July - September 2022 Summary of Changes

Chapter	Passage	Summary
0200	0230.0105 0240.0103 0240.0105	Adding technical requirement exception for applying for SSA benefits Adding EMA as an exception for applying for all other benefits Adding technical requirement exception for applying for SSA benefits
0800	0820.0500	Removed sanctioning language for failing to report a child's absence within five days. Also, language to evaluate ongoing Medicaid eligibility.
1420	1420.0509.01 1420.2000	Update refugee exemption from eight-months to 12-months Update refugee exemption from eight-months to 12-months; removed immunization learnfare language
1430	1430.0105, 1440.0105 1430.1400, 1440.1400	Created a list of the sections of the Immigration and Nationality Act (INA) that define a Qualified noncitizen Adding EMA as an exception for applying for all other benefits
1630	1640.0565.01 1640.0565.02	Updated to include household items, personal effects, personal property, and items held because their value or investment Passage deleted
2000	2030.1100, 2030.1100.02 2040.0810.05	Adding technical requirement exception for applying for SSA benefits
3600	3610.0000, 3610.0100, 3610.0500, 3610.0504, 3610.0505, 3610.1000, 3620.0000, 3620.0500, 3620.0504, 3620.0505, 3620.1000, 3630.0000, 3630.0500, 3630.0504, 3630.0505, 3630.1000, 3640.0000, 3640.0500,	Rename ACCESS Integrity to Benefit Investigations and Public Assistance Fraud to Division of Public Assistance Fraud

	3640.0504, 3640.0505, 3640.1000, 3650.0000, 3650.1000, 3660.0000, 3660.0500, 3660.0504, 3660.0505, 3660.1000	
	3610.0101, 3610.0306, 3610.0402, 3610.0501, 3610.0600, 3610.0702.03, 3610.0703, 3610.0711, 3610.0901, 3610.0902, 3620.0306, 3620.0404, 3620.0405, 3620.0406, 3620.0501, 3620.0600, 3620.0700, 3620.0705, 3620.0900, 3620.0901, 3620.0902, 3630.0307, 3630.0410.01, 3630.0411, 3630.0414, 3630.0501, 3630.0700, 3630.0709, 3640.0307, 3640.0411, 3640.0414, 3640.0501, 3640.0709, 3650.0306, 3650.0414, 3660.0306, 3660.0406.01, 3660.0501, 3660.0700	Updated passages and removed outdated language
	3610.0200, 3620.0200	Aligned client and Intentional Program Violation (IPV) for a claim within 72 months or less
	3610.0308	Removed wording ‘coupons’
	3610.0309, 3620.0309, 3630.0309, 3640.0309, 3650.0309, 3660.0309	Removed customer visit to office and failure to report change as ‘substantiate intent’
	3610.0312, 3620.0905	New section to include waiver of an administrative disqualification hearing
	3610.0400, 3620.0400, 3630.0400, 3640.0400, 3650.0400, 3660.0400,	Removed supervisor’s role/responsibilities
	3610.0401	Removed income $3 discrepancy and examples
	3610.0503, 3620.0503, 3630.0503, 3640.0503, 3660.0503	Changes for Benefit Recovery responsibilities
	3610.0700, 3640.0700	Policy change to allow minimum of 30 days for assistance group to respond prior to repayment
	3610.0702.01, 3620.0702, 3660.0702	Automation of recoupment

