042
Stats. Implemented: 411.060, 411.816, 418.100 412.049, 414.042
461-115-0090
Authorized Representatives; General

(1) The head of household, spouse (see OAR 461-001-0000), or any other responsible member of the household may designate an authorized representative to act on behalf of the household in making application for the program, in reporting changes, in obtaining benefits, or in using benefits. A person must provide adequate documentary evidence to the Department in order to serve as an authorized representative of a client.

(2) In all programs except the SNAP program, the Department must allow a person or persons of the applicant's choice to act as the authorized representative unless the person may cause harm to the client.

(3) In all programs except the Food Stamp SNAP program, if an authorized representative is needed but has not been designated by the client, the Department will appoint one.

(34) In the Food Stamp SNAP program, the selection of authorized representatives and their authority are limited by federal regulations in 7 CFR 273.2(n).

(45) A client who resides in a drug addiction or alcoholic treatment center identified in OAR 461-135-0550(2) may apply for Food Stamp SNAP program benefits only through an authorized representative. The authorized representative must be an employee of and designated by the center.

(56) A client with a disability (see OAR 461-001-0015) who participates in the Food Stamp SNAP program while residing in a group living facility (see OAR 461-001-0015) may participate through an authorized representative or on his or her own behalf, at the option of the group living facility (see OAR 461-135-0510(2)(e)).

(67) In the TANF program, a person not related to the dependent child may serve as authorized representative or alternate payee for not more than 60 days.

Stat. Auth.: ORS 411.060, 411.816, 418.100 412.014, 412.049, 414.042
Stats. Implemented: ORS 411.060, 411.816, 412.014, 412.049, 414.042, 418.100
This rule establishes verification requirements for the BCCM, MAA, MAF, OHP, and SAC programs in addition to the requirements of OAR 461-115-0610.

Except as provided in section (3) of this rule, each client declaring U.S. citizenship must provide acceptable documentation of citizenship and identity. For purposes of this rule, acceptable documentation consists of any of the documents permitted under section 1903(x) of the Social Security Act (42 U.S.C. 1396b).

(a) A new applicant must provide acceptable documentation as a condition of eligibility (see OAR 461-001-0000). Except for an applicant whose medical benefits previously were closed after March 31, 2009 for not providing acceptable documentation, an applicant's medical assistance may not be delayed for citizenship documentation while the eligibility decision is pending if all other medical assistance eligibility requirements have been met.

(b) A current recipient who has not already provided acceptable documentation must provide acceptable documentation as a condition of eligibility when requested by the Department.

(c) A client who already has provided acceptable documentation is not required to provide additional evidence during a subsequent application for benefits or redetermination of eligibility.

Each of the following clients is exempt from the requirements of section (2) of this rule, a client who is:

(a) Assumed eligible under OAR 461-135-0010(5);
(b) Eligible for OHP-CHP;
(c) Eligible for or receiving Medicare;
(d) Presumptively eligible for the BCCM program;
(e) Receiving Social Security Disability Income (SSDI); or
(f) Receiving Title IV-E benefits.

In the OHP program:

(a) At initial application and at any other time it affects the client, the following must be verified:
(A) The requirement in OAR 461-120-0210 to have or apply for a social security number.

(B) Alien status for an applicant who indicates he or she is not a U.S. citizen.

(C) The premium exemption allowed because a client is --

(i) A member of a federally recognized Indian tribe, band, or group;

(ii) An Eskimo, Aleut, or other Alaska native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act; or

(iii) An individual eligible for benefits through an Indian Health Program.

(D) Income from the past three months month prior to the budget month and income already received in the budget month. If income cannot be verified, the client's statement is accepted.

(b) At recertification, the following must be verified, except that if income cannot be verified, the client's statement is accepted:

(A) Unearned income if it has changed since the last certification.

(B) Earned income from the three months prior to the budget month.

(c) A client enrolled full time in higher education must provide verification, at application and recertification, that the client meets the requirements of OAR 461-135-1110.

(d) The following must be verified when it is first reported or changed:

(A) Pregnancy of the client, which must be verified by a medical practitioner, health department, clinic, or crisis pregnancy center or like facility.

(B) Amount of the premium for cost-effective employer-sponsored health insurance.

(e) A client must provide verification for any eligibility requirement questioned by the Department.

Stat. Auth.: ORS 409.050, 411.060, 414.042
Stats. Implemented: ORS 411.060, 414.042, 414.047
In all programs except the REF and REFM programs:

(1) For purposes of this chapter of rules, an individual is a "qualified non-citizen" if he or she is any of the following:

(a) A non-citizen who is lawfully admitted for permanent residence under the Immigration and Nationality Act (INA) (8 U.S.C. 1101 et seq).

(b) A refugee who is admitted to the United States as a refugee under section 207 of the INA (8 U.S.C. 1157).

(c) A non-citizen who is granted asylum under section 208 of the INA (8 U.S.C. 1158).

(d) A non-citizen whose deportation is being withheld under section 243(h) of the INA (8 U.S.C. 1253(h)) (as in effect immediately before April 1, 1997) or section 241(b)(3) of the INA (8 U.S.C. 251(b)(3)) (as amended by section 305(a) of division C of the Omnibus Consolidated Appropriations Act of 1997, Pub. L. No. 104-208, 110 Stat. 3009-597 (1996)).

(e) A non-citizen who is paroled into the United States under section 212(d)(5) of the INA (8 U.S.C. 1182(d)(5)) for a period of at least one year.

(f) A non-citizen who is granted conditional entry pursuant to section 203(a)(7) of the INA (8 U.S.C. 1153(a)(7)) as in effect prior to April 1, 1980.

(g) A non-citizen who is a "Cuban and Haitian entrant" (as defined in section 501(3) of the Refugee Education Assistance Act of 1980).

(h) In all programs except the Food Stamp SNAP program--a battered spouse or dependent child who meets the requirements of 8 U.S.C. 1641(c) and is in the United States on a conditional resident status, as determined by the U.S. Citizenship and Immigration Services.

(i) In the Food Stamp SNAP program--a non-citizen who has been battered or subjected to extreme cruelty in the United States by a spouse or parent or by a member of the spouse or parent's family residing in the same household as the non-citizen at the time of the abuse; a non-citizen whose child has been battered or subjected to battery or cruelty; or a non-citizen child whose parent has been battered.

(2) An individual meets the alien status requirements if he or she is one of the following:
(a) An American Indian born in Canada to whom the provisions of section 289 of the INA (8 U.S.C. 1359) apply.

(b) A member of an Indian tribe, as defined in section 4(e) of the Indian Self-Determination and Education Act (25 U.S.C. 450b(e)).

(3) In the ERDC and TANF programs, an individual meets the alien status requirements if he or she is one of the following:

(a) An individual who is a qualified non-citizen.

(b) A non-citizen who is currently a victim of domestic violence or who is at risk of becoming a victim of domestic violence.

(c) A "victim of a severe form of trafficking in persons" certified under the Victims of Trafficking and Violence Protection Act of 2000 (22 U.S.C. 7101 to 7112).

(d) A family member of a victim of a severe form of trafficking in persons who holds a visa for family members authorized by the Trafficking Victims Protection Reauthorization Act of 2003 (22 U.S.C. 7101 to 7112).

(e) An Iraqi or Afghan alien granted special immigrant status (SIV) under section 101(a)(27) of the Immigration and Nationality Act. Such an individual meets the alien status requirements for a maximum of eight months as follows:

(A) If the individual enters the United States with the special immigrant status, the month that the individual enters the United States counts as the first month.

(B) If the individual is granted special immigrant status after entering the United States, then the month in which the special immigrant status was granted counts as the first month.

(4) In the BCCM, CEC, CEM, EXT, MAA, MAF, OHP, OSIPM, QMB, and SAC programs, a qualified non-citizen meets the alien status requirements if he or she satisfies one of the following situations:

(a) Effective October 1, 2009, is an individual under 19 years of age.

(b) Was a qualified non-citizen before August 22, 1996.

(bc) Physically entered the United States before August 22, 1996, and was continuously present in the United States between August 22, 1996, and the date qualified non-citizen status was obtained. An individual is not continuously present in the United States if he or she is absent from the United States for more than 180 days.
than 30 consecutive days or for a total of more than 90 days between August 22, 1996 and the date qualified non-citizen status was obtained.

(ed) Is an individual granted any of the following alien statuses:

(A) Refugee--under section 207 of the INA.

(B) Asylum--under section 208 of the INA.

(C) Deportation being withheld under section 243(h) of the INA.

(D) Cubans and Haitians who are either public interest or humanitarian parolees.


(F) A "victim of a severe form of trafficking in persons" certified under the Victims of Trafficking and Violence Protection Act of 2000 (22 U.S.C. 7101 to 7112).

(G) A family member of a victim of a severe form of trafficking in persons who holds a visa for family members authorized by the Trafficking Victims Protection Reauthorization Act of 2003 (22 U.S.C. 7101 to 7112).

(H) An Iraqi or Afghan alien granted special immigrant status (SIV) under section 101(a)(27) of the Immigration and Nationality Act. Such an individual meets the alien status requirements for a maximum of eight months as follows:

(i) If the individual enters the United States with the special immigrant status, the month that the individual enters the United States counts as the first month.

(ii) If the individual is granted special immigrant status after they have already entered the United States, then the month in which the special immigrant status was granted counts as the first month.

(ef) In the OSIPM program, is receiving SSI benefits.

(fg) In the QMB program, is receiving SSI and Medicare Part A benefits.
In the GA and GAM programs, an individual meets the alien status requirement if he or she is one of the following:

(a) An individual who is blind or has a disability was lawfully residing in the United States on August 22, 1996, and is now a \textit{qualified non-citizen}.

(b) An individual granted one of the following statuses, but only for seven years following the date the status is granted:

\begin{itemize}
\item[(A)] Refugee--under section 207 of the INA.
\item[(B)] Asylum--under section 208 of the INA.
\item[(C)] Deportation being withheld under section 243(h) of the INA.
\item[(D)] An individual granted immigration status under section 584(a) of the Foreign Operations, Export Financing and Related Program Appropriations Act of 1988.
\item[(E)] Cubans and Haitians who are either public interest or humanitarian parolees.
\item[(F)] A "victim of a severe form of trafficking in persons" certified under the Victims of Trafficking and Violence Protection Act of 2000 (22 U.S.C. 7101 to 7112).
\item[(G)] A family member of a victim of a severe form of trafficking in persons who holds a visa for family members authorized by the Trafficking Victims Protection Reauthorization Act of 2003 (22 U.S.C. 7101 to 7112).
\end{itemize}

(c) An individual who meets one of the alien status requirements in section (2) or (7) of this rule.

(d) An Iraqi or Afghan alien granted special immigrant status (SIV) under section 101(a)(27) of the INA. Such an individual meets the alien status requirements for a maximum of eight months as follows:

\begin{itemize}
\item[(A)] If the individual enters the United States with the special immigrant status, the month that the individual enters the United States counts as the first month.
\item[(B)] If the individual is granted special immigrant status after they have already entered the United States, then the month in which the special immigrant status was granted counts as the first month.
\end{itemize}
In the OSIP program, an individual meets the alien status requirement if he or she is one of the following:

(a) An individual who is blind or has a disability, was lawfully residing in the United States on August 22, 1996, and is now a qualified non-citizen.

(b) A qualified non-citizen who physically entered the United States on or after August 22, 1996, has had the qualified non-citizen status for at least five years, and has forty qualifying quarters of coverage as defined in section (10) of this rule.

(c) An individual granted one of the following statuses, but only for seven years following the date the status is granted:

   (A) Refugee--under section 207 of the INA.

   (B) Asylum--under section 208 of the INA.

   (C) Deportation being withheld under section 243(h) of the INA.

   (D) An individual granted immigration status under section 584(a) of the Foreign Operations, Export Financing and Related Program Appropriations Act of 1988.

   (E) Cubans and Haitians who are either public interest or humanitarian parolees.

   (F) A "victim of a severe form of trafficking in persons" certified under the Victims of Trafficking and Violence Protection Act of 2000 (22 U.S.C. 7101 to 7112).

   (G) A family member of a victim of a severe form of trafficking in persons who holds a visa for family members authorized by the Trafficking Victims Protection Reauthorization Act of 2003 (22 U.S.C. 7101 to 7112).

(d) An individual receiving SSI benefits.

(e) An individual who meets one of the alien status requirements in section (2) or (7) of this rule.

(f) An Iraqi or Afghan alien granted special immigrant status (SIV) under section 101(a)(27) of the INA. Such an individual meets the alien status requirements for a maximum of eight months as follows:
(A) If the individual enters the United States with the special immigrant status, the month that the individual enters the United States counts as the first month.

(B) If the individual is granted special immigrant status after they have already entered the United States, then the month in which the special immigrant status was granted counts as the first month.

(7) In all programs except the ERDC and TANF programs, a qualified non-citizen meets the alien status requirement if he or she is:

(a) A veteran of the United States Armed Forces who was honorably discharged for reasons other than alien status and who fulfilled the minimum active-duty service requirements described in 38 U.S.C. 5303A(d).

(b) A member of the United States Armed Forces on active duty (other than active duty for training).

(c) The spouse or a dependent child of an individual described in subsection (a) or (b) of this section.

(d) In the FS SNAP program, a qualified non-citizen who meets the requirement in section (10) of this rule.

(8) Except as provided in sections section (2), subsection (3)(e), and sections (4), (5), and (7) of this rule, a non-citizen who entered the United States or was given qualified non-citizen status on or after August 22, 1996:

(a) Is ineligible for the BCCM, MAA, MAF, OHP, OSIPM, QMB, and SAC programs for five years beginning on the date the non-citizen received his or her qualified non-citizen status.

(b) Meets the alien status requirement following the five-year period.

(9) In the FS SNAP program, an individual meets the alien status requirement if he or she is one of the following:

(a) An individual granted any of the following alien statuses--

(A) Refugee--under section 207 of the INA.

(B) Asylum--under section 208 of the INA.

(C) Deportation being withheld under section 243(h) of the INA.
(D) Cubans and Haitians who are either public interest or humanitarian parolees.


(F) A "victim of a severe form of trafficking in persons" certified under the Victims of Trafficking and Violence Protection Act of 2000 (22 U.S.C. 7101 to 7112).

(G) A family member of a victim of a severe form of trafficking in persons who holds a visa for family members authorized by the Trafficking Victims Protection Reauthorization Act of 2003 (22 U.S.C. 7101 to 7112).

(H) An Iraqi aliens or Afghan alien granted special immigrant status (SIV) under section 101(a)(27) of the Immigration and Nationality Act. Such individuals meet an individual meets the alien status requirements for a maximum of eight months as follows:

(i) If the individual enters the United States with the special immigrant status, the month that the individual enters the United States counts as the first month.

(ii) If the individual is granted special immigrant status after they have already entered the United States, then the month in which the special immigrant status was granted counts as the first month.

(iii) There is no eligibility past September 30, 2008, even if the eight month limit has not been reached.

(I) — Afghan aliens granted special immigrant status (SIV) under section 101(a)(27) of the Immigration and Nationality Act. Such individuals meet the alien status requirements for a maximum of six months as follows:

(i) If the individual enters the United States with the special immigrant status, the month that the individual enters the United States counts as the first month.

(ii) If the individual is granted special immigrant status after they have already entered the United States, then the month in which the special immigrant status was granted counts as the first month.

(iii) There is no eligibility past September 30, 2009, even if the six month limit has not been reached.
(b) A qualified non-citizen under 18 years of age.

(c) A non-citizen who has been residing in the United States for at least five years while a qualified non-citizen.

(d) A non-citizen who is lawfully residing in the United States and who was a member of a Hmong or Highland Laotian tribe at the time that the tribe rendered assistance to United States personnel by taking part in a military or rescue operation during the Vietnam era (as defined in 38 U.S.C. 101).

(e) The spouse, the un-remarried surviving spouse, or an unmarried dependent child, of an individual described in subsection (d) of this section.

(f) A qualified non-citizen who has a disability, as defined in OAR 461-001-0015.

(10) A client who is lawfully admitted to the United States for permanent residence under the INA and has worked 40 qualifying quarters of coverage as defined under title II of the Social Security Act, or can be credited with such qualifying quarters as provided under 8 U.S.C. 1645, meets the alien status requirements for the FS SNAP program, subject to the following provisions:

(a) No quarter beginning after December 31, 1996, is a qualifying quarter if the client received any federal, means-tested benefit during the quarter. Federal means-tested benefits include FS SNAP, TANF, and Medicaid (except emergency medical).

(b) For the purpose of determining the number of qualifying quarters of coverage, a client is credited with all of the quarters of coverage worked by a parent of the client while the client was under the age of 18 and all of the qualifying quarters worked by a spouse of the client during their marriage, during the time the client remains married to such spouse or such spouse is deceased.

(c) A lawful permanent resident who would meet the alien status requirement, except for a determination by the Social Security Administration (SSA) that he or she has fewer than 40 quarters of coverage, may be provisionally certified for food stamp SNAP program benefits while SSA investigates the number of quarters creditable to the client. A client provisionally certified under this section who is found by SSA, in its final administrative decision after investigation, not to have 40 qualifying quarters is not eligible for food stamp SNAP program benefits received while provisionally certified. The provisional certification is effective according to the rule on effective dates for opening benefits, OAR 461-180-0080. The provisional certification cannot run more than six months from the date of original determination by SSA that the client does not have sufficient quarters.
Requirement to Provide or Apply for SSN

(1) In the CAWEM, ERDC, REF, and REFM programs, a member of a need group (see OAR 461-110-0630) or a benefit group (see OAR 461-110-0750) is not required to provide or apply for a social security number (SSN). In these programs, the Department may request that a member of the filing or need group provide an SSN on a voluntary basis.

(2) In the EA and TA-DVS programs, an individual must provide his or her SSN if the individual can.

(3) Except as provided in section (5) of this rule, in the OSIP, OSIPM, and QMB programs, to be included in the benefit group, an individual must:

(a) Provide a valid SSN for the individual; or

(b) Apply for a number if the individual does not have a valid one and provide the SSN when it is received.

(4) Except as provided in sections (5) to (7) of this rule, in all programs not covered by sections (1) to (3) of this rule, to be included in the need group, an individual (other than an unborn) must:

(a) Provide a valid SSN for the individual; or

(b) Apply for a number if the individual does not have one and provide the SSN when it is received.

(5) In the BCCM, CEC, CEM, EXT, FS, GA, GAM, MAA, MAF, OHP, OSIP, OSIPM, QMB, and SAC, and SNAP programs, an individual is not required to apply for or provide an SSN if the individual is ---

(a) A member of religious sect or division of a religious sect that has continuously existed since December 31, 1950; and

(b) Adheres to its tenets or teachings that prohibit applying for or using an SSN.

(6) The requirement to apply for or provide the SSN is delayed as follows:

(a) In the BCCM, CEC, CEM, EXT, MAA, MAF, OHP, and SAC programs, a newborn who is assumed eligible based on the eligibility of the mother of the newborn may receive benefits until one year of age without meeting the SSN requirements of section (4) of this rule.

(b) In the Food Stamp SNAP program:
(A) **Applicants** An applicant eligible for expedited services may receive their **his or her** first full month's allotment without meeting the SSN requirement but must meet the requirement before receiving a second full month's allotment.

(B) Before applying for or providing an SSN, a newborn may be added to an existing benefit group (see OAR 461-110-0750) for six months following the date the baby is born or until the group's next recertification, whichever is later.

(7) In the **Food Stamp SNAP** program:

(a) An individual who refuses or fails without good cause to provide or apply for an SSN when required by this rule is ineligible to participate. This period of ineligibility continues until the individual provides the SSN to the Department.

(b) An individual may participate in **FS SNAP** for one month in addition to the month of application, if the individual can show good cause why the application for an SSN has not been completed. To continue to participate, the individual must continue to show good cause each month until the application for an SSN is complete with Social Security Administration.

(c) An individual meets the good cause requirement in subsections (a) and (b) of this section if the individual provides evidence or collateral information that the individual applied for or made every effort to supply the Social Security Administration with the necessary information to complete the application process. Delays due to illness not associated with a disability (see OAR 461-001-0015), lack of transportation, or temporary absence do not qualify as good cause under this rule.

(8) This rule authorizes or requires the collection of an SSN for each of the following purposes.

(a) The determination of eligibility for benefits. The SSN is used to verify income and other assets, and match with other state and federal records such as the Internal Revenue Service (IRS), Medicaid, child support, Social Security benefits, and unemployment benefits.

(b) The preparation of aggregate information and reports requested by funding sources for the program providing benefits.

(c) The operation of the program applied for or providing benefits.

(d) Conducting quality assessment and improvement activities.
(e) Verifying the correct amount of payments, recovering overpaid benefits, and identifying any individual receiving benefits in more than one household.

Stats. Implemented: ORS 411.060, 411.070, 411.816, **412.049**, 414.042, 418.100
In all programs except the BCCM, FS CEC, OHP-CHP, and OHP-OPP, and SNAP programs:

(1) To be eligible for any program funded in whole or in part with federal grants under Titles IV-A (TANF) or IV-E of the Social Security Act, the filing group must assign to the state its right to receive, from any other person, child support that has accrued or that accrues during any time period that the group receives assistance, not to exceed the total amount of assistance paid.

(2) To be eligible for any program funded in whole or in part with federal grants under Title IV-E of the Social Security Act, the filing group must assign to the state its right to receive, from any other person, child support that has accrued or that accrues during any time period that the group receives assistance, not to exceed the total amount of assistance paid.

(3) To be eligible for the CEM, EXT, MAA, MAF, OHP-OPC, OHP-OP6, and OSIPM programs, a filing group must assign to the state the right of any Medicaid-eligible child in the filing group to receive any cash medical support that accrues while the group receives assistance, not to exceed the total amount of assistance paid.

(34) Cash medical support received by the Department will be retained by the Department as is necessary to reimburse the Department for CEM, EXT, MAA, MAF, OHP-OPC, OHP-OP6, and OSIPM program medical assistance payments made on behalf of an individual with respect to whom such assignment was executed. Once yearly, the remainder of such amount retained will be paid to such individual.

(45) When the Department provides benefits or services for the support of a child who is in a filing group in any program funded in whole or in part with a federal grant under Title IV-A (TANF) or IV-E of the Social Security Act, the right to child support for that child that any individual may have is deemed to be assigned to the state by operation of law.

Stats. Implemented: ORS 411.060, 411.070, 412.001, 412.024, 412.049, 414.025, 414.042
(1) In the CEC, CEM, EXT, GAM, MAA, MAF, OHP, OSIPM, QMB, REFM, and SAC programs, by signing the application for assistance, clients agree to turn over their rights to reimbursement for medical care costs to the Division Department. The Division may refuse to pay medical expenses for anyone in the benefit group when another party or resource should pay first.

(a) If a client or the client's authorized representative (see OAR 461-115-0090) refuses to assign the rights to reimbursement for medical care costs to the Department, the filing group is ineligible until the client complies with this requirement. This includes a client eligible for long term care (see OAR 461-001-0000) insurance payments who fails to comply as described in subsection (b) of this section.

(b) In all programs except the Program for All-Inclusive Care for the Elderly (PACE, see OAR 411-045-0000 to 411-045-0140), when a client has long term care insurance, the client complies with the requirements of this rule by reducing the Department's share of the long term care service costs by taking the following actions for the entire period of time that the client is eligible for Department-covered long term care services:

(A) For a client in a nursing facility:

(i) Submitting the necessary paperwork to receive the long term care insurance payments and designating the long term care facility as the payee for the long term care insurance benefits; or

(ii) When the insurance company will not pay the long term care insurance benefits directly to the long term care facility, submitting the necessary paperwork to receive insurance payments and then promptly turning over the long term care insurance payments to the long term care facility upon receipt.

(B) For a client in community based care (see OAR 461-001-0000):

(i) Submitting the necessary paperwork to receive the long term care insurance payments and designating the Department as the payee for the long term care insurance benefits; or

(ii) When the insurance company will not pay the long term care insurance benefits directly to the Department, submitting the necessary paperwork to receive the insurance payments and
then promptly turning over the long term care insurance payments to the Department upon receipt.

