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| **APPLICATION DATE:** | Enter application/RRR received date for program(s)  \*Note: some applications have multiple received dates | |
| **INITIAL/RRR DATE w/ NEW BENEFIT BEGIN DATE:** | Enter RRR month & payment month.  Example: FA RRR 7/2020 for payment starting 8/2020  If the document was from PEAK, include the PEAK tracking #. | |
| **CASE NUMBER:** | Client’s current case number | |
| **CLIENT/HOH INFO:** | Information for head of household/client as follows;  Last Name, First Name: SSN, DOB (AGE#), Marital Status and ethnicity  Ongoing Mode: Only need ages of all members of the household | |
| **PHONE NUMBER(S):** | Home and Cell phone numbers & email address, be sure to update CBMS | |
| **ADDRESS:** | Client’s current home address and mailing address if different | |
| **INTERVIEW DATE/TIME/TYPE:** | Time, date and type (Phone or F2F) of interview.  Note here if client missed interview. | |
| **PROGRAMS REQUESTED:** | List all programs requested by the client and any programs already active. | |
| **COMPANION CASES:** | List other cases were member is currently receiving benefits | |
| **PRIOR AID/TANF CLOCK COUNT (USED):** | List where, when & what programs for all household members.  CW Only: Ask client if they have ever lived outside of CO, and if so did they received cash assistance “out of state” to countable TANF months. In order to enter the used TANF months into CBMS we must have verification, we cannot use client statement  TANF: Have they used any CW Months? Put the amount here | |
| **DRUG/FLEEING FELON ADDRESSED:** | Are there any open warrants out for any members of the HH? | |
| **HH COMPOSITION:** | Total # of members of household applying for benefits  Example: 2A3C (2Adults 3 Children)  List each member’s Name, SSN, DOB (age#), relationships (half sibling, step sibling, step mom etc.)  Ongoing Mode: List Member, their age and relationship | |
| **OTHER INDVIDUALS IN THE HOME:** | Anyone else that lives at the same address but is not a mandatory household member and is not requesting benefits. | |
| **TAX FILER QUESTIONS:** | List all household members’ tax filer status. Who is filing taxes, who is a dependent and who is claiming the dependents.  List here name and contact information of parent(s) that claim applicant when Additional Tax Information Packet is requested | |
| **IDENTIFICATION/ CITIZENSHIP or NON-U.S. CITIZENSHIP w/ VERIFICATION SOURCE:** | List the documents the client provided or where they are currently found (example: EDOCS, EDMS, etc.). Or verified by (interface name). | |
| **SAVE:** | SAVE must be run at intake, RRR and at a minimum once a year for Non-Citizens with INS documentation  Enter the SAVE batch ID # and requested date. Print & scan into client’s file. | |
| **SPONSOR’S INFORMATION:** | Name, SSN & DOB of sponsor and spouse.  Sponsor’s household comp., income & resources. | |
| **AUTHORIZED REP:** | An individual authorized to discuss or make changes to the case.  Example: POA (Power of Attorney, Personal Rep. Form) must be in writing | |
| **PREGNANT/DUE DATE:** | Name of person pregnant and due date.  Include absent parent info.  It’s required for CW MA per rule.  CW and Employment First require verification of pregnancy. | |
| **EARNED INCOME/ SELF-EMPLOYMENT** | Client’s & employers name, wage frequency, hours worked per pay period, pay dates & gross amounts of checks received.  Include the income conversion calculation here | |
| **UNEARNED INCOME:** | All other money coming into the home.  Examples: Unemployment, SSA income (Title II or Title XVI), VA Income, Child Support/Alimony, rental income, gifts, pensions, lottery and gambling winnings.  Include the income conversion calculation here | |
| **RESOURCES** (Name, Type and Value)**:** | Liquid Assets (Checking/Savings accounts, 401k), Vehicles, Real Property (Homes), Annuities, Life insurance, Burial Asset.  List Asset Verification Program (AVP) response  \*Resources must be entered into CBMS if reported. Verification is required for all Non-Magi, SNAP Standard Eligibility Category and Adult Programs. | |
| **RENT, MORTGAGE, HOA, HOMEOWNER’S INSURANCE:** | Rent or mortgage, property taxes, homeowner’s insurance and home owner’s association fees if paid separate from mortgage.  Remember to ask the client if they have Sec8, housing assistance and/or roommates. If so, only enter the amount the client is responsible to pay.  If rent/shelter expense other than SUA is prorated, include the conversion calculation here | |
| **TYPE OF UTILITIES PAID/Received LEAP:** | List utility types and amounts.  Ask if client is responsible for heating *or* cooling. If client declares electric only, ask client if their electric runs their heater or AC (Evaporative or Swamp Cooler)  Was LEAP received at any address within the last 12 months for any adult in the home | |