	3610.0702.02	Policy removal of minimum eight percent allotment
	3610.0707, 3620.0707, 3630.0707, 3660.0707,	Removed language for unpaid overpayment when civil action is involved
	3610.0710, 3610.0904, 3620.0904, 3620.0710, 3260.0904, 3630.0710, 3640.0710, 3650.0710, 3660.0710	Updates to conclusion of hearing, disqualification hearings
	3610.0800, 3620.0800, 3630.0800, 3640.0800, 3660.0800	Update to transmittal of repayment
	3610.0903, 3620.0903	Removed counting expenses in their entirety
	3620.0100, 3620.0101, 3630.0100, 3630.0101, 3640.0100, 3640.0101, 3650.0100, 3650.0101, 3660.0100, 3660.0101	Strikethrough - see other reference within policy
	3610.0502, 3620.0406.02, 3620.0502, 3630.0301, 3630.0302, 3630.0304, 3630.0306, 3630.0502, 3640.0301, 3640.0302, 3640.0304, 3640.0306, 3640.0502, 3650.0701, 3660.0406.02, 3660.0502	Deleted passage
	3620.0406.03, 3620.0408, 3630.0410.02, 3630.0410.03, , 3660.0406.03, 3660.0408	Example removed
	3630.0200, 3660.0200	Update passage: For non-fraud (agency or client) error cases, a claim will not be established in the Medicaid Program
	3630.0300, 3640.0300	Update to include overpayment of fraud or intentional program violation
	3630.0310, 3650.0310	Removed: adjudication withheld and the individual charged with fraud must have signed a Disqualification Consent Agreement.
	3630.0708, 3640.0708	Removed: whether the overpayment was due to fraud or non-fraud
	3640.0200	Removed client error non-fraud

	3640.0413 3650.0700	Removed reportable overpayment when occurs in Optional State Supplementation Removed: benefit reduction RAP only

0230.0105 Emergency Medical Assistance for Noncitizens (MFAM)

This program provides emergency Medicaid coverage for noncitizens who would otherwise be eligible for Medicaid except for their noncitizen status. They must meet all technical requirements except for citizenship, child support enforcement cooperation, ~~and~~ welfare enumeration and the requirement to file for Social Security benefits.

To be eligible for emergency Medicaid benefits, the noncitizen must meet the income requirements for whichever Medicaid coverage group the noncitizen is determined to be eligible.

Medicaid coverage is for the duration of the emergency medical situation only, as certified by a health professional. This includes emergency labor and delivery.

0240.0103 Eligibility Criteria (MSSI, SFP)

The specific criteria for each SSI-Related Program will be listed under the program name below. To be eligible for any SSI-Related Program, an individual must meet general (technical) criteria, income, and asset requirements which vary by program, and any special criteria for a particular program.

For all SSI-Related Programs, the individual must meet the following technical eligibility criteria:

1. aged (65 or older), blind (does not apply to MEDS), or disabled;
2. U.S. resident;
3. Florida resident;
4. U.S. citizen or qualified noncitizen (except for EMA);
5. provide, or file for, an SSN (except for EMA);
6. file for all other benefits to which he may be entitled (except for EMA); and
7. assign rights to state to collect private health insurance (for MA-SSI only).

0240.0105 Emergency Medicaid for Noncitizens (MSSI)

This program provides emergency Medicaid coverage for noncitizens who would otherwise be eligible for Medicaid (either MEDS or Medically Needy) except for their noncitizen status. The noncitizen must meet all technical requirements except for citizenship status, CSE cooperation, ~~and~~ possession of an SSN and the requirement to file for Social Security benefits.

To be eligible for emergency Medicaid benefits, the noncitizen must meet the income and asset requirements for whichever Medicaid coverage group the noncitizen is determined to be eligible.

Special Criteria: Medicaid coverage is for an emergency medical condition only, for the duration of the emergency as certified by a health professional. This includes emergency labor and delivery.

0820.0500 CHANGES (TCA)

A change (expected or unexpected) may affect eligibility or level of benefits.

Expected: Expected changes become due on the first day of that month and become overdue on the first day of the following month. Set an expected change in the following situations:

1. An individual anticipates receipt of or a change in income, or a return to work.
2. A management review is required.
3. A check on approval of Social Security, Unemployment Compensation, or other benefits for which the individual applied is required.

4. The birth of a child will occur.
5. To obtain the Social Security number in the second month following the month any member of an AG applies for a Social Security number. If the Social Security number has not been received, reschedule the partial for the following month and each subsequent month until the number is obtained.
6. To determine the outcome of the petition to the court in the third month following the month the Department becomes aware of a trust that could have an effect on the AG's eligibility. If there is delay in a court decision, schedule a partial every 2 months thereafter until a decision is reached.

Unexpected: If the change does not require verification, complete action on the case within 10 calendar days of the date the Department becomes aware of the change. If the change requires verification to process, take action to place the case in pending status within two business days.