(2) The Department may refuse to pay medical expenses for anyone in the benefit group (see OAR 461-110-0750) when another party or resource should pay first.

(23) The amount the Division Department may collect in reimbursement is limited to the amount of medical services paid by the Division Department on the client's behalf.

(4) The Department establishes an overpayment if it is discovered after-the-fact that during any period of time a client or another individual submitting a long term care insurance claim on the client's behalf received a long term care insurance payment that was not turned over to the long term care facility or Department as required by subsection (1)(b) of this rule.

Stats. Implemented: ORS 411.060, 414.042
Clients Required to Obtain Health Care Coverage and Cash Medical Support; CEM, EXT, GAM, MAA, MAF, OHP (except OHP-CHP), OSIPM, SAC

This rule explains the obligation of clients to obtain health care coverage and cash medical support for members of the benefit group (see OAR 461-110-0750) in the CEM, EXT, GAM, MAA, MAF, OHP (except OHP-CHP), OSIPM, and SAC programs.

(1) Unless excused from the requirements of this section for good cause defined in OAR 461-120-0350, each adult client must assist the Department and the Division of Child Support of the Department of Justice in establishing paternity for each of his or her children and obtaining an order directing the non-custodial parent (see OAR 461-001-0000) of a child (see OAR 461-001-0000) in the benefit group to provide:

(a) Cash medical support for that child; and
(b) Health care coverage for that child.

(2) Each adult client must make a good faith effort to obtain available coverage under Medicare.

(3) To be eligible for the EXT, GAM, MAA, MAF, OHP (except OHP-CHP and OHP-OPU), OSIPM, and SAC programs, once informed of the requirement, an individual who is able to must apply for, accept, and maintain cost-effective, employer-sponsored health insurance (see OAR 461-155-0360). In the GAM and OSIPM programs, the client is not required to incur a cost for the health insurance.

(4) In the OHP-OPU program:

(a) An individual who can obtain health insurance through his or her employer must cooperate in determining eligibility for the Family Health Insurance Assistance Program (FHIAP). Rules for FHIAP are at OAR 442-004-0000 and following. If eligible for FHIAP, the individual must:

(A) Apply for and accept the employer-sponsored health insurance.
(B) Enroll the other OHP-OPU recipients who are eligible for insurance through FHIAP.

(b) The requirements of subsection (a) of this section do not apply to---

(A) Members of a federally recognized Indian tribe, band or group;
(B) Eskimos, Aleuts or other Alaska natives enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act;
(C) Individuals eligible for benefits through an Indian Health Program; and

(D) Individuals eligible under the CAWEM program.

(5) An individual who fails to meet an applicable requirement in sections (1), (2), (3), or (4) of this rule is removed from the need group (see OAR 461-110-0630) except that in the OHP program the individual is removed from the benefit group (see OAR 461-110-0750).

(6) In the case of an individual failing to meet the requirements of section (1) of this rule, the Department applies the penalty after providing the client with notice and opportunity to show the provisions of OAR 461-120-0350 apply.

(7) The penalty provided by this rule ends when the client meets the requirements of this rule.

Age Requirements for Clients to Receive Benefits

(1) If the year of a person's birth is known but the month is unknown, the month of birth is presumed to be July. If the date of birth is unknown, the date of birth is presumed to be the first of the month.

(2) To be eligible for the BCCM program, a woman must be under 65 years of age.

(3) **To be eligible for the CEC program, an individual must be under 20 years of age.**

(4) **To be eligible for the CEM program, an individual must be under 19 years of age.**

(5) To be eligible for the EXT, MAA, MAF, or TANF programs:

   (a) A *child* (see OAR 461-001-0000) must be--

      (A) Under 18 years of age; or

      (B) Under 19 years of age and *regularly attending school* full time, as determined by the school.

   (b) A caretaker relative may be any age.

(46) To be eligible for payment of child care costs for the ERDC or TANF program, a *child* must be--

   (a) Under 12 years of age for the ERDC program or under 13 years of age for the TANF program; or

   (b) Under 18 years of age and--

      (A) Physically or mentally incapable of selfcare;

      (B) Under court supervision;

      (C) Receiving foster care;

      (D) Eligible for the special need rate for child care in OAR 461-155-0150; or

      (E) Subject to circumstances that significantly compromise the *child's* safety or the caretaker's ability to work or participate in an assigned activity if child care is not available.

(57) To be eligible for the FS, OSIP-AB, OSIPM-AB, QMB-BAS, QMB-SMB, or REFM, or SNAP programs, a client may be any age.
To be eligible for the GA and GAM programs, a client must be--

(a) Eighteen years of age or older and less than 65 years of age; or

(b) Sixty-five years of age or older and must be a non-citizen who meets the requirements of OAR 461-120-0125.

To be eligible for the OHP program, a client must meet the age requirements in OAR 461-135-1100.

To be eligible for the OSIP-AD (except OSIP-EPD) program, a client must be 18 years of age or older and under 65 years of age.

To be eligible for the OSIP-EPD and OSIPM-EPD programs, the client must be 18 years of age or older or be legally emancipated.

To be eligible for the OSIP-OAA or OSIPM-OAA programs, a client must be 65 years of age or older.

To be eligible for the OSIPM-AD (except OSIPM-EPD) or QMB-DW programs, a client must be under 65 years of age.

To be eligible for the REF program, a client must be:

(a) 18 years of age or older;

(b) A legally emancipated minor; or

(c) Part of a TANF filing group that is ineligible for TANF.

To be eligible for the SAC program, the child must be under 21 years of age.

Stats. Implemented: ORS 411.060, 411.816, 412.049
Deprivation Based on Unemployment or Underemployment of the ADC-PWE Primary Wage Earner (PWE); MAA, TANF

(1) Deprivation in the MAA and TANF programs, deprivation based on the unemployment or underemployment of the ADC-PWE primary wage earner (PWE) exists if all the following are true:

(a) A child lives with two parents.

(b) The ADC-PWE PWE is unemployed or underemployed.

(c) The ADC-PWE PWE is not participating in a labor dispute.

(d) Except as provided otherwise under section (2) of this rule, the PWE is not separated from his or her most recent employment (see OAR 461-135-0070), for any of the following reasons:

(A) Discharged or fired for:

   (i) Misconduct (see OAR 461-135-0070); or

   (ii) Felony or theft.

(B) Voluntary quit --

   (i) In anticipation of discharge; or

   (ii) Without good cause (see OAR 461-135-0070).

(2) A need group (see OAR 461-110-0630) may not be denied TANF program benefits based on subsections (1)(c) and (d) of this rule if the PWE is one of the following:

(a) A Parents as Scholars (PAS) participant who temporarily becomes ineligible for TANF program benefits for four months or less due to income from a paid work experience (see OAR 461-190-0199);

(b) A teen parent returning to high school or equivalent;
(c) An individual fleeing from or at risk of *domestic violence* (see OAR 461-001-0000);

(d) An individual in the ninth month of pregnancy or experiencing a medical complication due to the pregnancy which is documented by a qualified and appropriate professional;

(e) An individual unable to work due to a disability or medical condition documented by a qualified and appropriate professional, and which is expected to last for 30 days or more from the *date of request* (see OAR 461-115-0030) for TANF program benefits;

(f) An individual who is separated from his or her *most recent employment* for a reason the Department determines is *good cause*.

461-125-0310
Basis of Need; **OSIP, OSIPM**

In the OSIP and OSIPM programs program, an individual must be one of the following:

(1) **Blind** (see OAR 461-125-0330) at any age (AB).

(2) **Age 65 or over** (see OAR 461-125-0350) (OAA).

(3) **An individual with a disability** (see OAR 461-125-0370) (AD). **A child** (see OAR 461-001-0000) with a disability is not eligible for the $1.70 SIP payment (see OAR 461-155-0250(4))

Stats. Implemented: ORS 411.060, 411.070, **411.704, 411.706, 414.042, 2009 Or. Laws ch. 849**
Specific Requirements; EXT

(1) To be eligible for EXT benefits, at least one member of the filing group must have been eligible for and received MAA or MAF for at least three of the six months prior to the beginning date of the EXT eligibility period (see OAR 461-135-0096(3) to determine the beginning date), and then become ineligible because of --

(a) An increase in the earnings of the caretaker relative;

(b) An increase in child support received; or

(c) A combination of an increase in both the earnings of the caretaker relative and child support received.

(2) If the filing group becomes ineligible for MAA or MAF when another change occurs in conjunction with the increase in earned income or child support, the filing group is not eligible for EXT if the other change, by itself, makes the group ineligible for MAA or MAF.

(3) Eligibility for EXT is limited to the members of the MAA or MAF benefit group at the time that those benefits end.

(4) Subject to the time periods established in OAR 461-135-0096(1):

(a) Once eligibility for EXT is established, members of the benefit group are ineligible if the filing group contains no dependent child.

(b) A benefit group may regain EXT eligibility after becoming ineligible, even if eligibility was lost due to moving out of state, whenever the group again meets EXT eligibility requirements.

(c) Persons who have lost EXT eligibility because they leave the household during the EXT eligibility period may regain eligibility when they return to the household.

(5) For purposes of this rule, "good cause" means a circumstance beyond the reasonable control of the client.

(6) To be considered for EXT benefits in the seventh month, unless good cause exists, the filing group must report the following information by the 21st day of the fourth month for each of the preceding three months:

(a) The gross earned income of the financial group; and

(b) Costs for child care necessary for the employment of the caretaker relative.
(7) Unless good cause exists, to be considered for EXT benefits in the eighth through tenth months, all of the following requirements must be met:

(a) The filing group must have met the requirements of section (6) of this rule.

(b) By the 21st day of the seventh month, the filing group must report all of the following information for each of the preceding three months:

(A) The gross earned income of the financial group.

(B) Costs for child care necessary for the employment of the caretaker relative.

(c) The caretaker relative must have had earnings in each of the preceding three months of the EXT period.

(d) The average adjusted earned income of the financial group for the reporting period must be below 185% of the federal poverty level (see OAR 461-155-0175).

(8) Unless good cause exists, to be considered for EXT benefits in the eleventh and twelfth months, all of the following requirements must be met:

(a) The filing group must have met the requirements of section (7) of this rule.

(b) By the 21st day of the tenth month, the filing group must report all of the following information for each of the preceding three months:

(A) The gross earned income of the financial group.

(B) Costs for child care necessary for the employment of the caretaker relative.

(c) The caretaker relative must have had earnings in each of the preceding three months of the EXT period.

(d) The average adjusted earned income of the financial group for the reporting period must be below 185% of the federal poverty level (see OAR 461-155-0175).

Stat. Auth.: ORS 411.060, **414.042**
Stats. Implemented: ORS 411.060, **414.042**
Eligibility Period; EXT

(1) For a client who meets the eligibility requirements for EXT, the period of eligibility is one of the following:

(a) If eligibility for EXT results from increased child support, the period of eligibility is four months and may not be extended.

(b) If eligibility for EXT results from an increase in the caretaker relative's earnings:

(A) The period of eligibility is six twelve months.

(B) The period of eligibility may be extended for no more than six additional months if the filing group meets the specific EXT requirements in OAR 461-135-0095 and the earned income of the filing group is below the EXT income standard in OAR 461-155-0175.

(2) The period of eligibility for EXT is based on the increase in the caretaker relative's earnings and is described in subsection (1)(b) of this rule in each of the following situations:

(a) A client meets the eligibility requirements for EXT based on an increase in the caretaker relative's earnings and also meets the eligibility requirements based on an increase in child support in the same month.

(b) A client meets the eligibility requirements for EXT based on a combination of increased income from the caretaker relative's earnings and child support, although either increase by itself does not make the filing group ineligible for MAA or MAF.

(3) The EXT eligibility period begins the first of the month following the month eligibility for MAA or MAF ends. If a benefit group received MAA or MAF benefits when they were eligible for EXT, the MAA or MAF benefits are not an overpayment. However, any month in which the client receives MAA or MAF benefits when eligible for EXT is counted as a month of EXT eligibility.

Stat. Auth.: ORS 411.060, 414.042
Stats. Implemented: ORS 411.060, 414.042
Eligibility for Pickle Amendment Clients; OSIPM

(1) An individual is eligible for OSIPM under this rule and the so-called Pickle amendment (Pub. L. No. 94-566, § 503, title V, 90 Stat. 2685 (1976)), if he or she meets all other eligibility requirements, and:

(a) Is receiving Social Security Benefits (SSB);

(b) Was eligible for and receiving SSI or state supplements but became ineligible for those payments after April 1977; and

(c) Would be eligible for SSI or state supplement if the SSB COLA increases paid under section 215(i) of the Social Security Act, after the last month the individual was both eligible for and received SSI or a supplement and was entitled to SSB, were deducted from current SSB benefits.

(2) The SSB amount received by the individual when he or she became ineligible for SSI or OSIP is used as the individual's countable Social Security income, for the purposes of the Pickle Amendment. If the amount cannot be determined, it is calculated in accordance with sections (3) and (4) of this rule.

(3) Determine the month in which the individual was entitled to Social Security and received SSI in the same month. Use the table in section (4) of this rule to find the percentage that applies to that month. Multiply the present amount of the individual's Social Security benefits by the applicable percentage. This amount, rounded down to the next lower whole dollar, is the individual's countable Social Security for purposes of this rule and the Pickle Amendment. Add that figure to any other countable unearned income plus adjusted earned income of the individual, and if the total is less than the full SSI income standard for a single individual plus the $20 unearned income deduction (OAR 461-160-0550), the individual is eligible for OSIPM for purposes of this rule and the Pickle amendment. For spouses in the same financial group, perform the above calculation for each spouse, combine the results and add the subtotal to all other countable unearned and adjusted earned income. If the total is less than the full SSI standard for a couple plus the $20 unearned income deduction (OAR 461-160-0550), the couple is eligible for OSIPM for purposes of this rule and the Pickle amendment. All other financial and non-financial eligibility criteria must be met.

(4) The following guide contains the calculations used to determine the SSB for prior years:

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Stat. Auth.: ORS 411.060, 411.070
Stats. Implemented: ORS 411.060, 411.070
Limits on Estate Claims

(1) In the BCCM, GA, GAM, OHP, OSIP, OSIPM, and QMB programs:

(a) The Department has a priority claim against the property or any interest therein belonging to the estate of any deceased person as provided in ORS Chapters 411 and 414. The Estate Administration Unit of the Department (EAU) is authorized to present and file such claim against the estate. It will be treated as a preferred claim and filed in a like manner as the claims of other creditors.

(b) In determining the extent of the estate resources subject to the Department's claim, except as provided in subsection (c) of this section, the Department must disregard resources in an amount equal to the value of resources excluded in the most recent eligibility determination under OAR 461-160-0855, based on payments received under a qualified partnership policy (see OAR 461-001-0000). The disregard of resources specific to the estate recovery claim applies to Medicaid benefits received after the effective date of the Medicaid eligibility determination in which a qualified partnership policy was considered and approved. The amount of any Medicaid assistance incurred in a prior Medicaid eligibility period where qualified partnership policy benefits were not considered would not be subject to the estate resource disregard.

(c) There is no disregard of resources under subsection (b) of this section if the client, or the spouse of the client, at any time transferred the value of the qualified partnership policy excluded resource amount to another individual for less than fair market value prior to the death of the client or the client's surviving spouse, or exhausted the disregarded resource amount by purchasing things of value to the client or the client's surviving spouse while either was living.

(d) For recipients who died prior to October 1, 2008:

(A) If there is a surviving spouse, the Department shall have a claim against the estate of the surviving spouse for public assistance paid to the surviving spouse.

(B) In addition, the Department shall have a claim against the estate of the surviving spouse for public assistance paid to the pre-deceased spouse, but only to the extent that the surviving spouse received property or other assets from the pre-deceased spouse through any of the following:

(i) Probate.

(ii) Operation of law.

(C) If estate recovery is deferred until the surviving spouse dies, the fair market value of the property subject to the Department's claim is
determined based on the current value (see OAR 461-135-0832) of the property in the surviving spouse's estate.

(D) However, neither claim is enforceable until after the death of the surviving spouse (if any) and only when there is no surviving child under age 21 (see OAR 461-135-0832), no surviving blind child (see OAR 461-135-0832) of any age, and no surviving disabled child (see OAR 461-135-0832) of any age.

(e) For recipients a recipient who die died on or after October 1, 2008:

(A) If there is a surviving spouse, the Department shall have has a claim against the estate of the surviving spouse for public assistance paid to the surviving spouse.

(B) In addition, the Department shall have has a claim against the estate of the surviving spouse for public assistance paid to the pre-deceased spouse, but only to the extent that the surviving spouse received property or other assets from the pre-deceased spouse through any of the following:

(i) Probate.

(ii) Operation of law.

(iii) An interspousal transfer, including one facilitated by a court order, which occurs:

(I) Before, on, or after October 1, 2008; and

(II) No earlier than 60 months prior to the first date of request (see OAR 461-135-0832) established from the pre-deceased spouse's and the surviving spouse's applications, or at any time thereafter, whether approved, withdrawn, or denied, for the public assistance programs referenced in section (2) of this rule.

(C) If estate recovery is deferred until the surviving spouse dies, the fair market value of the property subject to the Department's claim is determined based on the current value of the property in the surviving spouse's estate.

(D) However, neither claim is enforceable until after the death of the surviving spouse (if any) and only when there is no surviving child under age 21, no surviving blind child of any age, and no surviving disabled child of any age.
The amount of the claim is as follows:

(a) Any payments made at any age under the General Assistance provisions of ORS Chapter 411, categorized as GA, are recoverable from the estate of any deceased recipient or the estate of the recipient's spouse. In the GA and GAM programs, the amount of the claim will not exceed the total amount of cash and medical benefits paid. The claim will include benefits provided under the Home and Community-Based Care Waiver program. This applies to all General Assistance programs, even those that are no longer active.

(b) In the BCCM, OSIP-AD, OSIP-OAA, OSIPM-AD, OSIPM-OAA, and QMB programs, the amount of the claim shall include all GA category benefits paid at any age and all Title XIX benefits provided after the recipient reached age 55, except any QMB program payment. If the recipient was permanently institutionalized (see OAR 461-135-0832), the claim shall include the total amount of all GA category benefits and Title XIX benefits paid at any age. This applies to all Old Age Assistance and Aid to the Disabled recipients, including those served by Home and Community-Based Care Waiver programs. It also includes recipients covered by programs that are no longer active.

(c) In the OHP, OSIP-AB, and OSIPM-AB programs, the claim shall include the total amount of GA category benefits paid at any age and all Title XIX benefits provided after the recipient reached age 55. If the recipient was permanently institutionalized, the claim shall include the total amount of GA category and Title XIX benefits paid at any age. The claim shall include benefits provided under the Home and Community-Based Care Waiver program.

(d) In the OSIP, OSIPM-AB, OSIPM-AD, and OSIPM-OAA programs, the amount of the claim shall also include the total amount of GA category and Title XIX benefits provided to recipients who were age 55 to 64 on the date the GA category and Title XIX benefits were provided if the benefits were provided after July 18, 1995. GA category and Title XIX benefits will be considered to have been provided to a recipient on the day of provision of medical services for which medical assistance payments are made.

(3) The priority for payment of claims against the estate will be as established under ORS 115.125.

(4) EAU may nominate a personal representative for an estate if the Department has a claim and it appears that no person with a higher preference, as established in ORS 113.085, is willing to be the representative.

(5) Property disposal will be in accordance with OAR 461-135-0838.

Specific Requirements; Reimbursement of Cost-Effective, Employer-Sponsored Health Insurance Premiums

Clients in the CEM, EXT, GAM, MAA, MAF, OHP (except OHP-CHP and OHP-OPU), OSIPM, and SAC programs are reimbursed for their share of the premiums for employer-sponsored health insurance if--

1. The insurance is provided through a member of the *household group* (see OAR 461-110-0210);

2. The insurance covers a member of the *benefit group* (see OAR 461-110-0750);

3. The insurance coverage is a comprehensive plan (that is, includes basic or major medical services) or is a fully capitated health plan (FCHP) or physicians care organization (PCO); and

4. The premium is cost-effective (see OAR 461-155-0360).

Stat. Auth.: ORS 411.060, 411.070, 414.042
Stats. Implemented: ORS 411.060, 411.070, 414.042
In addition to eligibility requirements applicable to the OHP program in other rules in chapter 461 of the Oregon Administrative Rules, this rule sets out specific eligibility requirements for the OHP program.

(1) For purposes of this rule and OAR 461-135-1149, the term **private major medical health insurance** refers to health insurance coverage that provides medical care for physician and hospital services, including major illnesses, with a limit of not less than $10,000 for each covered individual. This term does not include coverage under the Kaiser Child Health Program.

(2) To be eligible for OHP, a person cannot---

(a) Be receiving, or deemed to be receiving, SSI benefits;

(b) Be eligible for Medicare, except that this requirement does not apply to OHP-OPP;

(c) Be receiving Medicaid through another program; or

(d) Be enrolled in a health insurance plan subsidized by the Family Health Insurance Assistance program (FHIAP, see ORS 735.720 to 735.740).

(3) To be eligible for the OHP-OPU program, a person must be 19 years of age or older and must not be pregnant. A person eligible for OHP-OPU is referred to as a health plan new/noncategorical (HPN) client. In addition to all other OHP eligibility requirements, an HPN client---

(a) Must not be covered by **private major medical health insurance** and must not have been covered by **private major medical health insurance** during the six months preceding the effective date for starting medical benefits. The six-month waiting period is waived if---

(A) The person has a condition that, without treatment, would be life-threatening or would cause permanent loss of function or disability;

(B) The person's private health insurance premium was reimbursed under the provisions of OAR 461-135-0990;

(C) The person's private health insurance premium was subsidized through FHIAP; or

(D) A member of the person's filing group was a victim of domestic violence.
(b) Must meet the following eligibility requirements:

(A) The resource limit provided in OAR 461-160-0015.

(B) The higher education student requirements provided in OAR 461-135-1110.

(C) Payment of premiums determined in accordance with OAR 461-155-0235 and paid in accordance with OAR 461-135-1120.

(D) Selection of a medical, dental and mental health managed health care plan (MHCP) or primary care case manager (PCCM) if available, unless the HPN client is exempted by OAR 410-141-0060.

(E) The requirements in OAR 461-120-0345 related to obtaining medical coverage for members of the benefit group through the Family Health Insurance Assistance Program (FHIAP), if applicable.

(4) To be eligible for the OHP-OPC program, a person must be less than 19 years of age.

(5) To be eligible for the OHP-OP6 program, a child must be less than six years of age and not eligible for OHP-OPC.

(6) To be eligible for the OHP-OPP program, a person must be pregnant or must be a newborn assumed eligible under OAR 461-135-0010(4).

(7) To be eligible for the OHP-CHP program, a person must be under 19 years of age and must---

(a) Not be eligible for OHP-OPC, OHP-OPP, or OHP-OP6;

(b) Meet the resource limit provided in OAR 461-160-0015;

(c) Meet budgeting requirements of OAR 461-160-0700;

(d) Select a medical, dental and mental health managed health care plan (MHCP) or primary care case manager (PCCM) if available, unless the client is exempted by OAR 410-141-0060; and

(ed) Not be covered by private major medical health insurance or by any private major medical health insurance during the preceding six two months. The six-month two-month waiting period is waived if---
(A) The person has a condition that, without treatment, would be life-threatening or cause permanent loss of function or disability;

(B) The loss of health insurance was due to the loss of or a change in employment;

(C) The person's private health insurance premium was reimbursed under OAR 461-135-0990;

(CD) The person's private health insurance premium was subsidized by FHIAP; or

(DE) A member of the person's filing group was a victim of domestic violence.

(8) A child who becomes ineligible for OHP because of age while receiving in-patient medical services remains eligible until the end of the month in which he or she no longer receives those services if he or she is receiving in-patient medical services on the last day of the month in which the age requirement is no longer met.

Stat. Auth.: ORS 411.060, 414.042
Stats. Implemented: ORS 411.060, 414.042
The "OHP 7210R Application" is an application mailed as a result of the individual's selection from the OHP Standard Reservation List and is subject to the conditions of this rule.