| **DEDUCTIONS** (Medical/Day Care/Child Support)**:** | Have the expenses been verified or are they client statement?  List all medical expense and amounts reported by client \*Note: Medical expenses only count for FA if household member is elderly or disabled.  List child care and/or child support expenses. Is the child support for “current” or “arrears”?  Does the client have the Medicare Buy-In (Yes/No)? If yes, does the client pay the Medicare premium? | |
| **STUDENT INFO:** | List individual name, school name & graduation date. FA & CW requires student information for all individuals age 16 and over.  Education may require verification if the higher education student meets an exemption to be eligible to receive FA benefits or if a HS student is working. | |
| **DISABILITY DETERMINATION** (referred)/MED 9/DATE IM-14 ENTERED/DATE IAR ENTERED/ARG: | Who is disabled and who verified disability?  SSA, Arbor (ARG)or Doctor’s statement.  Did anyone apply for SSI?  For AND-SO program: MED-9 How many months disabled? (6,7,8…12) IM-14 form received signed and valid | |
| **DSS1/ULTC 100.2:** | Yes, if current ULTC 100.2 in file has not expired. List Client’s current waiver program and Start and End dates as noted on ULTC 100.2  If No, request a current waiver from SEP – Date DSS1 was sent or date DSS1 was received from SEP | |
| **OTHER HEALTH INSURANCE:** | Who is the policy holder, Plan or Group #, if through employment Employer Name and what insurance company? Who is covered? What are the dates of coverage begin and end date? | |
| **DOLE/UIB:** | DOLE: Employer’s name and last quarter found.  UIB amount of benefit? When did UIB end or exhausted?  Verification of Child Support garnished from UIB?  Verification of Termination of Employment screen 18 received | |
| **WORK NUMBER:** | Document active employers within previous 3 months. Include verification of termination if need for a program(s). Upload into HSC ONLY if it has income or termination of income that will be used for eligibility on the case. Do not check Work # for MA Only cases. | |
| **IEVS RUN DATE/DATE CLEARED:** | Date: list hit run date; what was cleared and why or NRF | |
| **INTERFACES REVIEWED:**  (SVES; SDX/BENDEX; DRS; NDHR; PARIS; EDMS; HSC; EBT) | Date; list information found, if used for eligibility, upload into HSC | |
| **CLAIMS GENERATED?:** | Did you create any claims? Are there any Discrepancies that need to be researched? | |
| **EBT/EPPIC(CCAP ONLY) CARD:** | Does the client have a card? If no, complete EBT referral for the front desk and send the client to pick up a card. If they have a card, check to see if the card is active? Is the card in good condition? Does client know PIN? | |
| **VERIFICATIONS REQUESTED & DUE DATE:** | List verification requested and due date(s) for what program, and for which HH member | |
| **REFERRALS** (Date Given/Mailed) **EF102: WORKFORCE/ROADMAP/CCO2:**  **OAP:**  **WIC:**  **ARAPASOURCE:** | EF: EF102 completed and give/mailed to client. If exempt, list the reason for the exemption.  CW Assessment: IRC completed and Workforce referral given? CCO2 completed for CCAP?  OAP: Early retirement referral at 62 or SSI referral at 65  WIC: If pregnant, breastfeeding, postpartum, children up to age 5 explain WIC program and how to apply  Did you refer them to a homeless shelter or any other resources  Did you provide information about ArapaSource? | |
| **WRAP UP CALCULATIONS:**  (Would use this section only for New Hires or possibly for those on sign off) | # Eligible HH Members | How many eligible HH members? |
| Income (calculations above) | What is the total countable/converted, both earned and unearned income for the HH? |
| Gross Income Standard | What is the Gross income standard for all requested and/or active programs for the HH. List out each if there are different programs/categories |
| Total Housing Cost (calculations here or above) | What is the total housing cost? If the HH is undocumented. |
| Total Utility Cost | Put in the total deduction. If HCUA $485, BUA $310, etc. |
| Dependent Care | If paying for dependent care, enter monthly amount here. |
| Homeless Shelter Disregard | Are they homeless and receiving the homeless deduction? If yes, put the homeless deduction here. |
| Court Ordered Child Support | If paying child support, enter monthly amount here. |
| FA Medical Disregard | If eligible, enter the medical disregard given here |
| Resources | Enter amounts of any countable resources here |
| MA Disregards | Enter any MA disregards here |
| Does it match in wrap up? | After you have all your information here that you believe to be correct, now check against wrap up. If it does not match then there is a problem. Go back to the corresponding screen to look for the error. |
| **HOW MEETING EXPENSES?** | How is client meeting their expenses? Spell it out. | |
| **RIGHTS AND RESPONSIBILITIES DISCUSSED:** | Did you go over the rights and responsibilities? | |
| **ADDITIONAL COMMENTS** (Wrap Up Information)**:** | Summary of Case, results and program status | |
| **NEW RRR DUE DATES:** | List RRR month for all programs. | |
| **TECH NAME/ DATE:** | Your name and date you completed the case action. | |