Examples of unexpected changes include, but are not limited to:

1. change in income, assets;
2. change in living address;
3. change in composition of the SFU (This includes a request to add an adult to the AG.);
4. change in living situation;
5. change in TCA employment participation status;
6. corrective action for a case that failed to process (This activity might include an auxiliary payment.);
7. application or removal of sanctions;
8. marriage or remarriage of the payee whose needs are included in the SFU; or
9. approval of severance or relocation payments.

If delay in reporting or acting on the change causes overpayment, complete a BR referral.

~~Determine if a sanction is warranted when the participant fails to report the absence of a child from the home within five days.~~

~~If a change results in a closure, evaluate ongoing Medicaid eligibility.~~

Effective Date of Change: With the exception of the addition of new members, changes that result in a beneficial or adverse change are effective according to the following time frames:

1. Beneficial: When a participant provides verification with a reported change or within 10 days of the change, make the increased benefit available no later than the ~~month~~ following ~~the~~ month ~~the change was reported~~. If the participant does not provide verification, make benefits available the first month following the receipt of verification.

2. Adverse: the first month following the receipt of sufficient information to act on an adverse change, allowing for 10 days adverse action notice.

1420.0509.01 Immunization (TCA)

Applicants and recipients for Temporary Cash Assistance (TCA) who have a preschool child under age five must complete appropriate childhood immunizations for the child as a condition of eligibility. If the immunization requirement is not met, the child is sanctioned. When a refugee is applying for TCA with a child under age five, the immunization verification requirement is waived at initial application, if the initial application is within their 12-months ~~eight-months~~ from date of

entry, status, or asylum. At recertification, the eligibility worker must ensure that immunization requirements are met prior to reauthorizing benefits.

The child's income and assets must be counted. If the only child in the assistance group does not meet the requirement, TCA is denied/terminated.

Applicants and recipients must be informed of the availability of childhood immunizations through the Department of Health County Health Department or through the child's healthcare provider.

1420.2000 LEARNFARE (TCA)

School age children age six by February 1 of the current school year up to age 18 are subject to the school attendance requirement. Parents or caretaker relatives whose needs are included in the benefit calculation must participate in school conferences.

Note: Refugees applying for TCA are exempted from Learnfare requirements at initial application only, if the initial application is within 12-months ~~their eight-month~~ from date of entry/status/asylum. At recertification, the eligibility worker must ensure the household is complying with learnfare ~~that immunizations~~ requirements ~~are met~~ prior to reauthorizing benefits.

1430.0105 Qualified Noncitizens (MFAM)

Qualified noncitizens are defined as noncitizens who meet at least one of the following sections of the Immigration and Nationality Act (INA)~~.~~:

1. Lawful Permanent Residents;
2. Granted Asylum under section 208;
3. Refugee admitted under section 207;
4. Parolee under section 212(d)(5) admitted for at least 1 year;
5. Deportation withheld under section 243(h) or 241(b)(3);
6. Granted Conditional Entry pursuant to section 203(a)(7);
7. Cuban and Haitian Entrants;
8. Battered Spouse or Abused Child or the parent or child of a Battered person; and
9. Victims of Human Trafficking

1430.1400 REQUIREMENT TO FILE FOR OTHER BENEFITS (MFAM)

Individuals must apply for and diligently pursue to conclusion an application for all other benefits for which they may be eligible as a condition of eligibility. Need cannot be established nor eligibility determined upon failure to do so. Benefits that must be applied for include, but are not limited to:

1. pensions from local, state, or federal government,
2. retirement benefits,
3. disability,
4. Social Security benefits,
5. Veteran's benefits,
6. UC benefits,
7. Military benefits,
8. Railroad retirement benefits,
9. Worker's Compensation benefits,
10. Health and accident insurance payments, and
11. Medicare Part A, Part B and Part D.

Individuals applying for Family-Related Medicaid are not required to apply for SSI as a condition of eligibility.

In some cases, individuals who are already receiving benefits may be eligible for increased benefits due to a change in their circumstances. Individuals are required to apply for all increased benefits for which they might qualify.

Exception: Individuals applying for Emergency Medicaid for Aliens (EMA), and children under age 18 (unless a parent is deceased, aged, or disabled) are not required to apply for Social Security Disability (SSDI) payments.