The "OHP Standard Reservation List" means a list of individuals who may be considered for the OHP-OPU program as a new applicant at such times as the Department determines that new applicants may be added into the program. This list is used to manage enrollment of new applicants as defined by OAR 461-135-1102 into the program within the limits of program authority and funding.

An "OHP Standard Reservation List Applicant" means an individual who is eligible to apply for OHP-OPU under this rule and submits an OHP 7210R Application has been selected randomly under section (6) of this rule and establishes a date of request (see OAR 461-115-0030) within 45 days from the date the Department mails notification that the individual's reservation number has been selected randomly.

When the Department specifies that the OHP Standard Reservation List is open, an individual is placed on the OHP Standard Reservation List if all of the following requirements are met:

(a) The individual, or someone acting on behalf of the individual, may request placement on the OHP Standard Reservation List by calling the designated telephone number for the OHP Standard Reservation List or in writing. A written request must arrive through one of the following methods:

   (A) By mail to the designated mailing address for the OHP Standard Reservation List.
   (B) By fax or hand delivery to a local Department office that receives client applications for the Oregon Health Plan.
   (C) By electronic submission from the OHP website or by e-mail to the OHP Standard Reservation List e-mail address.

(b) The full name, date of birth, and mailing address of each individual requesting placement on the OHP Standard Reservation List must be provided to the Department and received by the Department as described in subsection (a) of this section before the request is considered complete.

(c) If the address of an individual changes after the individual makes a request, the individual must provide an updated address to the Department using a method described in subsection (a) of this section. If the individual reports an address change to the Department in a way other than that outlined in subsection (a) of
this section, the Department cannot guarantee the address change will be reflected in the reservation list, but will make reasonable efforts to incorporate that address change.

(54) The following procedures apply to the OHP Standard Reservation List:

(a) Individuals completing a request for placement on the OHP Standard Reservation List are assigned a reservation number. All members of an OHP filing group (see OAR 461-110-0400 for filing group composition) requesting placement on the OHP Standard Reservation List are assigned the same reservation number.

(b) The Department may request that individuals voluntarily provide their social security number (prior to the OHP 7210R Application). The Department may use the social security number for purposes of identification to help prevent duplicate reservations. The Department may not deny placement on the OHP Standard Reservation List because an individual does not provide a social security number.

(c) The Department sends confirmation to individuals who are placed on the OHP Standard Reservation List. If there is already a reservation established, individuals who have received confirmation from the Department need not make an additional request unless the reservation was removed (see section (8) of this rule), already used, or withdrawn.

(65) Requesting placement on the OHP Standard Reservation List, receiving a reservation number, or being placed on the OHP Standard Reservation List does not constitute an application for OHP-OPU or any other medical program administered by the Department. Individuals placed or refused placement on the OHP Standard Reservation List are not evaluated for DHS medical program eligibility.

(76) At such times that the Department determines that it has the requisite authority and funding and that new applicants can be added to the OHP-OPU program, and after the Department determines the number of new applicants that can be added, a designated number of individuals on the OHP Standard Reservation List will be randomly selected to be mailed an OHP 7210R Application according to the following conditions: randomly. Once an individual has been selected randomly, the reservation number assigned to that individual and its position on the list has been used and is no longer available.

(a) The Department will determine and designate the number of individuals on the OHP Standard Reservation List to receive the OHP 7210R Application. The Department will send an individual an OHP 7210R Application only if the reservation number is randomly selected to receive the application.

(b) The OHP 7210R Application must be received by the Department within 45 days from the date it is mailed for the individual to be considered an OHP Standard Reservation List Applicant.
(e) When an individual is mailed an OHP 7210R Application based on random selection from the OHP Standard Reservation List, the reservation number and its position on the list has been used and is no longer available.

(7) An OHP Standard Reservation List Applicant must file a Department application or amend a completed application (see OAR 461-115-0050) as a prerequisite of receiving OHP-OPU program benefits.

(8) When the Department determines that the OHP Standard Reservation List should be discontinued, all individuals currently on the list are removed except as provided in section (9) of this rule. If the Department reinstates the establishes a new OHP Standard Reservation List, the Department determines when an individual may again request placement on the list according to sections (3) and (4) and (5) of this rule.

(9) The Department may opt to use the reservation number of an individual not selected randomly from a discontinued list to create a new OHP Standard Reservation List. To be added to the new OHP Standard Reservation List, the Department may require each individual not selected randomly from the discontinued OHP Standard Reservation List to request placement on the new OHP Standard Reservation List and be assigned a new reservation number.

(10) Nothing in this rule prevents any individual from applying for medical assistance at any time. However, new applicants as defined in OAR 461-135-1102 for OHP-OPU are managed by this the OHP Standard Reservation List.

Stats. Implemented: ORS 409.010, 411.060, 414.042, 2009 Or. Laws ch. 867
THIS IS A NEW RULE

(1) "Continuous eligibility for non-CAWEM children" means a non-CAWEM child under 19 years of age the Department determines is eligible for Medicaid or OHP-CHP is deemed to be eligible for a total of 12 months regardless of any change in circumstances, other than --

(a) Moving out of state;

(b) Turning 19 years of age, however a pregnant individual who turns 19 years of age remains eligible for OHP-CHP through the last day of the month during which the pregnancy ends; or

(c) In the OHP-CHP program, receipt of private major medical health insurance.

(2) When a pregnant non-CAWEM child is eligible for and receiving OHP-CHP program benefits loses this eligibility, her medical assistance continues through the CEC program through the last day of the month in which the pregnancy ends as long as she is not a recipient of private major medical health insurance (see OAR 461-135-1100).

(3) To be eligible for the CEC program, a client must meet all of the following requirements:

(a) Be a U.S citizen or qualified non-citizen (see OAR 461-120-0125);

(b) Be under 20 years of age;

(c) Lose eligibility for OHP-CHP program medical benefits while pregnant; and

(d) Not be a recipient of private major medical health insurance.

(4) CEC program eligibility ends:

(a) The last day of the month in which the pregnancy ends;

(b) When the client moves out of state;

(c) When the client voluntarily ends OHP-CHP program benefits;

(d) When the client becomes a recipient of private major medical health insurance; or

(e) If the client becomes eligible for Child Welfare (CW) medical, EXT, MAA, MAF, OHP, OSIPM, or SAC program benefits.
(5) When a non-CAWEM child who is eligible for and receiving CW medical, EXT, MAA, MAF, OHP (except OHP-CHP), OSIPM, or SAC program benefits loses this eligibility with time remaining in the 12-month continuous eligibility period, the child's medical assistance continues for the remainder of the 12-month eligibility period through the CEM program.

(6) The CEM program eligibility period is based on the most recent CW medical, EXT, MAA, MAF, OHP (except OHP-CHP), OSIPM, or SAC program approval date. A child losing eligibility for CW medical, EXT, MAA, MAF, OHP (except OHP-CHP), OSIPM, or SAC program benefits less than 12 months after having been approved for benefits qualifies for CEM program benefits for the balance of the 12 month period following that approval.

(7) To be eligible for the CEM program, a client must meet all of the following requirements:

(a) Be a U.S citizen or a qualified non-citizen;

(b) Be eligible for and receiving CW medical, EXT, MAA, MAF, OHP (except OHP-CHP), OSIPM, or SAC program medical benefits;

(c) Be under 19 years of age; and

(d) Lose eligibility for CW medical, EXT, MAA, MAF, OHP (except OHP-CHP), OSIPM or SAC program medical benefits less than 12 months after having been approved for benefits, including approvals resulting from redeterminations.

(8) CEM program eligibility ends when the client --

(a) Becomes 19 years of age;

(b) Moves out of state;

(c) Voluntarily ends benefits; or

(d) Becomes eligible for CW medical, EXT, MAA, MAF, OHP, OSIPM, or SAC program benefits.

Stats. Implemented: ORS 409.050, 411.060, 411.070, 414.042, 2009 Or. Laws ch. 756
Senior Prescription Drug Assistance Program

THIS RULE IS REPEALED

(1) Program established. This rule establishes all the eligibility criteria for the Senior Prescription Drug Assistance Program (the program), created by ORS 414.342. The program becomes effective in accordance with the following schedule:


(b) Effective March 1, 2003 for applicants living in the following counties—Crook, Deschutes, Grant, Harney, Jefferson, Malheur, Morrow, Multnomah, and Umatilla.

(c) Effective April 1, 2003 for applicants living in the following counties—Coos, Curry, Lane, Marion, Polk, and Yamhill.

(d) Effective May 1, 2003 for applicants living in the following counties—Benton, Clackamas, Jackson, Josephine, Lincoln, and Linn.

(2) Eligibility Requirements. To be eligible for the program, a person must:

(a) Be a resident of Oregon.

(b) Have gross income not greater than 185% of the amount provided in OAR 461-155-0290 for a one-person need group. For purposes of this rule, income means income in cash or kind available to the applicant or recipient the receipt of which is regular and predictable enough to afford security in the sense that the applicant or recipient may rely upon it to contribute toward meeting the needs of the applicant or recipient.

(c) Be 65 years of age or older.

(d) Not be covered by any other public or private prescription drug benefit program and must not have been covered during the prior six months. "Any other public or private prescription drug benefit program" means a program that offers subsidized prescription drugs in which a portion of the cost is paid by the benefit program. The definition does not include a program that offers discounted drugs.

(e) Not have liquid resources with a total value of $2,000 or more. Residences and vehicles are not considered liquid resources.
(f) Pay a non-refundable enrollment fee of $50 to the Department and receive an enrollment card valid for twelve months.

(g) Apply for and be found eligible for the program annually.

(3) Eligibility and Procedures.

(a) Individual eligibility: An applicant’s eligibility is determined without regard to the potential eligibility or assets of another person.

(b) Applications: An applicant for the program must use the application form approved by the Department and must apply not earlier than 30 days prior to his or her 65th birthday. An applicant may, but is not required to, provide his or her social security number on the application.

(c) Enrollment card: The enrollment card issued to the enrollee is valid for 12 calendar months beginning the first month after the applicant has met all eligibility requirements. The card is not valid if the client no longer meets the requirements of section (2)(a) or (d) of this rule.

(4) Program Benefits: An eligible person (enrollee) may participate in the program in accordance with OAR 410-149-0000 and following.

(5) Appeals: The Department provides a contested case hearing to a person whose application for the program is denied.

Stat. Auth.: ORS 414.346
Stats. Implemented: ORS 414.342
461-135-1185
Low-Income Subsidy Program (LIS)

(1)——The Low-Income Subsidy (LIS) program (LIS) is a federal assistance program for Medicare clients who need extra help meeting their Medicare Part D prescription drug costs. The LIS program helps Medicare clients pay their monthly premium, deductible, and co-insurance costs under Part D. The LIS program is a means-tested program. All clients must qualify on the basis of household income, resources, and size as defined by the Social Security Administration.

(2)——LIS is not a part of the Senior Prescription Drug Assistance Program (OAR 461-135-1180, OAR Division 410-149, and ORS 414.340 to 414.348).

Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060
TA-DVS; Eligibility and Verification Requirements

In the TA-DVS program:

(1) Eligibility requirements are the same as for the TANF program, except as provided otherwise in OAR 461-135-1200 to 461-135-1235.

(2) The financial eligibility requirements are the same as for the TANF program except that:

(a) A TANF grant does not count as income.

(b) Income received during the budget month is not counted if the client does not have reasonable access to the money or cannot access the money independently of the abuser.

(c) Income received during the budget month is not counted if the client needs the money for expenses made necessary by a flight from abuse, for instance an expense for temporary lodging.

(d) There is no resource limit.

(e) The income limit is the applicable TANF Countable Income Limit Standard amount in OAR 461-155-0030, but uses net income instead of countable (see OAR 461-001-0000) income. For purposes of this subsection, net income means the income countable for TA-DVS minus income and FICA (Federal Insurance Contributions Act) taxes, and other mandatory payroll deductions.

(f) Other financial requirements may be waived in accordance with OAR 461-135-1200.

(g) SSI income is countable (see OAR 461-001-0000), if available in time to meet the emergent need (the immediate safety need) of the client.

(3) The non-financial requirements are the same as for the TANF program except that:

(a) Citizenship and alien status requirements (OAR 461-120-0110) are waived.

(b) The requirements to assign support and obtain assets (see OAR 461-120-0310 to 0350) are waived, but the Department will assist the client obtain support at the client's request.

(c) The requirement of regular school attendance (OAR 461-120-0530) is waived.

(d) The client is not required to participate in an employment program (see divisions 130 and 190 of this chapter of rules).
The TANF program requirement for a caretaker relative in the need group (see OAR 461-110-0630) to not have been separated from his or her most recent employment for a reason that would result in a denial of TANF program benefits under OAR 461-135-0070 is waived when there is risk of further or future domestic violence (see OAR 461-001-0000) against the need group.

Other non-financial requirements may be waived in accordance with OAR 461-135-1200.

Verification is required as in the TANF program except that no:

(a) No verification is required that the client is a victim of domestic violence (see OAR 461-001-0000) or needs to flee from abuse.

(b) If the individual has been arrested for or convicted of an act of domestic violence in the past and if it is uncertain whether the individual is a victim of domestic violence, the Department verifies that the individual is not or was not a perpetrator of domestic violence. A statement from a law enforcement officer, a district attorney, the court, a batterer intervention program, a victim's advocate, a Child Welfare staff person, a mental health provider, a health care or other medical provider, a member of the clergy, or other professional from whom the individual has requested assistance to address the alleged domestic violence indicating that the individual is not a perpetrator of domestic violence or is a self-defending victim is adequate verification. If no verification is available, the Department's central office DV Policy Analyst may assist field in determining what other verification is acceptable.

(c) Verification of other financial or non-financial eligibility factors is postponed if the delay in finding the client eligible would prevent the client from meeting an emergent need.
In the TA-DVS program:

(1) A client may receive benefits of the program for 90 days from the date the client was found eligible. A client may receive benefits simultaneously from the TA-DVS and TANF programs. A client may receive benefits under the TA-DVS program not to exceed $1,200 during the 90-day period of eligibility.

(2) Two 90-day eligibility periods may not overlap. Once a 90-day eligibility period has expired, the client may reapply for TA-DVS program benefits under section (4) of this rule.

(3) TA-DVS benefits address a specific crisis situation or episode of need related to the client's domestic violence (see OAR 461-001-0000) situation (such as securing new or temporary housing, payment of security deposit, first month's rent, moving expenses, furniture, and clothing replacement). TA-DVS benefits are not utilized to meet current ongoing or recurrent needs expected to continue beyond 90 days and are not used for the following items even if the client believes the item would contribute to the client's safety:

(a) Payment of attorney or other legal fees;

(b) Payment of a fine or other penalty;

(c) Payment of outstanding or past due costs such as rent or utilities when the client does not intend to stay in the residence or the need for the payment was not related to the current domestic violence situation;

(d) Payment of a pet fee (unless the pet is a service animal, and only when the service status has been verified by a medical or counseling professional);

(e) Payment for relocation of household or personal belongings from another state;

(f) Purchase of a car (including making car payments) or recreational vehicle, including a travel trailer;

(g) Purchase of a firearm or other weapon;

(h) Purchase of new furniture unless --

(A) The new furniture is not available through a community resource;

(B) A less costly alternative for acquiring the new furniture is not available;
(C) The old furniture was left behind when the client fled domestic violence; and

(D) The new furniture is essential to setting up a household (such as beds, dressers, a dining room table and chairs, a couch).

(i) Purchase of a non-essential item such as a television or computer, or service such as cable, satellite, internet, even if such an item or service was left behind when the client fled the domestic violence situation; or

(j) Purchase of a pet or guard animal.

(34) If a client submits an application meeting all eligibility criteria set forth in OAR 461-135-1215 and 461-135-1225 less than 12 months after the commencement ending of a 90-day period of eligibility in which the client received benefits under this program, that application must be jointly staffed and approved or denied by the Department's field and central offices.

(45) The client and the Department prepare a case plan that identifies activities necessary to enhance the client's safety. The case plan specifies the payments the Department makes to meet the client's needs for shelter and food and for relocation or other services that will enhance the client's safety.

(56) A client's available liquid resources may be considered when developing the case plan.

(67) A payment issued for an item in the client's case plan is issued as a dual-payee or vendor-pay check unless the use of a dual-payee or vendor-pay check is likely to put the client at risk of harm.

Stat. Auth.: ORS 411.060, 411.070, 412.049
Stats. Implemented: ORS 411.060, 411.070, 411.117, 412.049
461-145-0130
Earned Income; Treatment

(1) Earned income (see OAR 461-145-0120) is countable in determining eligibility for programs, subject to sections (2) to (9) of this rule.

(2) JOBS Plus income is earned income and is treated as follows:

(a) In the **FS SNAP** program:

   (A) JOBS Plus income earned by a TANF-PLS client:

      (i) Is counted in determining initial **FS SNAP** program eligibility.

      (ii) Is excluded in determining ongoing eligibility.

   (B) JOBS Plus wages received after the client's last month of work under a TANF-PLS JOBS Plus agreement are counted.

(b) In the TANF program:

   (A) JOBS Plus income earned by an NCP-PLS client is counted in determining initial TANF eligibility.

   (B) When determining the need for a TANF supplement for a TANF-PLS client, the income is treated as follows:

      (i) It is excluded in determining the countable income limit and in calculating the benefit equivalency standards.

      (ii) It is counted in calculating the wage supplement.

   (C) JOBS Plus wages received after the client's last month of work under a JOBS Plus agreement are counted.

(c) In all programs other than the **FS SNAP** and TANF programs, TANF-PLS income is counted.

(d) In all programs other than the TANF program, NCP-PLS income is counted as earned income.

(e) In all programs, client wages received under the Oregon Employment Department UI JOBS Plus or the Tribal TANF JOBS programs are counted as earned income.

(3) Welfare-to-Work work experience income is treated as follows:
(a) In the EXT, MAA, MAF, REF, REFM, and TANF programs, the income is earned income, and the first $260 is excluded each month.

(b) In the FS and OHP and SNAP programs, the income is earned income.

(4) In the ERDC and OHP programs, earned income of a child is excluded.

(5) In the EXT, MAA, MAF, REF, REFM, SAC, and TANF programs:

(a) Earned income of the following children is excluded:

(A) Dependent children under the age of 19 years, and minor parents under the age of 18 years, who are full-time students in grade 12 or below (or the equivalent level of vocational training, in GED courses), or in home schooling approved by the local school district.

(B) Dependent children under the age of 18 years who are attending school part-time (as defined by the institution) and are not employed full-time.

(C) Dependent children too young to be in school.

(b) Income remaining after the month of receipt is a resource.

(c) In-kind earned income is excluded (see OAR 461-145-0280 and 461-145-0470).

(6) In the FS SNAP program:

(a) If a cafeteria plan (see OAR 461-001-0000) benefit that the employee cannot elect to receive as a cash payment is designated and used to pay for child care, medical care, or health insurance, the benefit is excluded unless it is reimbursed by the Department or allowed as an earned income deduction.

(b) The following types of income are excluded:

(A) The earned income of an individual under the age of 18 years who is under the parental control of another member of the household and is:

(i) Attending elementary or high school;

(ii) Attending GED classes recognized by the local school district;

(iii) Completing home-school elementary or high school classes recognized by the local school district; or

(iv) Too young to attend elementary school.

(B) In-kind earned income, except as provided in section (7) of this rule.

(D) Income remaining after the month of receipt is a resource.

(7) In the FS and OHP and SNAP programs, earned in-kind income (see OAR 461-145-0280) is excluded unless it is an expenditure by a business entity that benefits a principal (see OAR 461-145-0088).

(8) In the MAA and MAF programs, earned income that would result in MAA or MAF ineligibility is excluded for a caretaker relative in an MAA or MAF filing group with at least one person eligible for and receiving MAA or MAF prior to meeting the three of six month requirement. (See OAR 461-135-0095.)

(9) In all programs except the EXT and FS SNAP programs, and for an OSIPM client in nonstandard living arrangement (see OAR 461-001-0000), the income of a temporary employee of the U.S. Census Bureau employed to assist in taking the census is excluded.

Stats. Implemented: ORS 411.060, 411.070, 411.700, 411.816, 412.014, 412.049, 414.042
(1) **A The** $250 economic recovery payment authorized by the American Recovery and Reinvestment Act of 2009 is excluded income in the month of receipt and an excluded resource in the month of receipt and for the following nine months.

(2) **In the GA, GAM, MAA, MAF, OHP, OSIPM, and QMB programs, a client qualifies for a $33 earned income exclusion per month.**

Stats. Implemented: ORS 411.060, 411.070, 411.700, 411.816, 412.049, 414.042
(1) **Home defined:** A home is the place where the filing group lives. A home may be a house, boat, trailer, mobile home, or other habitation. A home also includes the following:

(a) Land on which the home is built and contiguous property.

(A) In all programs except FS, the GA, GAM, OSIP, OSIPM, and QMB, and SNAP programs property must meet all the following criteria to be considered contiguous property:

(i) It must not be separated from the land on which the home is built by land owned by people outside the financial group (see OAR 461-110-0530).

(ii) It must not be separated by a public right-of-way, such as a road.

(iii) It must be property that cannot be sold separately from the home.

(B) In the FS, GA, GAM, OSIP, OSIPM, and QMB, and SNAP programs, contiguous property is property not separated from the land on which the home is built by land owned by people outside the financial group.

(b) Other dwellings on the land surrounding the home that cannot be sold separately from the home.

(2) **Exclusion of home and other property:**

(a) For a client who has an *initial month* (see OAR 461-001-0000) of long-term care or waivered services on or after January 1, 2006:

(A) For purposes of this subsection:

(i) The definition of "child" in OAR 461-001-0000 does not apply.

(ii) "Child" means a biological or adoptive child who is:

(I) Under age 21; or

(II) Any age and meets the Social Security Administration criteria for blindness or disability.
(B) The equity value of a home is excluded if one of the client or the spouse of the client occupies the home and the equity in the home is $500,000 or less: following requirements is met:

(i) The equity in the home is $500,000 or less and one of the following:

(I) The client occupies the home.

(II) The spouse of the client occupies the home.

(III) The child of the client occupies the home.

(IV) The home equity is excluded under OAR 461-145-0250.

(V) The home is listed for sale per OAR 461-145-0420.

(ii) The equity in the home is more than $500,000 and one of the following:

(C) The home is countable as a resource if the client has equity in the home of more than $500,000, unless one of the following requirements is met:

(i) (I) The spouse of the client occupies the home.

(ii) (II) The child of the client occupies the home.

(iii) (III) Notwithstanding OAR 461-120-0330, the client is legally unable to convert the equity value in the home to cash.

(iv) The home equity is excluded under OAR 461-145-0250.

(b) For all other filing groups, the value of a home is excluded when the home is occupied by any member of the filing group.

(c) In the Food Stamp SNAP program only, the value of land is excluded while the group is building or planning to build their home on it, except that if the group owns (or is buying) the home they live in and has separate land they intend to build on, only the home in which they live is excluded, and the land they intend to build on is treated as real property in accordance with OAR 461-145-0420.

(3) Exclusion during temporary absence: If the value of a home is excluded under section (2) of this rule, the value of this home remains excluded in each of the following situations:
(a) In all programs except the GA, GAM, OSIP, OSIPM, and QMB programs, during the temporary absence of all members of the filing group from the property, if the absence is due to illness or uninhabitability (from casualty or natural disaster), and the filing group intends to return home.

(b) In the Food Stamp SNAP program, when the financial group is absent because of employment or training for future employment.

(c) In the GA, GAM, OSIP, OSIPM, and QMB programs, when the client is absent to receive care in a medical institution, if one of the following is true:

(A) The absent client has provided evidence that he or she will return to the home. The evidence must reflect the subjective intent of the client, regardless of the client's medical condition. A written statement from a competent client is sufficient to prove the intent.

(B) The home remains occupied by the client's spouse, child, or a relative dependent on the client for support. The child must be less than 21 years of age or, if over the age of 21, blind or an individual with a disability as defined by SSA criteria.