1440.0105 Qualified Noncitizens (MSSI, SFP)

Qualified noncitizens are defined as noncitizens who meet at least one of the following sections of the Immigration and Nationality Act (INA)~~.~~:

1. Lawful Permanent Residents;
2. Granted Asylum under section 208;
3. Refugee admitted under section 207;
4. Parolee under section 212(d)(5) admitted for at least 1 year;
5. Deportation withheld under section 243(h) or 241(b)(3);
6. Granted Conditional Entry pursuant to section 203(a)(7);
7. Cuban and Haitian Entrants;
8. Battered Spouse or Abused Child or the parent or child of a Battered person; and
9. Victims of Human Trafficking

1440.1400 REQUIREMENT TO FILE FOR OTHER BENEFITS (MSSI, SFP)

Individuals must apply for and diligently pursue to conclusion an application for all other benefits for which they may be eligible as a condition of eligibility. Need cannot be established nor eligibility determined upon failure to do so. Benefits that must be applied for include, but are not limited to:

1. Pensions from local, state, or federal government,
2. Retirement benefits,
3. Disability,
4. Social Security benefits,
5. Veterans' benefits,
6. UC benefits,
7. Military benefits,
8. Railroad retirement benefits,
9. Workers' Compensation benefits,
10. Health and accident insurance payments, and
11. Medicare Part A, Part B and Part D.

Exception: Individuals applying for Emergency Medicaid for Aliens (EMA), and children under age 18 (unless a parent is deceased, aged, or disabled) are not required to apply for Social Security Disability (SSDI) payments.

Individuals applying for Medicaid on the basis of age (65 or older) or disability must apply for Medicare if the state will pay the Medicare premium, deductible or co-insurance. If the individual is not eligible for a Medicare Savings Program (MSP), there is no requirement to apply for Medicare.

The Medicare Enrollment Data Base (EDB) file received from the Center for Medicare and Medicaid Services (CMS) contains information on individuals receiving both Medicaid and Medicare. The information from the EDB file is used to automatically enroll individuals in Medicare.

The application for Social Security benefits based on age or disability is presumed to be an application for Medicare.

Individuals applying for SSI-Related Medicaid, HCDA, TCA, or Family-Related Medicaid are not required to apply for SSI as a condition of eligibility.

Individuals who apply for OSS and are potentially eligible for SSI must apply for SSI as a condition of eligibility.

Individuals are required to apply for all increased benefits for which they might qualify.

1640.0565.01 Personal Property (MSSI, SFP)

~~Household goods and personal effects of reasonable value are excluded as assets. Household goods and personal effects are of reasonable value if the individual's equity in such property does not exceed $2,000. Equity value is the value of an asset on the market less amounts owed on the asset.~~

~~Only the equity value in excess of the $2,000 limit is included as an asset. If the household goods are owned by more than one individual, the excess equity value is divided based on the proportion of the goods owned by each individual.~~

~~Two types of household goods are excluded regardless of their value:~~

~~1. one wedding ring and one engagement ring;~~
~~2. items required because of an individual's medical or physical condition.~~

~~Household goods and personal effects are assumed to be valued at $1,000 unless the individual indicates otherwise. No further development is necessary unless the individual declares he owns item(s) of unusual value.~~

Household Items and Personal effects

Exclude household goods and personal effects from resources, regardless of their dollar value.

Household goods

Household goods are items of personal property, found in or near the home, the householder uses on a regular basis. The householder needs household goods for maintenance, use, and occupancy of the premises as a home.

Examples of household goods include

- Furniture;
- Appliances;
- Electronic equipment, for instance computers and televisions;
- Carpets;
- Cooking and eating utensils; and,
- Dishes.

Personal effects

Personal effects are items of personal property ordinarily worn or carried by the individual, or items that have an intimate relation to the individual.

Examples of personal effects include
Personal effects may consist of the following:

- Personal jewelry, including wedding and engagement rings;
- Personal care items and clothing;
- Pets, such as a cat, dog, hamster, horse, monkey, or snake;
- Educational or recreational items, such as books, musical instruments, or hobby materials; or
- Items of cultural or religious significance to an individual, such as ceremonial attire.
- Items required because of an individual's physical or mental impairment

Other Personal Property
Other personal property may be a countable resource
Property that an individual acquires or holds because of its value or as an investment is a countable resource (unless excluded under a different provision); and is not considered a household good or personal effect for the purposes of this exclusion.