(d) In the MAA, MAF, REF, REF M, SAC, and TANF programs, when all members of the filing group are absent because:

(A) The members are employed in seasonal employment and intend to return to the home when the employment ends; or

(B) The members are searching for employment, and the search requires the members to relocate away from their home. If all members of the filing group are absent for this reason, the home may be excluded for up to six months from the date the last member of the filing group leaves the home to search for employment. After the six months, if a member of the filing group does not return, the home is no longer excluded.

Stats. Implemented: ORS 411.060, 411.070, 411.816, 412.049, 414.042, 418.100
Indian (Native American) Benefits

(1) The following Indian (Native American) benefits are excluded:

(a) Indian lands held jointly with the tribe, or land that cannot be sold without the approval of the Bureau of Indian Affairs (BIA).

(b) Payments to Puyallup Tribe members from the trust funds established under Public Law 101-41.

(c) Payments from the Confederated Tribes of the Colville Reservation Grand Coulee Dam Settlement Act (Public Law 103-436).

(2) Payments from the Bureau of Indian Affairs BIA are treated as follows:

(a) In the FS SNAP program, payments from the General Assistance program are counted as unearned income.

(b) In all programs except the FS SNAP program, payments from the General Assistance program are excluded.

(c) The treatment of educational income is covered by OAR 461-145-0150.

(3) In the GA and GAM programs, Indian benefits described in sections (4) to (12) of this rule are counted as periodic or lump-sum income (see OAR 461-140-0110 and 461-140-0120), unless the client verifies that such benefits are excluded by the public law for state-funded programs.

(4) In all programs except the GA and GAM programs, payments under Public Law 92-203 (Alaska Native Claim Settlement Act) are treated as follows:

(a) In the FS SNAP program, the entire payment is excluded.

(b) In all programs except FS, the GA, and GAM, and SNAP programs:

(A) Only the tax-exempt portion of the payment is excluded.

(B) The remainder of the payment is counted as unearned income.

(5) In all programs except the GA and GAM programs, the following types of distributions provided under Public Law 100-241 (Alaska Native Claim Settlement Act) are excluded:

(a) Stock.

(b) A partnership interest.
(c) Land or interest in land.

(d) An interest in a settlement trust.

(e) The first $2,000 of each per-capita payment per year for each member of the financial group (see OAR 461-110-0530) who receives the payment. The amount over $2,000 paid to each member of the financial group who receives the per-capita payment is counted as lump-sum income (see OAR 461-140-0120).

(6) In all programs except the GA and GAM programs, the Department excludes Indian benefit payments when federal law requires an exclusion. These include payments under each of the following federal laws:

(a) The Aroostook Band of Micmacs under Public Law 102-171.

(b) Blackfeet, Cherokee, Cheyenne, Chippewa, and Sioux tribes under Public Law 94-114, when the payment is from submarginal land held in trust by the United States.

(c) Blackfeet Indians under Public Law 92-254.

(d) Grand River Ottawa Indians under Public Law 94-540.

(e) Hopi or Navajo Indians under Public Law 93-531.

(f) Passamaquoddy Tribe and Penobscott Nation, including the Holton Band of Maliseet Indians, under the Indian Claims Settlement Act (Public Law 96-420).

(g) Umpqua Tribe Cow Creek Band under Public Law 100-139.

(h) Yakima Nation Confederated Tribes and Bands of the Mescalero Reservation Apache Tribe under Public Law 95-433.

(7) In all programs except the GA and GAM programs, payments received from trust or restricted lands under Public Law 93-134, Public Law 97-458, and Public Law 103-66 are excluded.

(8) In all programs except the GA and GAM programs, payments to Seminole Tribe members under Public Law 101-277 are treated as follows:

(a) The first $2,000 of each per-capita payment per year is excluded for each member of the financial group who receives the payment.

(b) The amount over $2,000 paid to each member of the financial group who receives the per-capita payment is counted as lump-sum income (see OAR 461-140-0120).
In all programs except the GA and GAM programs, payments from the distribution of
distribution of 
judgment funds to members of the Confederated Tribes of the Umatilla under Public Law
91-259 are treated as follows:

(a) The first $2,000 of each per-capita payment per year is excluded for each member of
the financial group who receives the payment.

(b) The amount over $2,000 paid to each member of the financial group who receives
the per-capita payment is counted as lump-sum income (see OAR 461-140-0120).

In all programs except the GA and GAM programs, payments for assets held in trust to
the Sac and Fox Tribe of Oklahoma and Sac and Fox Tribe of the Mississippi in Iowa by
the Indian Claims Commission under Public Law 94-189, Section 6 (The Sac and Fox
Indian Claims Agreement) are treated as follows:

(a) The first $2,000 of each per-capita payment per year is excluded for each member of
the financial group who receives the payment.

(b) The amount over $2,000 paid to each member of the financial group who receives
the per-capita payment is counted as lump-sum income (see OAR 461-140-0120).

In all programs except the GA and GAM programs, payments from judgment funds held
in trust by the U.S. Secretary of the Interior under Public Law 98-64 are excluded.

In all programs except the GA and GAM programs, Indian Child Welfare payments
under Public Law 95-608 are excluded.

Tribal payments for child care are treated as follows:

(a) Provider-direct payments are counted as the provider's earned income.

(b) All client-direct payments are excluded.

In each program, any Indian benefit payments distributed by the tribe and not excluded
for that program by public law are counted as unearned income.

Payments in the tribal-TANF program are counted in the same manner as TANF program
payments under OAR 461-145-0410.

In the GA, GAM, OSIP, OSIPM, and QMB programs, Individual Indian Money
(IIM) accounts are treated as follows:

(a) For a restricted account:
(A) A deposit required by the BIA is excluded as income and as a resource.

(B) A deposit not required by the BIA is counted or excluded as income in accordance with this chapter of rules based on the source of the deposit. The deposit is excluded as a resource.

(C) A withdrawal is treated in accordance with this chapter of rules based on the source of the funds withdrawn. When funds in the account include both excluded and non-excluded funds, the Department presumes that the non-excluded funds are withdrawn first.

(b) For an unrestricted account: Deposits and withdrawals are treated in accordance with this chapter of rules based on the source of the deposit or withdrawal. When funds in the account include both excluded and non-excluded funds, the Department presumes that the non-excluded funds are withdrawn first.

Stats. Implemented: ORS 411.060, 411.700, 411.816, 412.049, 414.042, 418.100
Plan for Self-support

(1) This rule covers two types of plans for self support.

(a) A plan for self support approved by the Social Security Administration.

(b) A plan for self support approved by the Department (see OAR 461-135-0708).

(2) Assets listed in an approved plan for self-support are treated as follows: excluded.

(a) In the Food Stamp program, assets designated for use in an approved plan for self-support are excluded.

(b) In all programs except FS, if assets are identified to meet a specific cost directly related to the occupational goal:

(A) Resources identified to meet costs, such as purchase of equipment for a trade or business, transportation, books and maintenance costs at school, are excluded.

(B) An income deduction is allowed for the amount identified to meet allowable costs necessary for complying with the plan for self support, including:

(i) Room and board, and other maintenance requirements, if the client must be away from home; and

(ii) Above-normal expenses, if the client remains at home but must buy meals or incur other known expenses while away from home during the day.

Stat. Auth.: ORS 411.060, 411.816, 418.100 412.049
Stats. Implemented: ORS 411.060, 411.816, 418.100 412.049
For a sponsored noncitizen:

(1) Deemed assets are the portion of the income and resources of an individual not in the financial group financial group (see OAR 461-110-0530) used to determine eligibility and benefit level for a financial group sponsored noncitizen who is a member of the financial group.

(2) To be eligible for benefits, clients sponsored noncitizen must provide necessary information about all people each individual whose assets are deemed to any the sponsored noncitizen who is a member of the financial group financial group.

(3) To determine countable assets for deeming, use the policy for the program for which the financial group financial group is applying for.

Stats. Implemented: ORS 411.060, 411.816, 412.006, 412.049
461-145-0930
Self-Employment; Determination of Countable Income

(1) The Department initially determines gross sales and receipts minus any returns and allowances (before excluding or deducting any costs). This rule explains how different programs exclude and deduct costs from self-employment gross sales and receipts.

(2) In the ERDC program, if a client claims an excludable cost permitted under OAR 461-145-0920, at least 50 percent of gross self-employment income is excluded. The maximum exclusion is the total excludable cost under OAR 461-145-0920.

(3) In the Food Stamp program, if there are any costs permitted under OAR 461-145-0920, there is a deduction of 50 percent of gross self-employment income.

(4) In the GA, MAF, OSIP, OSIPM, and QMB programs, all costs permitted under OAR 461-145-0920 are excluded.

(5) In the MAA and TANF programs:

   (a) For a client participating in the microenterprise component of the JOBS program, costs are excluded according to OAR 461-145-0920 and general accounting principles, as applied by a certified public accountant, bookkeeping firm, or other entity approved by the Department.

   (b) For all other clients, no costs are subtracted (excluded).

(6) In the OHP program, at least 50 percent of gross self-employment income is excluded. The maximum exclusion is the gross self-employment income for the month that the exclusion is taken.

(7) In the REF program, no costs are excluded.

(7) In the SNAP program, if there are any costs permitted under OAR 461-145-0920, there is a deduction of 50 percent of gross self-employment income.

Stat. Auth.: ORS 411.060, 411.816, 418.040, 418.100 412.006, 412.049
Stats. Implemented: ORS 411.060, 411.816, 418.040, 418.100 412.006, 412.049
In the OHP program:

(1) The *budget month* (see OAR 461-001-0000) is:

(a) For a new applicant, the month of application.

(b) For a client reapplying in the last month of an OHP *certification period* (see OAR 461-001-0000), no longer eligible for his or her current OHP program, or moving from the BCCM, EXT, GAM, MAA, MAF, OSIPM, REFM, or SAC programs to the OHP program, the last month of the current *eligibility* (see OAR 461-001-0000) period.

(c) For an individual joining a *filing group* (see OAR 461-110-0400), the month in which the individual requests medical benefits.

(d) For a late reapplication, the month the Department receives the new application.

(e) For a new applicant or current recipient who is not eligible using the *budget month* described in subsections (1)(a) to (1)(d) of this rule, any month falling within 45 days after the date of request.

(2) *Countable* (see OAR 461-001-0000) income is determined as follows:

(a) Income is considered available during a month under OAR 461-140-0040.

(b) Income is not annualized, converted, or prorated.

(c) For a self-employed client, *countable* self-employment income is determined under OAR 461-145-0920 and 461-145-0930.

(3) The average *countable* income of the *financial group* (see OAR 461-110-0530) is calculated as follows:

(a) The income of the *financial group* from the three months preceding *month prior to the budget month* and the actual income already received in the *budget month* plus income that reasonably may be expected to be received in the budget month is added.

(b) The total is divided by *three two*, and the result is the average *countable* income assigned to the budget month of the *financial group*.

(c) The average *countable* income of the *financial group* is used to determine *eligibility* for OHP under OAR 461-160-0700.
(4)  A change in income or resources during a certification period (see OAR 461-001-0000) does not affect the eligibility of the benefit group (see OAR 461-110-0750) for that certification period.

Stat. Auth.: ORS 411.060, 414.042
Stats. Implemented: ORS 411.060, 411.700, 414.042
461-155-0175
Income Standard; EXT

THIS RULE IS REPEALED

(1) For the first seven months of EXT eligibility, there is no income limit.

(2) To continue EXT eligibility after the first seven months, the average adjusted earned income of the financial group must be below 185 percent of the federal poverty level as described in OAR 461-155-0180, using income from:

   (a) The second three months of the EXT period to continue eligibility for the eighth through tenth months.

   (b) The third three months of the EXT period to continue eligibility for the eleventh and twelfth months.

Stat. Auth.: ORS 411.060, 411.070
Stats. Implemented: ORS 411.060, 411.070
In the OHP program:

(a) If a financial group (see OAR 461-110-0530) contains a person with significant authority in a business entity—a "principal" as defined in OAR 461-145-0088—the group is ineligible if the gross income assigned to the budget month (see OAR 461-001-0000) of the business entity exceeds $10,000. If the need group (see OAR 461-110-0630) is not ineligible under this section, its eligibility is evaluated under subsection (b) of this section.

(b) The countable income standards are as follows:

(A) The countable income standard for OHP-OPC and OHP-OPU is 100 percent of the federal poverty level, as listed in OAR 461-155-0180(2), based on the size of the need group.

(B) The countable income standard for OHP-OP6 is 133 percent of the federal poverty level, as listed in OAR 461-155-0180(3), based on the size of the need group.

(C) The countable income standard for OHP-OPP and OHP-CHP is 185 percent of the federal poverty level, as listed in OAR 461-155-0180(5), based on the size of the need group.

(D) The countable income standard for OHP-CHP is below 201 percent of the federal poverty level, as listed in OAR 461-155-0180(7), based on the size of the need group.

In the REFM program, the income standard is 200 percent of the federal poverty level, as listed in OAR 461-155-0180(6), based on the size of the need group.
Income and Payment Standard; OSIP, OSIPM

(1) For an OSIP (except OSIP-EPD) or OSIPM (except OSIPM-EPD) client in long-term care or in a waivered nonstandard living arrangement (see OAR 461-001-0000), the countable income limit standard is 300 percent of the full SSI standard for a single individual. Other OSIP and OSIPM clients do not have a countable income limit. A client who is assumed eligible per OAR 461-135-0010(7) is presumed to meet the income limits for the OSIPM program.

(2) A client in a nonstandard living arrangement (see OAR 461-001-0000) must have countable income that is equal to or less than 300 percent of the full SSI standard for a single individual (except OSIPM-EPD).

(3) The non-SSI OSIP and OSIPM (except OSIP-EPD and OSIPM-EPD) adjusted income standard takes into consideration the need for shelter (housing and utilities), food, and other items. The standard is itemized as follows:

<table>
<thead>
<tr>
<th>Non-SSI OSIP and OSIPM Standards</th>
<th>Items of Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjusted No. in Household</td>
<td>One Person in Need Group</td>
</tr>
<tr>
<td>Shelter</td>
<td>415.00</td>
</tr>
<tr>
<td>Food</td>
<td>163.70</td>
</tr>
<tr>
<td>Other</td>
<td>97.00</td>
</tr>
</tbody>
</table>

(4) The standard in this section is used as the adjusted income limit for non-SSI OSIP (except OSIP-EPD) and OSIPM (except OSIPM-EPD) clients. The OSIP-AB and OSIPM-AB adjusted income standard includes a transportation allowance. See OAR 461-155-0020 for the adjusted number in the household. The total standard is: A client, other than one identified in section (1), (2), or (6) of this rule, must have adjusted income below the standard in this section. The Department determines the adjusted number in the household under OAR 461-155-0020.
To be eligible for OSIP (except OSIP-EPD or OSIP-IC), a person must be receiving SSI or be eligible for an ongoing special need. The payment standard for SSI/OSIP clients living in the community is the SIP (supplemental income payment) amount. The SIP is a need amount added to any other special or service needs to determine the actual payment. In some cases, the need amount is zero.

(a) For clients whose unearned income minus any SSI or Veterans Nonservice-Connected Disability Benefits is less than $20:

<table>
<thead>
<tr>
<th>No. in Need Group</th>
<th>AD/OAA SIP (need)</th>
<th>AB SIP (need)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1.70</td>
<td>26.70</td>
</tr>
<tr>
<td>2</td>
<td>0.00</td>
<td>25.60</td>
</tr>
</tbody>
</table>

(b) For clients whose unearned income minus any SSI or Veterans Nonservice-Connected Disability Benefits is $20 or more:

<table>
<thead>
<tr>
<th>No. in Need Group</th>
<th>AD/OAA SIP (need)</th>
<th>AB SIP (need)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.00</td>
<td>18.70</td>
</tr>
<tr>
<td>2</td>
<td>0.00</td>
<td>17.60</td>
</tr>
</tbody>
</table>

(c) The SSI OSIP-AB standard includes a transportation allowance. The standard for two assumes one individual is blind and the other is not. If both are blind, $20 is added to the SIP amount.

(d) For spouses who each receive SSI and receive services in an AFC, ALF or RCF, an amount is added to each person's SIP payment that equals the difference.
between the individual's income (including SSI and other income) and the OSIP standard for a one-person need group.

(e) When one or both spouses receive SSI and are not included in subsection (d) of this section, the two-person need group is used to determine the SIP amount. This amount is used even if one (or both) of the individuals is receiving services and has a need group of one according to OAR 461-110-0630.

(5) In the OSIP and OSIPM programs program, individuals in a nursing facility or an ICF-MR are allowed the following amounts for clothing and personal incidentals:

(a) For clients who receive a VA pension based on unreimbursed medical expenses (UME), $90 is allowed.

(b) For all other clients, $30 is allowed.

(6) In the OSIP-EPD and OSIPM-EPD programs program, the adjusted earned income limit is 250 percent of the federal poverty level for a family of one.

Cost-Effective Health Insurance

(1) This rule applies to the following medical assistance programs: CEM, EXT, GAM, MAA, MAF, OHP (except OHP-CHP and OHP-OPU), OSIPM, and SAC. This rule explains how to determine whether an employer-sponsored health insurance plan is cost effective for the purpose of applying OAR 461-120-0345.

(2) The first step in making the determination of cost effectiveness is to determine the number of people in the household group who are in a benefit group of any of the programs listed in section (1) of this rule.

(3) Based on the number determined in section (2) of this rule, the maximum cost-effective premium is determined from the following tables:

<table>
<thead>
<tr>
<th>CEM/EXT/GAM/MAA/MAF/OHP-OPC, OHP-OP6, OHP-OPP/SAC</th>
<th>Cost-effective premium amount (Employee cost)</th>
</tr>
</thead>
<tbody>
<tr>
<td># in Benefit Group covered by insurance</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>$  82</td>
</tr>
<tr>
<td>2</td>
<td>$164</td>
</tr>
<tr>
<td>3</td>
<td>$246</td>
</tr>
<tr>
<td>4</td>
<td>$328</td>
</tr>
<tr>
<td>5</td>
<td>$410</td>
</tr>
<tr>
<td>6</td>
<td>$492</td>
</tr>
<tr>
<td>7</td>
<td>$574</td>
</tr>
<tr>
<td>8</td>
<td>$656</td>
</tr>
<tr>
<td>9+</td>
<td>$738</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OSIPM-AB</th>
<th>Cost-effective premium amount (Employee cost)</th>
</tr>
</thead>
<tbody>
<tr>
<td># in Benefit Group covered by insurance</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>$145</td>
</tr>
<tr>
<td>2</td>
<td>$289</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OSIPM-AD</th>
<th>Cost-effective premium amount (Employee cost)</th>
</tr>
</thead>
<tbody>
<tr>
<td># in Benefit Group covered by insurance</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>$167</td>
</tr>
<tr>
<td>2</td>
<td>$334</td>
</tr>
</tbody>
</table>
OSIPM-OAA

<table>
<thead>
<tr>
<th># in Benefit Group covered by insurance</th>
<th>Cost-effective premium amount (Employee cost)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$147</td>
</tr>
<tr>
<td>2</td>
<td>$294</td>
</tr>
</tbody>
</table>

(4) The insurance is cost effective if the employee's share of the premium is equal to or less than the amount determined in section (3) of this rule.

(5) If the health-insurance plan is cost effective, the Department will reimburse the actual amount of the premium, not to exceed the amount determined in section (3) of this rule.

Stat. Auth.: ORS 411.060, 414.042
Stats. Implemented: ORS 411.060, 414.042
Special Need; Food for Guide Dogs and Special Assistance Animals

(1) For an OSIP and or OSIPM clients who are program client receiving SSI, having an adjusted income less than the OSIPM program standard under OAR 461-155-0250, or receiving waivered services, a food allowance is allowed for guide dogs and special assistance animals that are individually trained to --

(a) Meet the client's specific medical needs by performing tasks, such as alerting and protecting a client who is having a seizure; or

(b) Perform specific physical tasks that the client is unable to do, such as picking up items that are dropped, turning on light switches, and pulling a wheelchair.

(2) The maximum amount to be authorized the Department authorizes for this special need is established yearly, based on average costs incurred by Schools for Guide Dogs $50 per month.

(3) Authorization of this special need must be based on a proven medical need to sustain the client's independence.

Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060, 411.706
Special Need; Laundry Allowances

(1) OSIP and OSIPM clients who are receiving SSI or waivered services or have adjusted income less than the OSIPM program income standard under OAR 461-155-0250, and GA and GAM clients, are eligible for a laundry allowance if they have proven, excessive, coin-operated laundry facility costs and do not:

(a) Have their own laundry facilities; OR
(b) Reside in nursing facilities, Residential Care Facilities, Adult Foster Homes, Specialized Living Facilities, unless the Specialized Living Facility is apartment based, or Assisted Living Facilities, an adult foster care home, assisted living facility, nursing facility, residential care facility, or specialized living facility, unless the specialized living facility is apartment based.

(2) This allowance will may not exceed an the amount required to wash and dry the laundry.

Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060, 411.706
In the OSIPM program:

(1) A client is considered living in a community based facility care facility (see OAR 461-001-0000) if the client resides at one of the following care settings licensed by the Department:

(a) Adult Foster Care.
(b) Residential Care.
(c) Assisted Living.
(d) Specialized Living.
(e) Group Care Home.

(2) In determining eligibility for OSIPM for an individual not covered by a home and community based care community based care waiver, the special need (see OAR 461-155-0010) is the amount of the service payment authorized by the Department and is added to the OSIP maintenance standard.

(3) If a client who meets the applicable income requirements begins living in a community based facility care facility:

(a) Payment for room and board may be authorized during the month of admission at the initial placement, limited to the approved rate.
(b) Room and board payments may be paid to the community based facility care facility during the temporary absence of a client if all of the following criteria are met:

(A) The absence occurs because the client is admitted to a hospital or nursing home.
(B) The Department determines the intent of the client to return to the community based facility care facility.
(C) The community based facility care facility is willing to accept the room and board payment.
(D) The client returns one month following the month in which the absence began.
(4) Spouses who each receive SSI and receive services in a *community based care* facility, are eligible for a payment in the amount that equals the difference between the OSIPM standard for a one-person need group and the individual's total countable income. If one spouse has income above the OSIPM standard, the excess income is applied to the other spouse's countable income.

Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060
461-155-0640
Special Need; Restaurant Meals

(1) To receive the restaurant meals special need payment, OSIP and OSIPM clients who are receiving SSI or waivered services or have adjusted income less than the OSIPM program income standard under OAR 461-155-0250, and GA and GAM clients, must have proven medical and nutritional needs that cannot be met with meals purchased with food stamps SNAP program benefits.

(2) Clients A client living in their his or her own home who are is unable to prepare their his or her own meals, but are is eligible for ES SNAP program benefits, may have their his or her meals prepared by attendants that volunteer or are compensated by the Seniors and People with Disabilities Division In-Home Services program. Clients may A client also may receive, if eligible, Meals on Wheels services to supplement their his or her diet.

(3) The payment standard for restaurant meals is $60 per month.

Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060, 411.706
Special Need; Accommodation Allowance

(1) An OSIP and or OSIPM clients program client living in a nursing facility are is not eligible for an accommodation allowance. An OSIP and or OSIPM clients program client living in a nonstandard living arrangement (see OAR 461-001-0000) are is not eligible for an accommodation allowance unless they are he or she is receiving, or are is eligible to receive after a temporary absence, in-home waivered services. An OSIP and or OSIPM clients who are program client receiving SSI or having an adjusted income less than the OSIPM program income standard (except those a client in a nursing facility) or are eligible to receive or are receiving in-home waivered services are is allowed an accommodation allowance if the client meets the criteria in section (2) or (3) of this rule.

(2) Temporary absence of client from home.

(a) A temporary accommodation allowance may be authorized, where when permitted under section (1) of this rule, if a client meets the following criteria:

(A) The client leaves his or her home or rental property and enters an adult foster care facility, assisted living facility, group care home, hospital, nursing facility, residential care facility, specialized living facility, or state psychiatric institution, or an adult foster care facility, assisted living facility, residential care facility, group care home, or specialized living facility;

(B) The client cannot afford to keep the home without the allowance;

(C) The client will be able to return home within six months of leaving, according to a written statement from a primary practitioner, RN, or PAS (pre-admission screening) RN; and

(D) The home will accommodate the service plan of the client when the client returns.

(b) The allowance may be authorized for six months. If, after six months, the client continues to meet the criteria in subsection (a) of this section, an extension may be approved in writing by a supervisor.

(c) The accommodation allowance equals the total of the client's housing cost, including taxes and insurance, plus the limited standard utility allowance for the Food Stamp SNAP program provided in OAR 461-160-0420.

(3) Additional cost for accommodation. A client receiving SSI benefits (except those in a nursing facility) or in home waivered services meeting the criteria in section (1) of this rule may receive an accommodation allowance if the client's shelter cost exceeds the
shelter standard in OAR 461-155-0250(2) and the requirements of one of the following subsections are met:

(a) The client has a documented increase in rent associated with access by a person with a disability; or

(b) The client has been assessed to need a live-in provider, has accepted the services of a live-in provider, and requires an additional bedroom for the live-in provider.

(4) The accommodation allowance is determined as follows:

(a) For a client who receives an accommodation allowance based on increased costs associated with access by a person with a disability, only the additional increase in cost for the accommodation is allowed.

(b) For a client who receives an accommodation allowance based on the need for an additional bedroom for a live-in provider, the amount of the accommodation allowance is the limited standard utility allowance for the FS SNAP program under OAR 461-160-0420 plus --

(A) One-third of the monthly rental cost; or

(B) One-third of the monthly payment on the property agreement (including mortgage, trust deed, or land sale contract). The property agreement is the agreement existing at the time the client is approved for the accommodation allowance. The accommodation allowance for the housing portion ends if the debt is refinanced, unless the refinancing was done only to reduce the original property agreement's interest rate or total monthly payment amount and the owner realized no direct or indirect payment of the home's equity value from the refinancing.

(i) If the refinancing requirement under this paragraph is met, the amount of the accommodation allowance is one-third of the refinanced property agreement amount plus the limited standard utility allowance under OAR 461-160-0420.

(ii) If the refinancing requirement under this paragraph is not met and the housing portion of the accommodation allowance ends, the client remains eligible only for the limited standard utility allowance portion under OAR 461-160-0420.

(5) Special requirements.

(a) A client who rents and qualifies for an allowance under section (3) of this rule must take the steps necessary to obtain subsidized housing under any federal or state housing program. A client who fails, at any time, to take the steps necessary
to obtain subsidized housing reasonably available is ineligible for the allowance. A client, who has been denied or revoked from participation in any rent subsidy program based on the client's own actions is ineligible for benefits under this rule.

(b) A client who rents housing and refuses subsidized housing will no longer be eligible for an accommodation allowance, except that if the housing that is offered is not suitable, related to accommodations, and the client continues to have increased costs related to accommodations in the client's current living situation, the accommodation allowance may continue until such time as appropriate subsidized housing is found.

Stat. Auth.: ORS 411.060, 411.070, 414.042
Stats. Implemented: ORS 411.060, 411.070, 411.706, 414.042
Special Need; Special Diet Allowance

(1) In the EXT, GA, GAM, MAA, MAF, OSIP, OSIPM, REF, REFM, SAC, SFPSS, and TANF programs, clients are not eligible for a special diet allowance if they are receiving any of the following:

(a) Room and board.

(b) Residential care facility (RCF) services or assisted living facility (ALF) care services.

(c) Long-term care Nursing facility services.

(d) Adult foster care (AFC) services.

(e) An allowance for restaurant meals.

(f) A commercial food preparation diet.

(2) An EXT, GA, GAM, MAA, MAF, REF, REFM, SAC, SFPSS, and or TANF clients client, and or an OSIP and or OSIPM clients client receiving SSI, having an adjusted income less than the OSIPM program income standard under OAR 461-155-0250, or long-term care services in the community, are receiving in-home services is eligible for a special diet allowance if they meet the client meets the following requirements:

(a) They The client would be in an imminent life-threatening situation without the diet, as verified by medical documentation from a Department-approved medical authority (see OAR 461-125-0830); and

(b) A nutritionist verifies that the special diet needed exceeds the cost of a regular diet.

(3) The amount of a special diet allowance is calculated as follows:

(a) In the EXT, MAA, MAF, REF, REFM, SAC, SFPSS, and TANF programs, the difference between the actual cost of the special diet and a prorated share of the FS SNAP program benefit for the appropriate number of clients in the benefit group (see OAR 461-110-0750).

(b) In the GA, GAM, OSIP, and OSIPM programs, the lesser of the following:

(A) The difference between the actual cost of the special diet and the amount provided in the basic standard for food (see OAR 461-155-0250).
(B) A maximum of $300 per month, or an exceptional amount, authorized by the SPD Program Assistance Section, which will not exceed the cost of home IV therapy.

(4) Local management staff must approve the request for a special diet allowance.

(5) Each special diet allowance must be reviewed at six-month intervals.

Stats. Implemented: ORS 411.060, 411.070, 418.100, 2007 Or. Laws ch. 861 411.706, 412.014, 412.049
In the OSIPM program:

(1) The Department provides a telephone allowance for a client receiving SSI eligibles, a client with an adjusted income less than the OSIPM program standard under OAR 461-155-0250, and a client receiving in-home services if they are the client is unable to leave their residence without assistance due to a documented medical condition.

(2) The telephone allowance may cover the following costs:

(a) The least expensive appropriate telephone service or the basic rate, whichever is less.

(b) The cost of telephone adaptive equipment, if the client has a medically documented need (for instance, TDD, a special headset, dialing mechanism, or emergency response system).

(c) Necessary installation charges.

(3) An SSI-eligible client or a client with an adjusted income less than the OSIPM program standard granted a telephone allowance must apply for a payment through the Oregon Telephone Assistance Program (OTAP). In addition, an SSI-eligible client or a client with an adjusted income less than the OSIPM program standard requesting payment for telephone installation must apply for Link-Up America. If the Link-Up America credit does not cover the installation cost, the Department provides the difference up to a maximum supplement payment of $30.

Stat. Auth.: 411.060, 411.070
Stats. Implemented: 411.060, 411.070, 411.706
THIS IS A NEW RULE

In the OSIPM program for a client who is receiving SSI as his or her only income:

(1) The Department will provide a payment for all Medicare Part D or Veteran's Administration Health Care prescription co-pays if a client's co-pays exceed $10 per month.

(2) Payment for Medicare Part D co-pays is limited to the current Low-Income Subsidy (LIS) program amounts for a fully dual eligible individual under 100 percent of the Federal Poverty Limit.

(3) If the payment exceeds $30 per month, it must be approved by Seniors and People with Disabilities Division central office staff.

Stat. Auth.: ORS 411.060, 411.706
Stats. Implemented: ORS 411.060, 411.704, 411.706
THIS IS A NEW RULE

In the OSIPM program:

(1) The following individuals may be eligible for a transportation services payment:

(a) A client who receives SSI as his or her only income; or

(b) A client who the Department determines meets the requirements of OAR 461-125-0370(1)(c) and has adjusted income less than the OSIPM standard (see OAR 461-155-0250).

(2) These services are for transportation to non-medical and non-waivered activities and resources approved by the Department. Examples of such transportation services include, but are not limited to: transportation provided by common carriers, taxicab, or bus; and assistance with purchase of a pass for public transportation.

(3) Transportation services do not include purchase of a vehicle, vehicle maintenance or repair, reimbursement for travel expenses, or transportation services that may be obtained through other means, such as the State Medicaid Plan, waiver, or other public or private resources available to the individual, including natural supports.

(4) Payment for services authorized by this rule may not exceed $25 per month.

(5) Service costs must be verified annually or when questionable.

Stat. Auth.: ORS 411.060, 411.706
Stats. Implemented: ORS 411.060, 411.704, 411.706
Resource Limits

(1) In the EA program, all countable (see OAR 461-001-0000) resources must be used to meet the emergent need.

(2) In the ERDC, EXT, and REFM programs, and for an individual whose eligibility is determined under the OHP-CHP, OHP-OPC, OHP-OP6, or OHP-OPP programs, there is no resource limit.

(3) In the FS program, the resource limit is:

(a) $3,000 for a financial group (see OAR 461-110-0530) with at least one member who is elderly (see OAR 461-001-0015) or an individual with a disability (see OAR 461-001-0015).

(b) $2,000 for all other financial groups.

(4) In the GA, GAM, OSIP, and OSIPM programs, the resource limit is as follows:

(a) $2,000 for a one-person need group (see OAR 461-110-0630) and $3,000 for a two-person need group.

(b) $1,000 for an OSIP need group eligible under OAR 461-135-0771. The total cash resources may not exceed $500 for a one-person need group or $1,000 for a two-person need group.

(c) $5,000 is the limit for the OSIP-EPD and OSIPM-EPD programs (see OAR 461-001-0035 and 461-145-0025 for funds that may be excluded as approved accounts).

(5) In the MAA, MAF, REF, SAC, and TANF programs, the resource limit is:

(a) $10,000 for a need group (see OAR 461-110-0630) with at least one JOBS participant who is progressing in a case plan.

(b) $10,000 for a need group with at least one member who is working under a JOBS Plus agreement.

(c) $2,500 for all other need groups, including all TANF applicants.

(6) In the OHP programs, the

(a) There is no resource limit for an individual whose eligibility is determined under the OHP-OPC, OHP-OP6, or OHP-OPP programs.
(b) The resource limit for an individual whose eligibility is determined under the OHP-OPU program is $2,000.

(e) The resource limit for children whose eligibility is determined under the OHP-CHP program is $10,000.

(76) In the QMB program, the resource limit is $4,000 for a one-person need group and $6,000 for a need group containing two or more individuals.

(7) In the SNAP program, the resource limit is:

(a) $3,000 for a financial group (see OAR 461-110-0530) with at least one member who is elderly (see OAR 461-001-0015) or an individual with a disability (see OAR 461-001-0015).

(b) $2,000 for all other financial groups.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.816, 412.100 412.049, 414.042
Stats. Implemented: ORS 411.060, 411.070, 411.816, 412.049, 414.042, 418.100
In the OSIP (except OSIP-EPD) and OSIPM (except OSIPM-EPD) programs program:

1. This rule applies to an institutionalized spouse institutionalized spouse (see OAR 461-001-0030) who has applied for benefits because he or she is in or will be in a continuous period of care (see OAR 461-001-0030).

2. Whether a legally married (see OAR 461-001-0000) couple lives together or not, the determination of whether the value of the couple's resources exceeds the eligibility limit for the institutionalized spouse for OSIPM program is made as follows:

   a. The first step is the determination of what the couple's combined countable resources were at the beginning of the most recent continuous period of care. (The beginning of the continuous period of care is the first month of that continuous period.)

      A. Division 461-140 and 461-145 rules applicable to OSIP OSIPM describe which of the couple's resources are countable resources, and are applicable to determine whether a community spouse's resources are countable, even if the rule only applies to OSIP OSIPM clients.

      B. The countable resources of both spouses are combined.

      C. At this point in the computation, the couple's combined countable resources are considered available equally to both spouses.

   b. The second step is the calculation of one half of what the couple's combined countable resources were at the beginning of the continuous period of care. The community spouse's half of the couple's combined resources is treated as a constant amount when determining eligibility.

   c. The third step is the determination of the community spouse's resource allowance. The community spouse's resource allowance is the largest of the four following amounts:

      A. The community spouse's half of what the couple's combined countable resources were at the beginning of the continuous period of care, but not more than $109,560.

      B. $21,912 (the state community-spouse resource allowance).

      C. A court-ordered community spouse resource allowance. In this paragraph and paragraph (2)(f)(C) of this rule, the term court-ordered community spouse resource allowance means a court-ordered community spouse resource allowance that, in relation to the income generated, would raise
the community spouse's income to a court-approved monthly maintenance needs allowance. In cases where the client became an institutionalized spouse on or after February 8, 2006, this resource allowance must use all of the client's available income and the community spouse's income to meet the community spouse's monthly maintenance needs allowance before any resources are used to generate interest income to meet the allowance.

(D) After considering the income of the community spouse and the income available from the institutionalized spouse, an amount which, if invested, would raise the community spouse's income to the monthly maintenance needs allowance. The amount described in this paragraph is considered only if the amount described in subparagraph (i) of this paragraph is larger than the amount described in subparagraph (ii); it is the difference between the following:

(i) The monthly income allowance computed in accordance with OAR 461-160-0620.

(ii) The difference between--

(I) The sum of gross countable income of the community spouse and the institutionalized spouse; and

(II) The applicable need standard under OAR 461-160-0620(3)(c).

(d) The fourth step is the determination of what the couple's current combined countable resources are when a resource assessment is requested or the institutionalized spouse applies for OSIPM. The procedure in subsection (2)(a) (first step) of this rule is used.

(e) The fifth step is the subtraction of the community spouse's resource allowance from the couple's current combined countable resources. The resources remaining are considered available to the institutionalized spouse.

(f) The sixth step is a comparison of the value of the remaining resources to the OSIPM resource standard for one person (under OAR 461-160-0015(4)(a)). If the value of the remaining resources is at or below the standard, the institutionalized spouse meets this eligibility requirement. If the value of the remaining resources is above the standard, the institutionalized spouse cannot be eligible until the value of the couple's combined countable resources is reduced to the largest of the four following amounts:

(A) The community spouse's half of what the couple's combined countable resources were at the beginning of the continuous period of care (but not more than $109,560) plus the OSIPM resource standard for one person.
(B) $21,912 (the state community-spouse resource allowance), plus the OSIP OSIPM resource standard for one person.

(C) A court-ordered community spouse resource allowance plus the OSIP OSIPM resource standard for one person. (See paragraph (2)(c)(C) of this rule for a description of the court-ordered community spouse resource allowance.)

(D) The OSIP OSIPM resource standard for one person plus the amount described in the remainder of this paragraph. After considering the income of the community spouse and the income available from the institutionalized spouse, add an amount which, if invested, would raise the community spouse's income to the monthly maintenance needs allowance. Add this amount only if the amount described in subparagraph (i) of this paragraph is larger than the amount described in subparagraph (ii); it is the difference between the following:

(i) The monthly income allowance computed in accordance with OAR 461-160-0620.

(ii) The difference between--

(I) The sum of gross countable income of the community spouse and the institutionalized spouse; and

(II) The applicable need standard under OAR 461-160-0620(3)(c).

(3) Once eligibility has been established, resources equal to the community spouse's resource allowance (under subsection (2)(c) of this rule) must be transferred to the community spouse if those resources are not already in that spouse's name. The institutionalized spouse must indicate his or her intent to transfer the resources and must complete the transfer to the community spouse within 90 days. This period may be extended for good cause. These resources are excluded during this period. After this period, resources owned by the institutionalized spouse but not transferred out of that spouse's name will be countable and used to determine ongoing eligibility.

(4) The provisions of paragraph (2)(c)(C) of this rule requiring income to be considered first may be waived if the Department determines that the resulting community resource allowance would create an undue hardship on the spouse of the client.

Stats. Implemented: ORS 411.060, 411.070, 411.700, 414.042
(1) **Clients** A client in the OSIP (except OSIP-EPD) and OSIPM (except OSIPM-EPD) programs who live in or enter a long-term care setting or who receive Title XIX waivered receives long-term care (see OAR 461-001-0000) services must, in order to remain eligible, make the payment required by this rule, except as provided in sections (2) to (6) of this rule. These clients The client must apply their his or her adjusted income to the cost of their care or service. This amount is their the client liability. If their the client's adjusted income exceeds their the cost of care or service, they the client must pay the full cost of care but have has no additional liability.

(2) **Clients** A client who receive receives SSI, or are is deemed to receive SSI under section 1619(b) of the Social Security Act (42 U.S.C. § 1382h(b)), are is eligible for OSIP and OSIPM program benefits without having to make a payment.

(3) The IC service payment of clients a client in the OSIP-IC and OSIPM-IC programs is reduced by the amount of their his or her liability.

(4) The following clients, if they receive the services described in section (5) of this rule, are exempt from payments required by this rule:

(a) A disabled adult child under OAR 461-135-0830.

(b) A widow or widower under OAR 461-135-0820.

(c) A Pickle amendment client under OAR 461-135-0780.

(5) A client identified in section (4) of this rule is exempt from payments required by this rule if the client receives --

(a) *Waivered services* (see OAR 461-001-0030); or

(b) Mental health services and lives in a *mental health residential treatment facility*. For purposes of this rule, only the following types of treatment centers qualify as a *mental health residential treatment facility*:

(A) A mental health adult foster home.

(B) A mental health residential treatment home.

(C) A mental health residential treatment facility.

(D) A mental health secure residential treatment facility.
(6) In the initial month of placement, a client may be exempt from payments required under this rule if the Department determines that the client's income has been exhausted prior to placement. If any income remains, the client must contribute to the cost of care or service.

(7) A client residing in an acute care hospital is exempt from payments required by this rule while residing in the acute care hospital. If a service benefit was received prior to admission to the acute care hospital, payment must be made for that service.

Stat. Auth.: ORS 411.060, 411.070, 414.042
Stats. Implemented: ORS 411.060, 411.070, 414.042
Use of Income; OHP

Income is used to determine eligibility for OHP as follows:

(1) The average countable income of the financial group (see OAR 461-110-0530) assigned to the budget month (see OAR 461-001-0000) is determined in accordance with OAR 461-150-0055.

(2) For each member of the need group (see OAR 461-110-0630), the average countable income of the financial group assigned to the budget month is compared to the applicable OHP program income standard. If the average countable income of the financial group is below the applicable income standard for the need group size and all other financial and non-financial eligibility requirements are met, the need group member is eligible for OHP program benefits. If the average countable income of the financial group equals or exceeds the applicable OHP program income standard, the need group member is ineligible for OHP program benefits except as provided by section (3) of this rule.

(3) The following members of the need group who are not eligible under section (2) of this rule are eligible for OHP program benefits if all other financial and non-financial eligibility requirements are met and the financial group's countable income of the financial group, received or anticipated to be received in the budget month, is below the applicable OHP program income standard:

(a) Victims of domestic violence.

(b) OHP-CHP program clients.

(b) OHP-OPC program clients.

(c) OHP-OP6 program clients.

(d) OHP-OPP program clients.

(e) Victims of domestic violence.

Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060, 411.700
461-165-0010
Legal Status of Benefit Payments

(1) Under Oregon law, cash benefits are not subject to assignment, transfer, garnishment, levy, or execution, as long as they can be identified as program payments and are separate from other money in the client's possession.

(2) A cash payment accrues to and becomes vested in the client when issued.

(3) Except for EBT, the Department considers a benefit issued if the check has been handed to the client in the branch office, or mailed to the client. The Department considers a benefit issued, and received by the client, when a direct check deposit is made to the client's bank account.

(4) For EBT, the Department considers benefits issued and received when an EBT card and personal identification number (PIN) have been issued in person to the client, or the EBT card and PIN have been received by the client in the mail during conversion, and the benefits have been deposited to the client's EBT account.

(5) FS benefits issued by EBT remain available for client access for 12 calendar months from the date of issuance. The EBT system expunges unused benefits after 12 calendar months.

(6) Benefits to the client are unrestricted and do not require accountability for individual expenditures or amounts.

(7) In the TA-DVS program, a payment issued on behalf of a client as a vendor or dual payee payment or directly to the client becomes vested in the client when issued. The Department considers the benefit to be issued if the Department has mailed the payment to the vendor or has hand delivered or mailed a dual payee check to the client. Benefits in the TA-DVS program are restricted to uses outlined in OAR 461-135-1230.

Stat. Auth.: ORS 411.060, 411.816, 412.014, 412.049, 414.042
Stats. Implemented: ORS 418.047 411.060, 411.117, 411.816, 412.014, 412.049, 412.151, 414.042
Restoring Benefits

(1) A client is entitled to a supplemental payment of benefits for the current month or restoration of benefits lost in a previous month if the client received a lower benefit than he or she was entitled to for the reasons given in this rule. A client may receive a restoration of lost benefits even if no longer eligible.

(2) A client may receive a supplemental payment if there was a change in the client's circumstances that would cause an increase in benefits, if the report of change was made before the first day of the payment month but too late for the Department to adjust the next payment.

(3) A client may receive a supplemental or restorative benefit if the Department caused an administrative underpayment. An administrative underpayment includes, but is not limited to, an underpayment caused by the following:

(a) Failure to take action on information reported to the Department.

(b) Use of an incorrect effective date.

(c) Denial, closure or reduction of benefits in error and a failure to send the client a required notice of proposed action.

(d) Making a calculation error.

(4) A client is entitled to a restoration of lost benefits if:

(a) The restoration results from a final order in a contested case.

(b) The Department withheld too much of the client's grant in the collection of an overpayment.

(c) The restoration results from a court order.

(d) Food stamp SNAP program benefits deposited in an EBT account were returned because they had the benefits aged off.

(e) After receiving proper notification, the Department failed to cancel the EBT card of an individual leaving a SNAP program household and that individual continues to access the household's SNAP program benefits in subsequent months.

(5) Restored benefits are added to the benefits of a currently eligible client. In the Food Stamp SNAP program, the Department will honor a reasonable request by a client to restore benefits in monthly installments.
(6) A client who moves from Oregon remains eligible for a restoration of benefits.

Stat. Auth.: ORS 411.060, 411.816, 418.100 412.014, 412.049, 414.042
Stats. Implemented: ORS 411.060, 411.816, 418.100 412.014, 412.049, 414.042
Calculating Restored and Supplemental Benefits

(1) Supplemental and restorative benefits are calculated and paid as follows:

(a) The effective date of the lost benefits is determined.

(b) The benefit group is not eligible for restored benefits in any month that eligibility for the benefits cannot be established. The benefit group has an opportunity to prove eligibility for any months in question.

(c) The correct benefits for the months in question are calculated.

(d) The amount the benefit group actually received is subtracted from the amount they should have received.

(e) The restoration amount for EBT aged-off FS benefits is the full amount of inaccessible benefits, if the request for restoration is made within nine months of the date the benefits were aged off.

(f) The amount of restored benefits is offset against overdue or suspended overpayments.

(g) The group with the largest number of people who were in the benefit group at the time the loss occurred is entitled to the restorative payment. If the location of that group is unknown, the benefit is paid to the benefit group containing the primary person at the time the loss occurred.

(2) When, after receiving proper notification, the Department failed to cancel the EBT card of an individual leaving a SNAP program household and that individual continues to access the household's SNAP program benefits in subsequent months, the amount of SNAP program benefits to be restored is the amount used by the former household member.

Stat. Auth.: ORS 411.060, 411.816, 412.014, 412.049, 414.042
Stats. Implemented: ORS 411.060, 411.816, 412.014, 412.049, 414.042
Replacing FS Benefits and EBT Cards

(1) The Department does not replace food stamp SNAP program benefits after they are delivered to the EBT account unless the Department failed to cancel the EBT card of an individual leaving a SNAP program household and that individual continues to access SNAP program benefits in subsequent months.

(2) The Department will replace the value of food purchased with food stamp SNAP program benefits if the food is destroyed by a verified household misfortune and the benefit group reports the loss within ten days of occurrence. The amount of the replacement cannot exceed one month's allotment. The Department will replace the loss within ten days after the household provides sufficient verification.

(3) The Department will replace an EBT card reported lost, stolen, or not received only after the current card has been deactivated. An EBT card that is damaged or not functioning properly is replaced only after the card's status is changed to "card damaged" and the card is destroyed.

Stat. Auth.: ORS 411.060, 411.816, 412.014, 412.049
Stats. Implemented: ORS 411.060, 411.816, 412.014, 412.049
Notice Situation; MRS, SRS, or TBA

(1) When a benefit group (see OAR 461-110-0750) is entered into the MRS (see OAR 461-170-0100), the Department sends a basic decision notice (see OAR 461-001-0000) for the GA, GAM, OSIP, OSIPM, and QMB programs and a continuing benefit decision notice (see OAR 461-001-0000) for all other programs.

(2) When the Department takes action on information reported on the Monthly Change Report or Interim Change Report form, the Department sends a continuing benefit decision notice for clients in the ERDC, FS, MAA, MAF, OSIP, OSIPM, QMB, REF, REFM, SNAP, and TANF programs. Except in the FS program, the notice includes:

(a) The amount of income used to determine the benefits or ineligibility; and

(b) The amount of each deduction.