Examples of other personal property

- Gems;
- Jewelry that one does not wear or does not hold for family significance;
- Animals for investment purposes, such as a horse or dog for breeding, for resale, or investment; and
- Collectibles.

Items held because of their value or investment
Items an individual acquires or holds because of their value, or as an investment, are not considered household items or personal effects; even if they otherwise meet the definitions provided above

Example:
Mrs. Willis received $10,000 from an insurance settlement. Staff must determine how she spent the $10,000.
Mrs. Willis paid back creditors with $7,000 and purchased $3,000 in jewelry that she wears.
Because Mrs. Willis wears the jewelry, staff must determine if the jewelry should be treated as a personal effect or as other personal property.
Mrs. Willis's statements establish that the jewelry has no family significance and that she purchased the jewelry **for its value**, to spend down the $10,000.
Staff determines the jewelry is not an excludable personal effect because it was purchased for its value. Staff treated the jewelry as "other personal property" and evaluates it using normal resource counting rules.

~~**1640.0565.02 Household Goods/Personal Effects (MSSI, SFP)**~~

~~Household goods and personal effect items valued at more than $500 are included as assets. These items are called "items of unusual value" and may include items such as:~~

1. ~~expensive china;~~
2. ~~silver or glassware;~~
3. ~~art works;~~
4. ~~Oriental, Persian and similar valuable carpets;~~
5. ~~antiques;~~
6. ~~heirlooms;~~

~~7. musical instruments;~~
~~8. hobby collections;~~
~~9. jewelry made with precious stones or metals; or~~
~~10. expensive furs.~~

~~It is the fair market value (FMV) of the item, rather than its nature, that determines whether an item is of unusual value. For example, a violin worth $600 is an item of unusual value, while a violin worth $200 is not.~~

2030.1100 EMA TO INELIGIBLE NONCITIZENS (MFAM)

To be eligible for Emergency Medical Assistance for Noncitizens (EMA) benefits, the noncitizen must meet all technical (including residency) and financial requirements for a Medicaid coverage group, except: citizenship, child support enforcement cooperation, ~~and~~ Social Security number requirement and the requirement to apply for Social Security benefits.

2030.1100.02 Exceptions to Medicaid Policy and Procedures (MFAM)

The following Medicaid exceptions to policy and procedures apply to Emergency Medical Assistance for Noncitizens:

1. An ex parte determination is not required.
2. Dates of eligibility will be for the time period of the emergency only.
3. There is no postpartum coverage for pregnant women.
4. Ten days advance notice of termination is not required.
5. There is no requirement to apply for Social Security benefits.

2040.0810.05 Technical Criteria for EMA (MSSI)

The following technical criteria apply to this coverage group:

1. The noncitizen is not required to be lawfully admitted for permanent residence or permanently residing in the U.S. under color of law.
2. The noncitizen is not required to meet the enumeration requirements.
3. The noncitizen must be aged, blind, or disabled as defined by SSI.
4. The noncitizen must assign to the state the right to any payments for medical care and cooperate with the state in obtaining such third party payments.
5. The noncitizen must be a Florida resident.
6. The noncitizen is not required to file for Social Security benefits.

3610.0000 Food Stamps

This chapter presents policy regarding referrals to Benefit Recovery for determination of overpayment, fraud, benefit recovery, and disqualification.

In this chapter:

1. "fraud" encompasses intentional program violation,
2. "suspected fraud" refers to client errors pending determination as the result of an administrative disqualification hearing or court decision,
3. "inadvertent household error" encompasses non-fraud client error,
4. "agency" refers to administrative error or Department errors,
5. "overpayment" will mean both overpayment and overissuance, and
6. "Benefit Investigations ~~ACCESS Integrity~~" refers to the Department's pre-eligibility fraud screening and investigation program.