(3) For all changes not reported on the Monthly Change Report or Interim Change Report form, which result in a closure or reduction in benefits, the Department sends a timely continuing benefit decision notice.

(4) For a benefit group in the MRS, when ending TANF benefits because of information acquired through the information match with the Child Support program, the Department sends a continuing benefit decision notice.

(5) When the Department changes the reporting system from one reporting system to another reporting system, the Department provides a continuing benefit decision notice if the change occurs at a time other than at the start of a certification period (see OAR 461-001-0000).

Stats. Implemented: ORS 411.060, 411.111, 411.816, 412.049, 414.042
In the CEC, CEM, EXT, MAA, MAF, OHP, OSIPM, QMB, and SAC programs, when the Department initiates a redetermination of eligibility, the Department must review each individual in the filing group for eligibility for the other medical programs listed in this rule prior to reducing or ending medical benefits. If additional information is needed to redetermine eligibility, members of the benefit group (see OAR 461-110-0750) remain eligible from the date the review is initiated until the Department determines their eligibility in accordance with the application processing time frames in OAR 461-115-0190.

Stat. Auth.: ORS 409.050, 411.060, 414.042
Stats. Implemented: ORS 409.010, 411.060, 414.042
Effective Dates; Initial Month Medical Benefits

The effective date for starting medical benefits for an eligible client is as follows:

1. In the CEC and CEM programs, it is the first of the month following the month that eligibility for Child Welfare medical, EXT, MAA, MAF, OHP, OHP-CHP, OSIPM, or SAC program benefits ends.

2. In the EXT program, it is the first of the month following the month that MAA or MAF program eligibility ends.

3. In the GAM, MAA, MAF, OHP, OSIPM, QMB-DW, REFM, and SAC programs:
   (a) Except as provided for in sub-section (b) of this section:
      (A) If the client meets all eligibility requirements on the date of request (see OAR 461-115-0030), it is the date of request. An OSIPM client who is assumed eligible under OAR 461-135-0010(7) meets "all eligibility requirements" for the purposes of this section as follows:
         (i) Effective the first day of the month of the initial SSI payment if the client is age 21 or older.
         (ii) Effective the first day of the month prior to the month of the initial SSI payment if the client is under the age of 21.
      (B) If the client does not meet all eligibility requirements on the date of request, it is the first day following the date of request that all eligibility requirements are met.
   (b) If the client does not complete the application within the time period described in OAR 461-115-0190 (including the authorized extension), the determination of an effective date requires a new date of request.

4. In the QMB-BAS program, it is the first of the month after the benefit group (see OAR 461-110-0750) has been determined to meet all QMB-BAS eligibility criteria and the Department receives the required verification; or

   (a) The first of the month after the Low Income Subsidy (LIS) information is received, if the QMB-BAS application was generated by the electronic transmission of LIS data from the Social Security Administration.

45. In the QMB-SMB and QMB-SMF programs, it is the --
(a) The first of the month in which the benefit group meets all program eligibility criteria and the Department receives the required verification; or

(b) The first of the month in which the Low Income Subsidy (LIS) information is received, if the SMB or SMF application was generated by the electronic transmission of LIS data from the Social Security Administration.

(§6) Retroactive eligibility is authorized under certain circumstances in some medical programs (see paragraph (2)(a)(A) of this rule, OAR 461-135-0875, and 461-180-0140).

Stat. Auth.: ORS 411.060, 411.070, 414.042
Stats. Implemented: ORS 411.060, 411.070, 414.042
Parents as Scholars

(1) Parents as Scholars (PAS) is a JOBS program component that assists TANF parents who are or will be undergraduates to begin or continue their education at a two- or four-year educational institution.

(2) The following definitions apply to PAS:

(a) "Educational institution" means any post-secondary educational institution approved or accredited by the Northwest Commission on Colleges and Universities, by its regional equivalent, or by the appropriate official, department, or agency of the state or nation in which the institution is located and that is:

(A) A four-year college or university;

(B) A junior college or community college; or

(C) A technical, professional or career school.

(b) "Participant" refers to a participant in the PAS component of the JOBS program.

(c) "PAS" means the Parents as Scholars component of the JOBS program.

(3) The number of participants in PAS in a calendar year is limited as follows--

(a) The number of participants in PAS in a calendar year may not exceed one percent of the number of households receiving TANF on January 1 of that calendar year.

(b) If one percent of the number of households receiving TANF on January 1 of the current calendar year is less than one percent of the number of households receiving TANF on January 1 of the previous calendar year, the Department will not fill PAS slots vacated on or after January 1 of the current calendar year until the total number of slots is equal to one percent of the households receiving TANF for the current calendar year.

(4) A PAS participant receives TANF cash assistance as well as necessary support services provided through the JOBS program. JOBS support services --

(a) May not be used to pay for the cost of tuition and fees associated with enrollment by a participant at an educational institution.

(b) Notwithstanding OAR 461-190-0211, may be used to pay for books and supplies associated with enrollment by a participant at an educational institution subject to the following provisions:

(A) The books and supplies are required for completion of the participant's coursework at an educational institution;
(B) There is no other funding available to the PAS participant for books and supplies; and

(C) No more than $100 per academic term or semester may be paid per PAS participant for books and supplies.

(5) Applying for PAS. A parent who is applying for or receiving TANF may apply for PAS by completing and signing the PAS application and submitting it to the Department. The application and other documentation required by this rule must be submitted to Department of Human Services JOBS Unit (PAS), 2nd Floor, 500 Summer Street NE E48, Salem, Oregon 97301.

(6) PAS Selection Process; Wait List.

(a) PAS applications received from PAS applicants will be processed in the order in which the Department receives the applications.

(b) If the maximum number of PAS slots for a calendar year has not been filled, the Department will notify an applicant when he or she has been approved.

(c) When the maximum number of PAS slots for a calendar year has been filled and there is a wait list, the Department will notify an applicant when he or she has been added to the wait list.

(d) Once each year, the Department will contact PAS applicants on the wait list to determine if the PAS applicant’s name should be removed from the wait list.

(e) When the maximum number of PAS slots for a calendar year has been filled and there is a wait list and a PAS slot becomes available, the Department will notify the next applicant on the wait list that an opening has become available.

(f) The Department will inform an applicant for PAS who does not qualify or no longer qualifies for placement on the wait list because the applicant becomes ineligible for TANF or no longer meets the requirements of this rule.

(7) Selection Requirements.

(a) A PAS applicant must meet the financial and nonfinancial eligibility requirements for TANF.

(b) A PAS applicant who is not applying for or receiving TANF at the time of selection may not participate in PAS or remain on the wait list.

(c) A PAS applicant must include documentation that the PAS applicant is an undergraduate who has been accepted for full-time attendance into or is enrolled full-time at an educational institution.
(d) A PAS applicant must demonstrate as part of the PAS application that completion of the educational program is likely to result in employment that provides the wages and benefits necessary for the applicant to support the applicant's family without TANF.

(8) Requirements of Participants; Limitations.

(a) A participant must provide documentation to the Department quarterly, or following completion of each academic term at the educational institution, that the participant is making satisfactory academic progress, as defined by the educational institution, toward a degree.

(b) A participant must provide documentation to the Department, prior to the start of each new academic term or semester, that the PAS applicant is an undergraduate who is enrolled full-time at an educational institution.

(c) A participant must attend classes full-time as defined by the educational institution, unless there is good cause (see OAR 461-130-0327) to limit attendance to less than full-time.

(ed) Unless there is good cause for not attending year round, a participant must either:

(A) Attend classes year round, including during the summer if classes are offered by the educational institution; or

(B) If not attending classes year round, participate in work experience related to the field of study of the participant when not attending classes. If a work experience related to the participant's field of study is not available, participate in another appropriate work experience.

(de) During the first twelve months of participation in PAS, a participant must record attendance and homework time weekly and must provide this information to the Department no less frequently than monthly.

(ef) Except as provided in subsection (fg) of this section, a participant must remain eligible for TANF.

(fg) If a participant becomes temporarily ineligible for TANF during a period of four or fewer months due to income from a paid work experience, the applicant may retain their PAS slot when school resumes if:

(A) The participant regains TANF eligibility; and

(B) PAS is still an appropriate activity for the participant.

(9) Ending PAS. PAS shall be ended for a PAS participant when:

(a) The PAS participant completes his or her degree program;
(b) Except as provided in subsection (8)(f) of this rule, the PAS participant becomes ineligible for TANF; or

(c) All of the following are true:

(A) The PAS participant fails to meet one or more of the requirements of subsections (8)(a) through (8)(d) of this rule;

(B) Attempts to re-engage the PAS participant pursuant to OAR 461-190-0231 are unsuccessful; and

(C) There is a determination that the PAS participant does not have good cause (see OAR 461-130-0327) for failure to meet one or more requirements of subsections (8)(a) through (8)(d) of this rule.

Stats. Implemented: ORS 411.060, 412.016, 412.017, 412.049, 412.124
Eligibility Requirements; Refugee Case Services Project (RCSP)

In the RCSP program, to be eligible an applicant must meet the requirements of sections (1) to (6) of this rule, and section (7) if section (7) applies:

(1) Meet all REF or TANF program eligibility (see OAR 461-001-0000) requirements.

(2) Meet the alien status requirements under OAR 461-120-0120.

(3) Reside in Clackamas, Multnomah, or Washington County.

(4) Have resided in the U.S. for eight months or less. The first month is, for an individual meeting the alien status requirements of OAR 461-120-0120 --
   (a) Section (1), (3), (4), or (5), the month the individual entered the United States.
   (b) Section (2), (6), or (7), the month the individual was granted the individual's immigration status.
   (c) Section (8) --
      (A) If the individual entered the U.S. with special immigrant status, the month the individual entered the United States.
      (B) If the individual is granted special immigrant status after entering the U.S., the month in which the special immigrant status was granted.
   (d) Each month in the U.S. is counted as a whole month, there is no prorating of any month.

(5) Be 64 years old or younger.

(6) Not be enrolled as a full-time student or intending to enroll as a full-time student within six months of RCSP program intake.

(7) For a newborn, a parent must provide verification of the child's birth, including the date of birth. The newborn child's U.S. arrival date and eligibility period are the same as those for the child's mother.

Stat. Auth.: ORS 411.060, 411.116
Stats. Implemented: ORS 411.060, 411.116
Refugee Project Inquiries and Complaints

THIS RULE IS REPEALED

(1) The participant, a third party, or a third party on the behalf of a participant may submit an oral or written inquiry regarding clarification or additional information regarding project policy, services, or other information.

(a) Handle inquiries and complaints in a courteous and effective manner. When the complaint is made about or on behalf of a participant by an interested third party, confidential information shall be safeguarded.

(b) Letters of complaint received about project employees shall be forwarded to their directors.

(c) Letters of inquiry which are beyond the organization's project scope shall be forwarded to the director of the project organization who has direct service responsibility.

(d) Letters of inquiry which are directly related to project policy shall be forwarded to the project manager.

(2) The participant may file a complaint anytime he/she is dissatisfied with the project, its policies, etc. A complaint is filed with the completion of the Grievance Review and Outcome.

(a) The participant may file a complaint within 30 calendar days from the date the project worker's actions result in the participant's complaint.

(b) If the project is closed for any reason while the participant is in the process of filing a complaint or complaint appeal, the complaint process shall proceed even after the case closes.

(c) If a participant is not satisfied with the response to his/her inquiry, the participant may request a review with the project worker regarding this decision.

(3) Reviewing a Grievance:

Note: This section applies to all project case complaints except those cases involved in contested case appeals for penalty staffing.

(a) All appeals must be requested in writing by the participant.

(b) Requests for an appeal must be received within 30 calendar days from the date of the decision on the Grievance Review and Outcome.
(c) Appeals shall be scheduled within five working days of the receipt of the written request.

(d) If, in the review outcome, it is decided that the action was not within project policy, the grievance is valid.

   (A) If the action was not implemented, no follow-up is needed.

   (B) If the action was implemented, the action will be removed and any loss of benefits to the participant will be restored retroactively to the date the benefits were affected.

(e) If, in the review outcome, it is decided that the action taken by the project worker was proper, the grievance is not valid. A written reply shall be sent to the participant.

(f) The participant shall be notified of the outcome of the review by mail within two working days of the decision.

(g) If the participant fails to appear at the review without good cause, the grievance review shall be closed. Reviews for the same complaint shall not be processed.

(4) Level 1 - With the Agency Supervisor:

   (a) The level 1 appeal is at the supervisor level. The appeal shall include the agency supervisor, as well as the participant, participant's representative, and agency worker.

   (b) The supervisor reviews the grievance, the action which initiated the grievance, and project policy pertaining to the action.

   (c) If the participant does not agree with the outcome of the appeal, he/she may appeal the decision to the next level.

(5) Level 2 - With the Agency Director:

   (a) The level 2 appeal is at the director level. The appeal shall include the agency director, as well as the participant, participant's representative, agency worker, and supervisor.

   (b) The director reviews the grievance, the action which initiated the grievance, and project policy pertaining to the action.

   (c) If the participant does not agree with the outcome of the appeal, he/she may appeal the decision to the next level.
(6) Level 3—With the Project Manager:

(a) The level 3 appeal is at the project manager level. The appeal shall include the project manager, as well as the participant, participant’s representative, agency worker, supervisor, and director.

(b) The project manager reviews the grievance, the action which initiated the grievance, and project policy pertaining to the action.

(c) The appeal with the project manager is the highest grievance review level available in the project. The outcome of the grievance review at Level 3 is considered final.

Stat. Auth.: ORS
Stats. Implemented: ORS
Exemption From Participating; New Arrival Employment Services (NAES)

(1) Participation in the NAES program is limited to RCSP program adult clients and refugees who would be eligible for the RCSP program, but have been in the U.S. for more than eight months and less than 13 months. A RCSP program client who meets the requirements of OAR 461-120-0120(8) may not be in the NAES program beyond his or her first eight months in the United States.

(2) An adult client is exempt from participation in or disqualification from the NAES program when the requirements of one of the following subsections are met:
   
   (a) In the ninth month of pregnancy or when experiencing medical complications due to pregnancy that prevent participation in the NAES program.
   
   (b) During the first six months after giving birth, except that the client may be required to participate in parenting classes or family stability activities.
   
   (c) Under 20 years of age during the first 16 weeks after giving birth, except that the client may be required to participate in suitable activities with a preference for educational activities, parenting classes, and family stability activities.
   
   (d) A parent providing care for a family member who lives in the home and has a disability (see OAR 461-001-0000).
   
   (e) Sixty-five years of age or older.
   
   (f) Receiving supplemental security income (SSI) from the Social Security Administration.
   
   (g) Participation likely would cause undue hardship or is contrary to the best interest of a child or needy caretaker relative.
   
   (h) Volunteering, except that a client may not be disqualified for conduct that occurred while a volunteer. Volunteering, as used in the NAES program rules, means that a client who is otherwise exempt from participating in the NAES program chooses to participate in an employment program nevertheless.
   
   (i) A medical condition documented by a licensed medical professional.

(3) An adult client is exempt from disqualification from the NAES program when participating more than 10 hours per week during the seventh and eighth months of pregnancy.

Stats. Implemented: ORS 411.060, 411.116, 412.006
Refugee Project Staffing

THIS RULE IS REPEALED

A staffing is an opportunity for an applicant or a participant to ask for a review of a decision or a proposed decision to a higher authority.

(1) All refugee projects must have policy and procedures for a staffing defined in their project.

(a) A participant may have a staffing if any of the following applies:

(A) The project has not acted on an application for project benefits/services within 30 days of the application.

(B) The project acts to deny, reduce, close, or suspend project services or benefits.

(C) The project claims that a project payment was an overpayment.

(b) The participant and project staff have the following rights:

(A) To submit evidence to establish all pertinent facts and circumstances in the case.

(B) To bring witnesses.

(C) To advance arguments without interference.

(D) To question any testimony or evidence.

(E) To receive a complete description of the issues.

(F) To have the staffing conducted in a language the participant understands.

(G) To respond to the incident.

(H) To know what penalties could be imposed.

(I) To be informed of appeal policy regarding the staffing decision.

(J) To appeal the decision of the staffing.

(2) For NAES and Refugee Case Service projects:
(a) A request for a staffing must be in writing and not later than 5 working days following the date of the notice proposing the action. The request is complete when a staffing request form is filled out and signed by the participant and received by the organization that is proposing the action.

(b) When staffing is requested, the proposed action indicated in the decision notice shall not be applied.

(c) A staffing request shall be dismissed only when:

   (A) The request for the staffing was untimely (more than 5 working days following the date of the decision notice), unless it was untimely due to circumstances beyond the control of the participant;

   (B) A staffing decision has previously been issued by the project on the same issue for the same participant; OR

   (C) All issues of the staffing become moot before the staffing decision is made.

(d) The staffing must be scheduled within 2 working days of receiving the request.

   (A) The participant must be informed of the scheduled staffing in writing and by mail.

   (B) The participant must attend the staffing. The staffing shall also include the case services and employment service supervisors, case manager, and job worker.

   (C) If the participant does not appear for the scheduled staffing within 15 minutes of the time set for the staffing, the staffing shall be dismissed. The proposed action shall be implemented immediately. The staffing shall be rescheduled only if the participant had good cause for not appearing within the time frame. If good cause is found, the staffing shall be rescheduled within 3 working days.

(e) A postponement of the staffing may be granted one time upon the request of the participant. Requests must be made no later than one day prior to the scheduled staffing. Both the participant and project staff must agree to the postponement, with rescheduling occurring within 2 working days.

(f) A participant may withdraw a staffing request at any time. The withdrawal shall be effective when received by project staff. The project shall implement the action as defined in the decision notice.
(g) The supervisor conducts the staffing and may expel a person from the staffing if a person engages in conduct that disrupts the staffing. The supervisor may terminate the staffing if the participant's conduct is disruptive or does not allow the staffing to proceed in an orderly manner. If a staffing is terminated because of the participant's disruption of the staffing, the decision will be based on the record created before the staffing was terminated.

(h) A staffing decision must be made for all staffings on the day of the staffing and are effective immediately. The staffing decision is made by the supervisor conducting the staffing.

Stat. Auth.: ORS
Stats. Implemented: ORS
461-193-0980
Refugee Project Staffing Appeals

THIS RULE IS REPEALED

(1) All refugee projects must have policy and procedures for appealing a staffing decision defined in their project.

(a) The participant has the right to appeal the outcome of a staffing.

(b) The appeal must be in writing.

(2) For NAES and Refugee Case Service projects:

(a) The appeal must be received within 5 calendar days from the date of the staffing decision.

(b) The appeal is not valid until the participant has signed the appeal request form.

(c) The proposed action shall not be implemented when an appeal is made. The proposed action shall remain pending until the appeal process has been completed.

(d) The appeal shall be scheduled within 5 working days of the receipt of the written request.

(e) All rules of schedule and conducting a staffing shall also apply to appeals.

(f) The appeal is conducted by the project director and a decision rendered the day of the appeal.

(g) If the appeal decision is the same as the staffing decision, the proposed action in dispute shall be implemented immediately.

(h) The participant shall be provided with a copy of appeal decision the same day as the appeal.

(i) If the participant does not agree with the appeal decision, they may appeal the decision further to the State Refugee Coordinator.

(j) The State Refugee Coordinator shall review the appeal decision and issue a decision.

(k) If the participant does not agree with the State Refugee Coordinator's decision, the participant has the right to file a hearing request with AFS.

Stat. Auth.: ORS
Stats. Implemented: ORS
THIS RULE IS REPEALED

(1) To receive continued transportation support services the participant must have completed mass transit training, unless they have good cause.

(2) Each active NAES participant shall receive five (5) full months of bus passes. The first month of resettlement is considered a partial month and the participant may receive either a bus pass or bus tickets, depending on cost.

(3) After the first five (5) full months of bus passes and for continued Pre-Employment Training classes and employment stabilization, participants may be authorized bus tickets, bus passes or gas money to assist in reaching the employment site. This is based on the need to help stabilize employment, until the first pay period. Support services authorized after the first pay period need to have a detailed case narrative justification and management signature authorization.

(4) To receive gas money in lieu of bus tickets, the participant shall have a vehicle, a valid driver's license, and proof of current automobile insurance. Gas money authorization shall not exceed the actual purchase costs for bus transportation for the same distance and same period of time.

Stat. Auth.: ORS 411.060, 411.116, 411.135(1)
Stats. Implemented: ORS 411.070, 414.025(2), 418.040, 418.100
To be eligible for child care support service payments:

(a) NAES participant children must be under 13 years of age, or a documented special needs child per OAR 461-155-0150.

(b) Child care must be needed because the adult family member(s) is participating in approved NAES employment plan activities or is employed.

(c) The adult family member(s) must attend the child care orientation provided by CASE, which covers information about the American laws of child care and appropriate child care providers.

The standards for CASE child care payment rates are the same as AFS per OAR 461-155-0150.

Support service child care shall be authorized to child care providers who are in compliance with OAR 461-165-0180 or registered through the Child Care Division.

The coordination specialist identifies appropriate child care providers with compatible language in the participant's geographic area and arranges for the participant to contact the provider. The participant is informed of the time frame in which they need to contact the Project to authorize child care.

If the participant does not select the presented child care provider, they must have good cause.

The coordination specialist shall follow up with the participant within five (5) working days of placing the participant's child(ren) in care to determine if the referral was successful. If a child care barrier still remains, the coordination specialist and job worker will continue to work with the family to resolve the barrier.

Stat. Auth.: ORS 411.060, 411.116, 411.135(1)
Stats. Implemented: ORS 411.070, 414.025(2), 418.040, 418.100
Standards for NAES Support Service Eligibility Requirements; CASE Payments

THIS RULE IS REVISED IN ITS ENTIRETY

(1) Refugees may be eligible for support services if they meet the following eligibility criteria:

(a) The refugee is fully cooperating with NAES activities and responsibilities. Participants who have a disqualification are not eligible to receive CASE services unless they have agreed to cooperate.

(b) The participant does not have other resources or income available. Other resources that are considered a higher priority than CASE support services are:

(A) For child care, any of the following:

(i) Employment/Education-Related Day Care (ERDC).

(ii) An adult in or out of the household available to provide care free of charge.

(iii) Changing employment plan activities so that a family member can care for the child.

(B) The participant has resources or support services from their sponsor or other previously resettled extended family members.

(2) Support services will be made available case by case, based on the participant's individual needs. The job worker shall develop a support service action plan which will be adjusted as the case conditions change. The coordination specialist shall approve support service action plans and issue payments to support the services as authorized.

(3) Support services are available to participants to:

(a) Allow participation in employment service authorized activities and components.

(b) Remove or reduce barriers to employment.

(c) Support job entry, including enabling disqualified participants, who are cooperating, to attend a verified job interview or accept a verified job offer.

(d) Help to maintain employment.

(e) Support voluntary job search.

(f) Enable completion of approved training.
(4) Support service payments:

(a) Must be issued directly to the provider, for child care payments.

(b) May be issued to the participant or the provider, as determined by the coordination specialist.

(5) Project support service components include:

(a) Coordination of services.

(b) Transportation support services.

(c) Mass transit training.

(d) Child care support services.

(e) Child care training.

(f) Individualized support services such as work clothing, tools, employment card, and over-the-counter reading glasses.

(g) Identifying and resolving medical barriers to employment.

(6) Authorization of support services shall be as follows:

(a) There shall be no retroactive reimbursement provided of transportation costs.

(b) Support services shall be dispensed based on the most cost-effective use of funding, effective use of CASE staff time, and administrative cost-effectiveness.

(c) All direct employment-related individualized support services shall have a written justification of need from the employer or transcribed by the project from the employer. This justification shall have a detailed accounting of the specific items required for the position. The coordinator and the job worker shall review the specific need. They shall jointly determine if the employment situation is stable, if the support service will translate into long-term employment retention for the client, and if the project can justify the outlay.

(d) The purchase of over-the-counter glasses may be requested from the participant, training instructor, job worker, or employer. Reading glass purchase is based on the best judgment of the coordinator from information received. No prescription glasses shall be purchased with support service funding.

(e) For other services, the employer and/or the participant shall submit a detailed written justification for support service to retain or enter employment. The coordinator and the job worker shall review the specific need. They shall jointly determine if the employment situation is stable, if the support will
translate into a long-term retention for the client, and if the Project can justify the outlay.

(7) The provider of all individualized support services shall fully account for purchases with receipts attached to the justification document.

(1) The Department helps an individual comply with the individual's case plan (see OAR 461-001-0025) by providing payments for child care, housing, transportation, and other needs to make participation in required activities (see OAR 461-001-0025) successful. These payments are provided for costs directly related to participation in activities, for costs necessary to obtain and retain a job, and for enhancing wages and benefits.

(a) In approving NAES support service payments, the Department must consider lower-cost alternatives.

(b) It is not the intent of the Department or of this rule to use Department funding when other funding is available in the community. It is the Department's expectation that case managers and clients work collaboratively to seek resources that reasonably are available to the client to facilitate participation in required activities.

(c) An NAES program client is not eligible to receive any support service payment, except for child care or transportation, during his or her first 30 days in the United States.

(2) An NAES program support service payment must be authorized in advance and is subject to the limitations of this rule.

(3) Subject to the limitations of state funding and this rule, an NAES program support services (see OAR 461-001-0025) payment is made available to an individual if all of the following requirements are met:

(a) The individual is an NAES participant.

(b) The individual has agreed to participate in a NAES activity or other approved activities as specified in the individual's case plan.

(4) Denials and Reductions. The Department may reduce, close, or deny in whole or in part an individual's request for an NAES support service payment in each of the following circumstances:

(a) If the individual is disqualified for failing to comply with a case plan, unless the payment in question is necessary for the client to comply with his or her case plan.

(b) If the purpose for the payment is not related to the individual's case plan.
(c) If the client disagrees with a support service payment offered or made by the Department as outlined in the client's case plan.

(5) **Required Verification.**

(a) The Department may require the individual to provide verification of a need for the support service prior to approval and issuance of payment if verification is reasonably available.

(b) The Department may require the individual to provide verification of costs associated with a support service if verification is reasonably available.

(6) **Child Care.** Payments for child care are authorized, as limited by OAR 461-160-0040, if necessary to enable the individual to participate in NAES program activities or other approved activities specified in the individual's case plan. If authorized, payment for child care will be made for:

(a) The lesser of the actual rate charged by the care provider and the rate established in OAR 461-155-0150. The Department rate for children in care less than 158 hours in a month is limited by OAR 461-155-0150, except that the cost of child care may be paid up to the monthly maximum when a child is in care less than 158 hours per month and---

(A) Appropriate care is not accessible to the individual at the hourly rate; or

(B) The individual is a teen parent using on-site care while attending education activities.

(b) The minimum hours necessary, including meal and commute time, for the individual to participate in NAES program activities, other approved activities, or to obtain and maintain employment.

(7) Child care payments may be provided when an individual is not participating in NAES program activities or other approved activities if payment is necessary for the client to retain his or her child care provider. Only the minimum amount necessary to maintain the child care slot with the provider may be covered as established in OAR 461-155-0150. Not more than 30 days between scheduled NAES program activities or other approved activities may be covered.

(8) Unless good cause (see OAR 461-193-0890) has been determined, an NAES program client must attend an NAES program child care orientation to receive on-going child care payments.

(9) **Housing and Utilities.** In addition to a payment for basic living expenses under OAR 461-135-0475, a payment may be provided to an NAES program participant to secure or maintain housing and utilities in the following situations:
(a) To prevent an eviction or utility shut-off, secure housing to find or maintain employment, or participate in activities listed in the individual's case plan. Payment is available when all of the following requirements are met:

(A) The individual cannot make a shelter or utility payment due to a lack of assets.

(B) The lack of assets did not result from an NAES program or Child Support disqualification, a reduction due to an IPV recovery, overpayment recovery (other than administrative error), or failure by the individual to pay shelter or utility expenses when funds were reasonably available.

(C) The individual's case plan addresses how subsequent shelter or utility payments are to be made.

(b) The shelter need results from domestic violence (see OAR 461-001-0000) and all of the following requirements are met:

(A) The individual is not eligible for the TA-DVS program.

(B) The individual is able to pay all subsequent shelter costs, either through the individual's own resources or through other resources available in the community.

(C) The individual's case plan addresses how subsequent shelter costs are to be paid.

(c) An NAES program client who receives a cash grant through the RCSP program is expected to meet the housing and utility expenses out of the amount received each month in the cash grant. A NAES program client who receives an RCSP program cash grant may receive a housing and utility support services payment on a case-by-case basis, if the client otherwise meets the support service payment eligibility criteria of this section.

(10) Transportation. The Department provides support services payments for transportation costs incurred in travel to and from NAES program activities or other approved activities. Payment is made only for the cost of public transportation or the cost of vehicle insurance, repairs, and fuel for a personally owned vehicle. The Department may not authorize payment for repair of a vehicle owned by an individual who is not in the filing group (see OAR 461-110-0330). A transportation support service payment is subject to the following considerations:

(a) A payment for public transportation is given priority over a payment for a privately owned vehicle.

(b) A payment for a privately owned vehicle is provided if the client or driver has a valid license and one of the following requirements is met:
(A) No public transportation is available or the client is unable to use public transportation because of a verifiable medical condition or disability for which no accommodation is available; or

(B) Public transportation is available but is more costly than the cost of car repair or fuel.

(11) Unless good cause has been determined, an NAES program client must attend an NAES program mass transit training to receive on-going transportation payments.

(12) Other Payments. The Department provides support services payments for other items directly related to participation in NAES program activities. A payment under this section may be authorized for:

(a) Reasonable accommodation of a client's disability (see OAR 461-001-0000).

(b) Costs necessary in obtaining and retaining a job or enhancing wages and benefits, such as:

   (A) Clothing and grooming for participation in NAES program activities or job interviews.

   (B) Moving expenses necessary to accept employment elsewhere.

   (C) Tools, bonding, and licensing required to accept or retain employment.

(c) Tuition for vocational training (see OAR 461-001-0025) through the NAES program only ---

   (A) After the client has been approved for vocational training;

   (B) When no other funding is available;

   (C) To the extent that Department funding designated for this purpose is available; and

   (D) When the training is necessary for a job leading to a higher wage and high demand occupation, as defined by the Workforce Investment Act (WIA).

Stats. Implemented: ORS 411.060, 411.070, 412.006, 412.049, 414.025(2), 418.040, 418.100

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Definitions and Categories of Overpayments

THIS RULE IS REVISED IN ITS ENTIRETY

The definitions in this rule apply to programs covered by Chapter 461 of the Oregon Administrative Rules other than child care programs.

(1) Except as provided otherwise in section (4) of this rule, an overpayment is any of the following:

(a) A cash, medical or food stamp benefit received by or on behalf of a client, or a vendor payment made by the Department on behalf of a client, that exceeds the amount for which the client is eligible.

(b) Public assistance payments designated by the Department for a specific purpose which are spent by a person on an expense not approved by the Department and not considered a basic requirement under standards adopted by the Department pursuant to ORS 411.070.

(c) Misappropriated public assistance when a person cashes and retains the proceeds of a check from the Department on which that person is not the payee and the check has not been lawfully endorsed or assigned to the person.

(d) Public assistance furnished for a need when that person is compensated by another source for the same need and the person fails to reimburse the Department when required by law.

(e) A cash benefit received by a client in the GA or SFPSS programs for a month for which the client receives a retroactive SSI lump-sum payment.

(f) A JOBS or SFPSS program support payment (see OAR 461-190-0211) used by a client for other than the intended purpose or issued when a client was not eligible for TANF as a result of fraud.

(2) Overpayments are categorized as follows:

(a) Except as otherwise provided in subsections (c) and (d) of this section, an administrative error overpayment is an overpayment caused by any of the following circumstances—

(A) The Department failed to reduce, suspend, or end benefits after timely receipt of information that required such action;

(B) The Department failed to use the correct benefit standard;

(C) The Department failed to compute or process a payment correctly;
(D) The Department failed to require a general assistance client to complete an interim assistance agreement; or

(E) The Department committed a procedural error that was no fault of the filing group or authorized representative.

(b) An administrative technical overpayment is an overpayment in a program other than the Food Stamp program caused by a client's failure to register for the JOBS program, to have a social security number, or to make a declaration of citizenship or alien status.

(c) A client error overpayment is an overpayment caused by misunderstanding or error on the part of a client, a client's receipt of unreduced benefits pending a hearing decision, a client's failure to return a benefit known by the client to exceed the correct amount, or a client's use of a JOBS or SFPSS program support payment (see OAR 461-190-0211) used for other than the intended purpose.

(d) A fraud overpayment occurs when an overpayment is determined to be an intentional program violation (see OAR 461-195-0601 and 461-195-0611) or is substantiated through a criminal prosecution.

(e) In the Food Stamp program, a provider error overpayment is an overpayment made to a drug or alcohol treatment center or residential care facility that acted as a client's authorized representative.

(3) In the Food Stamp program, trafficking is the buying or selling of food stamp benefits for cash or consideration other than eligible food; or the exchange for food benefits of firearms, ammunition, explosives, or controlled substances.

(4) It is not an overpayment when—

(a) Specifically so provided by rule;

(b) The benefit is paid pending a contested case hearing in a disqualification case unless the client was ineligible for the benefit for a reason other than the disputed disqualification; or

(c) A client is found eligible as a result of an error in judgment by the Department when judgment is permitted and the eligibility decision was based on the best information available to the client and the Department.

This rule applies to benefits and services delivered under chapters 410, 411 and 461 of the Oregon Administrative Rules.

(1) "Overpayment" means:
(a) A benefit or service received by or on behalf of a client, or a payment made by the Department on behalf of a client, that exceeds the amount for which the client is eligible.

(b) A payment made by the Department and designated for a specific purpose which is spent by a person on an expense not approved by the Department.

(c) A payment for child care made by the Department to, or on behalf of, a client that:

   (A) Is paid to an ineligible provider;

   (B) Exceeds the amount for which a provider is eligible;

   (C) Is paid when the client was not engaged in an activity that made the client eligible for child care, such as an activity of the JOBS program (see OAR 461-001-0025 and OAR 461-190-0151 to OAR 461-190-0401); or

   (D) Is paid when the client was not eligible for child care benefits.

(d) A misappropriated payment when a person cashes and retains the proceeds of a check from the Department on which that person is not the payee and the check has not been lawfully endorsed or assigned to the person.

(e) A benefit or service provided for a need when that person is compensated by another source for the same need and the person fails to reimburse the Department when required to do so by law.

(f) A cash benefit received by an individual in the GA or SFPSS programs for each month for which the client receives a retroactive SSI lump sum payment.

(g) In the TA-DVS program, only when an IPV in the TA-DVS program is established.

2. The Department may establish an overpayment for the initial month (see OAR 461-001-0000) of eligibility under circumstances including but not limited to:

   (a) The filing group, ineligible student, or authorized representative (see OAR 461-115-0090) withheld information;

   (b) The filing group, ineligible student, or authorized representative provided inaccurate information;

   (c) The Department fails to use income reported as received or anticipated in determining the benefits of the filing group; or
(d) The error was due to an error in computation or processing by the Department.

(3) Overpayments are categorized as follows:

(a) An administrative error overpayment is an overpayment caused by any of the following circumstances:

(A) The Department fails to reduce, suspend, or end benefits after timely reporting by the filing group, ineligible student, or authorized representative of a change covered under OAR 461-170-0011 and that reported change requires the Department to reduce, suspend, or end benefits;

(B) The Department fails to use the correct benefit standard;

(C) The Department fails to compute or process a payment correctly based on accurate information timely provided by the filing group, ineligible student, or authorized representative;

(D) In the GA and SFPSS programs, the Department fails to require a client to complete an interim assistance agreement; or

(E) The Department commits a procedural error that was no fault of the filing group, ineligible student, or authorized representative.

(b) A client error overpayment is:

(A) An overpayment caused by the failure of a filing group, ineligible student, or authorized representative to declare or report information or a change in circumstances as required under OAR 461-170-0011, including information available to the Department, that affects the client's eligibility to receive benefits or the amount of benefits;

(B) A client's unreduced liability or receipt of unreduced benefits pending a contested case hearing decision or other final order favorable to the Department;

(C) A client's failure to return a benefit known by the client to exceed the correct amount;

(D) A client's use of a JOBS or SFPSS program support payment (see OAR 461-190-0211) for other than the intended purpose;

(E) A payment for child care when the client was not engaged in an activity that made the client eligible for child care, such as an activity
of the JOBS program (see OAR 461-001-0025 and OAR 461-190-0151 to OAR 461-190-0401);

(F) A payment for child care when the client was not eligible for child care benefits; or

(G) The failure of a client to pay his or her entire share of the cost of services or the participant fee (see OAR 461-160-0610 and 461-160-0800) in the month in which it is due.

(c) A fraud overpayment is an overpayment determined to be an intentional program violation (see OAR 461-195-0601 and 461-195-0611) or substantiated through a criminal prosecution.

(d) In the SNAP program, a provider error overpayment is an overpayment made to a drug or alcohol treatment center or residential care facility that acted as a client's authorized representative.

(e) In the child care program, a provider error overpayment is a payment made by the Department on behalf of a client to a child care provider when:

(A) Paid to an ineligible provider;

(B) The payment exceeds the amount for which a provider is eligible.

(4) When an overpayment is caused by both an administrative and client error in the same month, the Department determines the primary cause of the overpayment and assigns as either an administrative or client error overpayment.

(5) In the SNAP program, the trading of a controlled substance (as defined in section 102 of the Controlled Substances Act in 21 U.S.C. 802) is the buying or selling of SNAP program benefits for cash or consideration other than eligible food; or the exchange for SNAP program benefits of firearms, ammunition, explosives, or controlled substances.

(6) In the TANF program, when an overpayment puts the client at greater risk of domestic violence (see OAR 461-001-0000), the overpayment is waived (see OAR 461-135-1200).
461-195-0511
Child Care Overpayments

THIS RULE IS REPEALED

(1) This rule defines overpayments in the Department’s child-care programs and explains when clients and providers are liable for an overpayment.

(2) Except as provided otherwise in section (3) of this rule, a child care overpayment is any of the following:

(a) A payment for child care made by the Department to, or on behalf of, a client that is paid to an ineligible provider or exceeds the amount authorized by law for the care provided.

(b) A payment designated by the Department for child care services which is spent by a client for some other purpose not approved by the Department and not considered a basic requirement under standards adopted by the Department pursuant to ORS 411.070.

(c) A misappropriated child care payment when a client cashes and retains the proceeds of a check from the Department on which the client is not the payee and the check has not been lawfully endorsed or assigned to the client.

(3) It is not a child care overpayment if any of the following subsections apply:

(a) A client fails to make a required report of a change in income during a reporting period, other than the changes covered in OAR 461-170-0011.

(b) The total due and paid to two or more providers exceeds the monthly limit the Department may pay on behalf of the client. The exception provided by this subsection does not apply if—

(A) Two or more providers are paid at the full-time rate; or

(B) One of the providers provides child care under a contract with the Department.

(c) A client unintentionally provides an inaccurate estimate of prospective income or other information.

(d) A client would otherwise be eligible for a payment and provides inaccurate information due to an aspect of a documented disability of the client.

(4) A child care payment is a client overpayment if made for care provided when a client:
(a) Was not engaged in an activity that made the client eligible for child care, such as an activity of the JOBS program (see OAR 461-001-0025 as well as OAR 461-190-0151 and following);

(b) Was not eligible for child care benefits;

(c) Has received and spent the payment intended for child care assistance for some other purpose not approved by the Department and not considered a basic requirement under standards adopted by the Department pursuant to ORS 411.070; or

(d) Misappropriated the child care payment by cashing and retaining the proceeds of a check from the Department on which the client is not the payee and the check has not been lawfully endorsed or assigned to the client.

(5) A child care overpayment occurring after November 30, 1999, not caused by the client or the provider is collectible as follows:

(a) The provider is liable for a provider overpayment made on behalf of a client eligible for child care payments.

(b) The client is liable for an overpayment if the client was not eligible for the payment.

(6) A client is liable for a client overpayment, and a provider is liable for an overpayment caused by the provider. The client and provider are jointly and severally liable for an overpayment caused by both. In the case of an alleged provider overpayment, a provider's failure to provide contemporaneous records of care provided creates a rebuttable presumption that the care was not provided.

(7) The Department may recover a child care overpayment for which a provider is liable by reducing up to 100 percent any future child care payments for which the provider bills the Department.

(8) An adult who cosigned an application with a minor provider applicant is responsible to repay an overpayment incurred by the minor provider.

Stat. Auth.: ORS 411.060, 418.100
Stats. Implemented: ORS 411.060, 411.122, 411.620, 411.640, 411.690, 418.100
THIS RULE IS REVISED IN ITS ENTIRETY

This rule outlines procedures for calculating an overpayment.

(1) If a client directly receives support that should be, but is not, used to reduce benefits, there is an overpayment for the amount of support the client received directly that should have been used to reduce benefits. This section does not apply if the support received makes the client ineligible for benefits.

(2) When an overpayment occurs due to the failure of a person to reimburse the Department, when required by law, for assistance (including cash medical support) furnished for a need for which that person is compensated by another source, the liability of such person is limited to the lesser of the following:

(a) The amount of the payment from the Department; or

(b) The amount by which the aggregate sum of all payments exceeds the maximum amount payable for such need under Department rules.

(3) If a client fails to comply with the requirements of OAR 461-120-0345 relating to medical insurance, an overpayment is calculated according to this section. The client is not included in the need group (see OAR 461-110-0630) during any period in which the client fails to meet a requirement of OAR 461-120-0345 by withholding information or giving false information. Therefore, there is an overpayment equal to the difference between the benefits the group received and the reduced amount it would have received had the client been removed from the need group.

(4) If the benefit group (see OAR 461-110-0750) was categorically eligible for food benefits, there is no food benefits overpayment based on resources, Social Security number, or residency. A food benefits overpayment may exist based on incorrect income.

(a) For a group found eligible for food benefits under OAR 461-135-0505(1)(a), (b) or (c), and the actual income made the group ineligible for the related program, the group remains categorically eligible for food stamps. A benefit group of one or two individuals would be entitled to at least the minimum food benefits allotment under OAR 461-165-0060.

(b) For a group found eligible for food benefits only under OAR 461-135-0505(1)(d), and the actual income equals or exceeds 185 percent of the Federal Poverty Level, the group is no longer categorically eligible. The overpayment is the amount of food benefits incorrectly received.
(5) When a client receives benefits in the OSIPM program and does not pay his or her share of the cost of service (client liability), the overpayment consists of all payments made by the Department on behalf of the client, including but not limited to capitation payments, Medicare Part D payments, all medical expenses for that period, waived service payments (including home-delivered meals and non-medical transportation), Medicare Buy-In (if not concurrently eligible for a Medicare Savings Program such as QMB), and mileage reimbursement.

(6) Credit against an overpayment is allowed as follows:

(a) In the GA, REF, and TANF programs, a credit is allowed for a client's payment for medical services made during the period covered by the overpayment, in an amount not to exceed the Department fee schedule for the service, but credit is not allowed for an elective procedure unless it would have been authorized if requested.

(b) Credit is allowed for an underpayment of benefits.

(c) In the FS program, if the overpayment was caused by unreported earned income, verified child-care costs are allowed as a credit to the extent the costs would have been deductible under OAR 461-160-0040 and 461-160-0430.

(d) In the TANF program, if the overpayment is caused by reported earned income, a credit is allowed for the Post-TANF grant if the client meets eligibility under OAR 461-135-1250 and the client has received less than 12 months of Post-TANF benefits.

(7) Benefits paid during the notice period (see OAR 461-175-0050) are included in the calculation of the overpayment if:

(a) The client failed to report changes within the reporting time frame; and

(b) Benefits could have been adjusted in time to prevent the overpayment if the client had reported changes at any time within the reporting time frame.

(8) An overpayment is determined and calculated by assigning unreported income to the applicable budget month without averaging the unreported income. There is a rebuttable presumption that a client's earnings reported in a quarterly earnings report from the Employment Department were received by the client in equal amounts during the months identified in the report.

(9) Earned income deductions are applied in calculating an overpayment except as follows:

(a) In the MAA, MAF, REF, and TANF programs, no earned income deduction (see OAR 461-160-0160 and 461-160-0190) is allowed for a client who, without good cause (see section (10) of this rule), did either of the following:
(A) Failed to report all earned income within the reporting time frame.

(B) Under reported earned income.

(b) In the FS program, no deduction is applied to earned income not timely reported.

(10) For the purposes of section (9) of this rule, good cause means circumstances beyond the client's reasonable control that caused the client to be unable to report income timely and accurately.

(11) When support has been retained by the Department.

(a) In the TANF program, the amount of support (other than cash medical support) retained by the Department as current reimbursement each month is added to other income to determine ineligibility. In the case of a client not eligible for TANF, the overpayment is offset by support retained by the Department as current reimbursement.

(b) In the medical programs, the amount of the cash medical support retained by the Department each month is excluded income and not used to determine eligibility for medical benefits. When a client has incurred a medical overpayment, it is offset by the amount of the cash medical support retained by the Department during each month of the overpayment.

(12) When a client has incurred an overpayment due to both an administrative error (see OAR 461-195-0501) and a client error (see OAR 461-195-0501) in the same month, the client error overpayment is calculated by determining the total overpayment for the month and subtracting from it the portion due to administrative error.

(13) When prospective budgeting (see OAR 461-001-0000) is used and the actual income differs from the amount determined under OAR 461-150-0020(2), there may be a client error overpayment only if the financial group (see OAR 461-110-0530) withheld information, failed to make a required change report, or provided inaccurate information. In such a case, the Department uses the actual income to determine whether there is, and the amount of, an overpayment.

(14) In the medical programs:

(a) There is no overpayment if the client was ineligible for financial assistance but, during the period in question, would have been eligible for EXT or any other medical program.

(b) When an overpayment of benefits from the GA, OSIP, REF, SFPSS, or TANF programs is caused by administrative error (see OAR 461-195-0501):
(A) The overpaid benefits are not counted as income in calculating eligibility for EXT, GAM, MAA, MAF, OSIPM, REFM, and SAC; and

(B) There is no corresponding medical program overpayment if the client had been eligible to receive medical benefits under EXT, GAM, MAA, MAF, OSIPM, REFM, or SAC.

(15) In the Food Stamp program, in compliance with the American Recovery and Reinvestment Act of 2009, effective April 1, 2009 through September 30, 2009, the amount between the normal Thrifty Food Plan (TFP) benefit amount under this section and the increased TFP benefit amount under OAR 461-155-0190 is not counted in the overpayment amount.

<table>
<thead>
<tr>
<th>No. in Need Group</th>
<th>Amount</th>
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<tbody>
<tr>
<td>4</td>
<td>$176</td>
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<td>8</td>
<td>1,058</td>
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<tr>
<td>Each additional individual</td>
<td>132</td>
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Normal TFP for October 1, 2008—September 30, 2009

This rule specifies how the Department calculates an overpayment (see OAR 461-195-0501).

(1) The Department calculates an overpayment by determining the amount the client received or the payment made by the Department on behalf of the client that exceeds the amount for which the client was eligible.

(2) When a filing group, ineligible student, or authorized representative (see OAR 461-115-0090) fails to report income, the Department calculates and determines the overpayment by assigning unreported income to the applicable budget month without averaging the unreported income, except a client's earned income reported quarterly from the Employment Department is considered received by the client in equal amounts during the months identified in the report.

(3) When using prospective budgeting (see OAR Division 461-150) and the actual income differs from the amount determined under OAR 461-150-0020(2), there may be a client error overpayment only when the filing group, ineligible student, or authorized representative withheld information, failed to report a change, or provided inaccurate information. In such a case, the Department uses the actual income to determine the amount of an overpayment.
When a filing group, ineligible student, or authorized representative fails to report all earned income within the reporting time frame, the earned income deduction (see OAR 461-145-0930, 461-160-0160, 461-160-0190, 461-160-0430, 461-160-0550, and 461-160-0552) is applied as follows:

(a) In the ERDC, OSIP, OSIPM, QMB, and REFM programs, the Department allows the earned income deduction.

(b) In the MAA, MAF, REF, and TANF programs, the Department allows the earned income deduction when good cause (see section (5) of this rule) exists.

(c) In the SNAP program, no deduction is applied to earned income not timely reported.

For the purposes of OAR 461-195-0501 to 461-195-0561, "good cause" means circumstances beyond the client's reasonable control that caused the client to be unable to report income timely and accurately.

When the Department retains support:

(a) In the TANF program, the amount of support (other than cash medical support) the Department retains as a current reimbursement each month is added to other income to determine eligibility. When a client is not eligible for TANF program benefits, the overpayment is offset by the support the Department retains as a current reimbursement.

(b) In the medical programs, the amount of the cash medical support the Department retains each month is excluded income and not used to determine eligibility for medical program benefits. When a client has incurred a medical program overpayment, the overpayment is offset by the amount of the cash medical support the Department retains during each month of the overpayment.

In the REF and TANF programs, when a client directly receives support used to determine eligibility or calculate benefits, the overpayment is:

(a) If still eligible for REF or TANF program benefits, the amount of support the client received directly; or

(b) If no longer eligible for REF or TANF program benefits, the amount of program benefits the client received.

When an overpayment occurs due to the failure of an individual to reimburse the Department, when required by law to do so, for benefits or services (including cash medical support) provided for a need for which that individual is compensated by another source, the overpayment is limited to the lesser of the following:
(a) The amount of the payment from the Department;

(b) Cash medical support; or

(c) The amount by which the total of all payments exceeds the amount payable for such a need under the Department's rules.

(9) Benefits paid during a required notice period (see OAR 461-175-0050) are included in the calculation of the overpayment when:

(a) The filing group, ineligible student, or authorized representative failed to report a change within the reporting time frame under OAR 461-170-0011; and

(b) Sufficient time existed for the Department to adjust the benefits to prevent the overpayment if the filing group, ineligible student, or authorized representative had reported the change at any time within the reporting time frame.

(10) In the SNAP program:

(a) If the benefit group (see OAR 461-110-0750) was categorically eligible, there is no overpayment based on resources.

(b) For a filing group (see OAR 461-110-0370) found eligible for SNAP program benefits under OAR 461-135-0505(1)(a) to (c), and the actual income made the group ineligible for the related program, the group remains categorically eligible for SNAP program benefits as long as the eligibility requirement under OAR 413-135-0505(1)(d) is met. A benefit group of one or two individuals would be entitled to at least the minimum SNAP program benefit allotment under OAR 461-165-0060.

(c) For a filing group found eligible for SNAP program benefits only under OAR 461-135-0505(1)(d), and the actual income equals or exceeds 185 percent of the Federal Poverty Level, the filing group is no longer categorically eligible. The overpayment is the amount of SNAP program benefits incorrectly received.

(11) In the OSIP and OSIPM programs, when a client does not pay his or her share of the cost of services or the EPD program participant fee (see OAR 461-160-0610 and 461-160-0800) in the month in which it is due, an overpayment is calculated as follows:

(a) All payments made by the Department on behalf of the client during the month in question are totaled, including but not limited to any payment for:
(A) Capitation;
(B) Long term care services;
(C) Medical expenses for the month in question;
(D) Medicare buy-in (when not concurrently eligible for an MSP);
(E) Medicare Part D;
(F) Mileage reimbursement;
(G) Special needs under OAR 461-155-0500 to 416-155-0710; and
(H) Waivered services, including home delivered meals and non-medical transportation.

(b) Any partial liability payment made by a client receiving in-home waivered services or participant fee paid by an EPD program client is subtracted from the total calculated under subsection (a) of this section. The remainder, if any, is the amount of the overpayment.

(12) When a client's liability is unreduced pending the outcome of a contested case hearing about that liability the overpayment is the difference between the liability amount determined in the final order and the amount, if any, the client has repaid.

(13) When a client was not eligible for benefits under his or her medical program during the period in question, but during the period in question was eligible for another medical program with a lesser benefit level, the overpayment is the amount of medical program benefit payments made on behalf of the client exceeding the amount for which the client was eligible.

(14) When an overpayment is caused by administrative error (see OAR 461-195-0501), any overpayment of GA, OSIP, REF, SFPSS, or TANF program benefits is not counted as income when determining eligibility for the EXT, GAM, MAA, MAF, OSIPM, REFM, and SAC programs.

(15) Credit against an overpayment is allowed as follows:

(a) In the GA, REF, and TANF programs, a credit is allowed for a client's payment for medical services made during the period covered by the overpayment, in an amount not to exceed the Department fee schedule for the service, but credit is not allowed for an elective procedure unless the Department authorized the procedure prior to its completion.
(b) In the SNAP program, if the overpayment was caused by unreported earned income, verified child care costs are allowed as a credit to the extent the costs would have been deductible under OAR 461-160-0040 and 461-160-0430.

(c) In the SFPSS and TANF programs, if the overpayment is caused by reported earned income, a credit is allowed for the Post-TANF grant if the client meets eligibility under OAR 461-135-1250 and the client has received less than 12 months of Post-TANF program benefits.

(d) In all programs, for an underpayment of benefits.

(16) In the SNAP program, in compliance with the American Recovery and Reinvestment Act of 2009, effective April 1, 2009 through September 30, 2009, the amount between the normal Thrifty Food Plan (TFP) benefit amount under this section and the increased TFP benefit amount under OAR 461-155-0190 is not counted in the overpayment amount unless the filing group was ineligible for SNAP program benefits.

Normal TFP for October 1, 2008 - September 30, 2009

<table>
<thead>
<tr>
<th>SNAP Payment Standard (TFP)</th>
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<tbody>
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Establishment of Overpayments

THIS RULE IS REPEALED

(1) The Department will not establish an administrative technical overpayment if the client was willing and able to meet the eligibility requirements and would have been eligible for the same amount of benefits had the requirements been met.

(2) The Department will establish an overpayment for the initial month of eligibility only when:

   (a) The client withheld material information;

   (b) The client provided false information;

   (c) The Department failed to use income reported as received or anticipated in determining the client’s benefits; or

   (d) The error was due to an error in computation by the Department.

(3) In the TA-DVS program, the Department will establish an overpayment only if an IPV in the TA-DVS program has been established.

Stat. Auth.: ORS 411.060, 411.660, 411.816
Stats. Implemented: ORS 411.630, 411.635, 411.660
Liability for Overpayments and Trafficking

THIS RULE IS REVISED IN ITS ENTIRETY

(1) For all programs except BCCM, EXT, FS, GAM, MAA, MAF, OHP, OSIPM, QMB, REFM, and SAC, the following individuals are liable for repayment of an overpayment:

(a) Each individual included in the benefit group (see OAR 461-110-0750) when the overpayment was incurred, except for individuals who did not reside with, and did not know they were included in, the benefit group.

(b) A caretaker relative (see OAR 461-001-0000) and his or her spouse (see OAR 461-001-0000) who were not part of, but resided with, the filing group when the overpayment was incurred.

(c) A parent (see OAR 461-001-0000) or caretaker relative of a child (see OAR 461-001-0000) in the benefit group and the spouse of the parent or caretaker relative if the parent, caretaker relative, or spouse was a member of or resided with the filing group when the overpayment was incurred.

(d) If an individual currently in a benefit group is liable for an overpayment, the entire benefit group is liable for the overpayment. In this case, the Department will not collect from the benefit group until it has unsuccessfully attempted to collect the overpayment from all other liable individuals.

(2) In the Food Stamp program, the following individuals are liable for repayment of an overpayment or a claim that results from trafficking (see OAR 461-195-0501(3)):

(a) The primary person (see OAR 461-001-0015) of any age, an ineligible student in the household, and all adults who were members of the filing group (see OAR 461-110-0370) when excess benefits were issued, except no member of a financial group (see OAR 461-110-0530) is liable for an overpayment caused by a change the group was not required to report.

(b) A sponsor of a non-citizen household member if the sponsor is at fault.

(c) A drug or alcohol treatment center or residential care facility that acted as the authorized representative of the client if this authorized representative gave incorrect or incomplete information or withheld information resulting in the overpayment.

(3) In the BCCM, EXT, GAM, MAA, MAF, OHP, OSIPM, QMB, REFM, and SAC programs, the following individuals are liable for repayment of an overpayment:

(a) The primary person, if that person is an adult, and all other adults in the filing group except the following:
(A) An adult not in the benefit group, except a parent (see OAR 461-001-0000) of a child (see OAR 461-001-0000) in the benefit group.

(B) An adult who was in the benefit group when the overpayment occurred but who did not live with the benefit group and was unknowingly in the benefit group.

(b) If an individual currently in a benefit group is liable for an overpayment, the entire benefit group is liable for the overpayment. In this case, the Department will not collect from the benefit group until it has unsuccessfully attempted to collect the overpayment from all other liable persons.

(4) In all programs, both the non-citizen and the sponsor of a non-citizen are liable for an overpayment incurred if the overpayment results from the failure of the sponsor to provide correct information (see OAR 461-145-0820 to 461-145-0840). If the sponsor had good cause for withholding the information, the non-citizen alone is liable for the overpayment.

(1) In all programs except the BCCM, CEC, CEM, EXT, GA, GAM, MAA, MAF, OHP, OSIP, OSIPM, QMB, REFM, SAC and SNAP programs or a child care program, the following persons are liable for repayment of an overpayment (see OAR 461-195-0501):

(a) Each individual in the filing group or required to be in the filing group and the payee when the overpayment was incurred, except an individual who did not reside with and did not know he or she was included in the filing group.

(b) A caretaker relative (see OAR 461-001-0000) and his or her spouse (see OAR 461-001-0000) who were not part of, but resided with, the filing group when the overpayment was incurred.

(c) A parent (see OAR 461-001-0000) or caretaker relative of a child (see OAR 461-001-0000) in the benefit group (see OAR 461-110-0750) and the spouse of the parent or caretaker relative if the parent, caretaker relative, or spouse was a member of or resided with the filing group when the overpayment was incurred.

(d) An individual determined liable for an overpayment remains liable when the individual becomes a member of a new filing group.

(e) An authorized representative (see OAR 461-115-0090) when the authorized representative gave incorrect or incomplete information or withheld information resulting in the overpayment.

(2) In the BCCM, CEC, CEM, EXT, MAA, MAF, OHP, REFM, and SAC programs, the following persons are liable for repayment of an overpayment:
(a) Each individual in the filing group or required to be in the filing group and the payee when the overpayment was incurred, except an individual who ---

(A) Was a child or dependent child (see OAR 461-001-0000) at the time of the overpayment; or

(B) Did not reside with and did not know he or she was included in the filing group.

(b) A caretaker relative (see OAR 461-001-0000) and his or her spouse (see OAR 461-001-0000) who were not part of, but resided with, the filing group when the overpayment was incurred.

(c) A parent (see OAR 461-001-0000) or caretaker relative of a child (see OAR 461-001-0000) in the filing group and the spouse of the parent or caretaker relative if the parent, caretaker relative, or spouse was a member of or resided with the filing group when the overpayment was incurred.

(d) An authorized representative (see OAR 461-115-0090) when the authorized representative gave incorrect or incomplete information or withheld information that resulted in the overpayment.

(3) In a child care program:

(a) An overpayment caused by administrative error is collectible as follows:

(A) The provider is liable for a provider overpayment made on behalf of a client eligible for child care payments.

(B) The client is liable for an overpayment if the client was not eligible for the payment.

(b) A client is liable for a client overpayment, and a provider is liable for an overpayment caused by the provider. The client and provider are jointly and severally liable for an overpayment caused by both. In the case of an alleged provider overpayment, a provider's failure to provide contemporaneous records of care provided creates a rebuttable presumption that the care was not provided.

(c) An adult who cosigned an application with a minor provider applicant is liable for an overpayment incurred by the minor provider.

(4) In the GA, GAM, OSIP, OSIPM, and QMB programs, the following persons are liable for repayment of an overpayment:
(a) Each individual in the filing group or required to be in the filing group and the payee when the overpayment was incurred, except an individual who ---

(A) Was a child or dependent child (see OAR 461-001-0000) at the time of the overpayment; or

(B) Did not reside with and did not know he or she was included in the filing group.

(b) A caretaker relative (see OAR 461-001-0000) and his or her spouse (see OAR 461-001-0000) who were not part of, but resided with, the filing group when the overpayment was incurred.

(c) A parent (see OAR 461-001-0000) or caretaker relative of a child (see OAR 461-001-0000) in the filing group and the spouse of the parent or caretaker relative if the parent, caretaker relative, or spouse was a member of or resided with the filing group when the overpayment was incurred.

(d) An authorized representative (see OAR 461-115-0090) when the authorized representative intentionally gave incorrect or incomplete information or intentionally withheld information that resulted in the overpayment.

(5) In the SNAP program, the following persons are liable for repayment of an overpayment or a claim that results from the trading of a controlled substance (see OAR 461-195-0501(6)):

(a) The primary person (see OAR 461-001-0015) of any age, an ineligible student in the household, and all adults who were members of or required to be in the filing group (see OAR 461-110-0370) when excess benefits were issued.

(b) A sponsor of a non-citizen household member if the sponsor is at fault.

(c) A drug or alcohol treatment center or residential care facility that acted as the authorized representative of the client.

(6) In all programs, both a non-citizen and the sponsor of the non-citizen are liable for an overpayment incurred if the overpayment results from the failure of the sponsor to provide correct information (see OAR 461-145-0820 to 461-145-0840). If the sponsor had good cause (see OAR 461-195-0521(5)) for withholding the information, the sponsor is not liable for the overpayment.
Methods of Recovering Overpayments

THIS RULE IS REVISED IN ITS ENTIRETY

(1) For all programs, in addition to judicial process, the Department may recover overpayments through an agreed repayment plan, reduction in benefits, voluntary payment from the client, and offset of the debt. In medical programs, benefits are reduced to collect an overpayment only in the GAM program, and only non-medical benefits are reduced.

(2) The Department reduces current benefits to collect an overpayment only as follows:

(a) In the Food Stamp program, unless the Department and the client agree to a repayment plan and the filing group (see OAR 461-110-0370) meets the terms of the plan, the Department collects an overpayment from a liable filing group participating in the Food Stamp program by reducing the food stamp allotment of the benefit group (see OAR 461-110-0750) each month as follows:

(A) For an overpayment caused by client error (see OAR 461-195-0501) or administrative error (see OAR 461-195-0501), 10 percent of the group’s monthly allotment or $10 a month, whichever is greater.

(B) For an overpayment caused by conduct that constituted an IPV (see OAR 461-195-0601), 20 percent of the group’s monthly entitlement or $20 a month, whichever is greater.

(b) In the GA, GAM, and OSIP programs, the Department may recover an overpayment by reducing cash benefit payments by the lesser of the following:

(A) The total overpayment amount.

(B) The total benefit amount.

(C) 10 percent of the client’s total benefit requirement at the standard of need.

(c) For overpayments in the REF, SFPSS, and TANF programs, the Department:

(A) Allows only half of the 50 percent earned income deduction described in OAR 461-160-0160.

(B) Reduces the benefit payment for REF, SFPSS, and TANF, in an amount equal to 10 percent of the total benefit requirement of the benefit group at the full standard of need. The benefit payment after such reduction, when combined with all other income (before allowing the 50 percent earned income deduction), must be sufficient to provide the benefit group with 90
percent of the standard for a family with no income. In the TANF program, the cooperation incentive (see OAR 461-135-0210) is not included in the calculations prescribed by this paragraph.

(3) For overpayment of child care benefits, the Department may not recover an overpayment through reduction of a client's child care benefits.

(4) The Department may recover an overpayment by offset as follows:

(a) For all programs, the Department uses the collection services provided by the Department of Revenue and any other state or federal agency to collect a liquidated claim established by:

(A) A court judgment.

(B) A confession of judgment.

(C) A document signed or acknowledged by the debtor that acknowledges the debt, such as:

(i) The Department-designated form to acknowledge an IPV.

(ii) A plea-bargain agreement.

(iii) Any other document acknowledging the overpayment.

(D) A written notification of overpayment from the Department to the debtor, advising the debtor of the basis and amount of the overpayment and the right to request a hearing, if the debtor has exhausted his or her rights of administrative appeal.

(E) A written communication from the debtor acknowledging the debt.

(b) In cases that have both an underpayment and an overpayment in the same program, the Department offsets one against the other.

(c) The amount of any retroactive payment or restoration of lost benefits otherwise payable to the client, when the retroactive payment corrects a prior underpayment of benefits in the program in which the overpayment occurred.

(d) By offsetting the full amount of the overpayment against restored benefits owed to the benefit group or to another FS benefit group that a liable member of the overpaid group has joined.
(e) Through use of a warrant authorized by ORS 18.900 or 411.703. Upon issuance of the warrant, the Department may issue a notice of garnishment in accordance with ORS 18.854.

(5) A confession of judgment is used in the case of a client error overpayment. The Department may not file a confession of judgment while the client receives public assistance and may file one only if the client has refused to agree to or has defaulted on a repayment plan.

(6) The Department may not take collection action against a filing group while a member of the group is working under a JOBS Plus agreement.

(1) In addition to judicial process, the Department may recover an overpayment (see OAR 461-195-0501) through an agreed repayment plan, reduction in benefits, voluntary payment from the client or authorized representative (see OAR 461-115-0090), and offset of the debt.

(2) The Department reduces current benefits to collect an overpayment only as follows:

(a) In the GA and OSIP programs, the Department may recover an overpayment by reducing cash benefit payments by the lesser of the following:

(A) The total overpayment amount;

(B) The total benefit amount; or

(C) Ten percent of the client's total benefit requirement at the standard of need.

(b) In the REF, SFPSS, and TANF programs, the Department:

(A) Allows only half of the 50 percent earned income deduction described in OAR 461-160-0160.

(B) Reduces the benefit payment by 10 percent of the total benefit requirement of the benefit group (see OAR 461-110-0750) at the adjusted income payment standard. The reduced benefit payment after such reduction, when combined with all other income may not be less than 90 percent of the benefit group's adjusted income payment standard for a family with no income. In the TANF program, the cooperation incentive (see OAR 461-135-0210) is not included in the calculations prescribed by this paragraph.

(c) In the SNAP program, unless the Department and the client agree to a repayment plan and the filing group (see OAR 461-110-0370) meets the terms of the plan, the Department collects an overpayment from a liable member of
a filing group participating in the SNAP program by reducing the SNAP program benefit allotment of the benefit group each month as follows:

(A) For an overpayment caused by client error (see OAR 461-195-0501) or administrative error (see OAR 461-195-0501), 10 percent of the group's monthly allotment or $10 a month, whichever is greater.

(B) For an overpayment caused by an IPV (see OAR 461-195-0601), 20 percent of the group's monthly entitlement or $20 a month, whichever is greater.

(3) In the child care programs:

(a) The Department may not recover an overpayment through reduction of a client's child care program benefits.

(b) When a child care program provider is liable for a child care overpayment (see OAR 461-195-0501) the Department may recover the child care overpayment by reducing up to 100 percent any future child care payment for which the provider bills the Department.

(4) The Department may recover an overpayment by offset as follows:

(a) Using the collection services provided by the Department of Revenue and any other state or federal agency to collect a liquidated claim established by:

(A) A court judgment.

(B) A confession of judgment.

(C) A document signed or acknowledged by the debtor that acknowledges the debt, such as:

(i) The Department-designated form to acknowledge an IPV.

(ii) A plea-bargain agreement.

(iii) Any other document acknowledging the overpayment.

(D) A written notification of overpayment from the Department to the debtor, advising the debtor of the basis and amount of the overpayment and the right to request a hearing, if the debtor has exhausted his or her rights of administrative appeal.

(E) A written communication from the debtor acknowledging the debt.
(b) The amount of any retroactive payment or restoration of lost benefits otherwise payable to the client, when the retroactive payment corrects a prior underpayment of benefits in the program in which the overpayment occurred.

(c) Through use of a warrant authorized by ORS 411.703. Upon issuance of the warrant, the Department may issue a notice of garnishment in accordance with ORS 18.854.

(d) In the SNAP program, by offsetting the full amount of the overpayment against restored benefits owed to the benefit group or to another benefit group that a liable member of the overpaid group has joined.

(5) A confession of judgment is used in the case of a client error (see OAR 461-195-0501) overpayment. The Department may not file a confession of judgment while the client receives public assistance and may file one only if the client has refused to agree to or has defaulted on a repayment plan.

(6) The Department may not take collection action against a filing group while a member of the filing group is working under a JOBS Plus agreement.

Compromise of an Overpayment Claims Claim

THIS RULE IS REVISED IN ITS ENTIRETY

(1) This rule establishes the policy of the Department for compromising claims for overpayments in the Child Support, ERDC, Food Stamp, medical, SFPSS, and TANF programs. The Department may consider a request to compromise an overpayment claim only if the costs of administration and collection necessary to collect the account in full would likely exceed the current balance of the overpayment. In making the determination whether to compromise, the Department considers the requester’s ability to repay the overpayment in full within a reasonable time, as evidenced by such factors as:

(a) Income less than 200 percent of the federal poverty level (see OAR 461-155-0180(6)); or

(b) Income and liquid assets that are small compared with the outstanding overpayment.

(2) The following limitations and considerations apply to the evaluation by the Department of a request to compromise an overpayment claim:

(a) The authority of the Department to compromise may be limited by federal or state law.

(b) The Department may allow a compromised claim to be paid in installments over a period not to exceed 90 days.

(c) The Department may compromise a claim only once it is a liquidated claim; liquidated claim is described in OAR 461-195-0551.

(d) The Department may compromise a claim that exceeds $20,000 only to the extent permitted by the rules of the Secretary of State.

(e) Except for an overpayment in the child support program, the Department may not agree to compromise a claim for less than 75 percent of the total amount of the claim. In the child support program, the amount for which a claim will be compromised is determined following the applicable standards in OAR 137-055-6120(1).

(f) During the 12 months following the date of the compromise agreement, the Department reserves the right to collect the original, unmitigated claim through benefit reduction (see OAR 461-195-0551). This subsection does not apply to claims in the child support program.

(3) The following limitations apply to a request to compromise an overpayment:
(a) A request for compromise may be considered only if 36 months have passed since the requester was first notified of the overpayment.

(b) A request for compromise may be considered only if 12 months have passed since the requester was last eligible for and received benefits of the program in which the overpayment occurred or last received a direct provider payment for child care (see the rules in division 165 of this chapter of rules). This subsection does not apply to claims in the child support program.

(c) An overpayment caused by the requester’s conduct is subject to compromise only if caused by his or her inadvertent error or by circumstances beyond his or her reasonable control.

(d) The Department may not compromise a claim if the requester has not made a good faith effort to repay the overpayment.

(e) The Department is more likely to approve a request to compromise if the requester has not previously caused an overpayment in the same program.

This rule specifies when and how the Department may compromise an overpayment (see OAR 461-195-0501) claim.

(1) The Department may consider a request to compromise an overpayment claim only if the estimated administration and collection costs necessary to collect the account in full likely exceed the current balance of the overpayment.

(2) The following limitations apply to the compromise of an overpayment claim:

(a) The authority of the Department to compromise may be limited by federal or state law.

(b) The Department may compromise a claim only once it is a liquidated claim (see OAR 461-195-0551).

(c) The Department may compromise a claim only if the requester has made a good faith effort to repay the overpayment.

(d) The Department may not compromise:

(A) A fraud overpayment claim;

(B) Any overpayment claim, unless 36 months have passed since the requester initially was notified of the overpayment;
(C) An overpayment claim if the debtor has the ability to repay the overpayment in full within 36 months of the request date.

(D) An overpayment claim for less than 75 percent of the total amount of the claim.

(E) An overpayment claim if the debtor is a member, currently or in the previous 12 months, of a filing group that received benefits under the program in which the overpayment occurred.

(F) A child care provider overpayment claim if the provider, currently or in the previous 12 months, received a direct provider payment for child care under division 165 of this chapter of rules.

(3) The Department may allow a compromised claim to be paid in installments over a period not to exceed 90 days.

(4) During the 12 months following the date of the compromise agreement, the Department reserves the right to collect the original unmitigated claim through benefit reduction under OAR 461-195-0551.