3610.0100 BENEFIT RECOVERY/BENEFIT INVESTIGATIONS ~~ACCESS INTEGRITY~~ BACKGROUND (FS)

The need to recover improperly issued benefits and to identify and prosecute individuals who willfully and fraudulently obtained, or attempted to obtain, these benefits led to the development of a statewide system for the identification, investigation, determination, and collection of public assistance overpayments.

This system is comprised of:

1. the Benefit Investigations~~ACCESS Integrity~~ Program (BI) ~~at the Region or Circuit level~~;
2. the Benefit Recovery (BR) Program ~~olicy Development Unit at Headquarters~~; and
~~3. the Benefit Recovery (BR) units located in each Region or Circuit; and~~
~~4.~~ 3. the Division of Public Assistance Fraud (DPAF).

~~The ACCESS Integrity (AI) units~~(BI) conduct pre-eligibility, fraud screening, investigations and refer cases of attempted fraud to Administrative Disqualification Hearings. Referrals from BI~~AI units~~ to the Office of the Secretary Inspector General Hearings (OSIH) are no program loss and program loss cases ~~only~~. Cases suspected of past overpayment from suspected fraud are referred by ~~the~~ BI~~AI unit~~ directly to the Division of Public Assistance Fraud (DPAF) by using the FLORIDA BVBR screen.

~~The~~ BR ~~unit~~ establishes the existence, circumstances and amount of public assistance overpayment and pursues recovery of overpayments from members of the overpaid assistance group or person responsible for causing the overpayment (i.e., authorized representative).

The DPAF ~~unit~~ handles fraud investigations and referrals to the State Attorneys and administrative disqualification hearings where appropriate in all programs covered in Chapters 409 and 414, Florida Statutes.

3610.0101 Legal Basis (FS)

The legal bases for fraud and recovery of overpayments are established by:

1. Florida Statutes, Sections 409.325/414.41[1996], and 409.335/414.39[1996];
2. Section 7 CFR 273.18 of the Code of Federal Regulations;
3. Title IV-A of the Social Security Act;
4. Section 45 CFR 233; and
5. Florida Administrative Code Chapter 65A-1.

According to Section 409.325/414.41[1996], Florida Statutes, "Any person who knowingly fails by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose a material fact used in making a determination as to such person's qualification to receive aid or benefits under any state or federally funded assistance program, or fails to disclose a change in circumstances in order to obtain or continue to receive under such program aid or benefits to which he is not entitled, or who knowingly aids and abets another person in the commission of any such act is guilty of a crime and will be punished as provided in Subsection (5)." This subsection provides that assistance wrongfully sought or received which is valued at less than $200 in a 12-month period will be punishable as a misdemeanor of the first degree. Assistance of $200 or more in a 12-month period will be punishable as a third-degree felony.

According to Section 409.335/414.39[1996], Florida Statutes, "Whenever it becomes apparent that any person has received any assistance or benefits under this chapter to which he is not

entitled, through either simple mistake or fraud, the Department shall take all necessary steps to recover the overpayment".

According to Section 414.095(16), Florida Statutes, an applicant who meets an error prone profile, as determined by the Department, is subject to pre-eligibility fraud screening as a means of reducing misspent funds and preventing fraud. The Department created an error prone or fraud prone case profile within its public assistance information system and shall screen each application for Temporary Cash Assistance under the Welfare Transition Program against the profile to identify cases that have a potential for error or fraud. Each case so identified is subject to pre-eligibility fraud screening.

According to Section 414.39 (10), the Department shall create an error-prone case profile within its public assistance information system and shall screen each application for public assistance, including food stamps, Medicaid, and Temporary Cash Assistance, against the profile to identify cases that have a potential for error or fraud. Each case so identified shall be subjected to pre-eligibility fraud screening.

3610.0200 STATUTES OF LIMITATION FOR ESTABLISHING CLAIMS (FS)

For agency error cases, claims are established when 12 months or less have elapsed between the month the overpayment occurred and the month the overpayment was initially discovered by, or reported to, the Department.

For client error, or inadvertent household error, a claim will be established when 72 months or less have elapsed between the month an overpayment occurred and the month the overpayment was initially discovered by, or reported to, the Department.

~~For fraud cases, a Benefit Recovery referral will be made when 72 months or less have elapsed between the month the overpayment occurred and the month the overpayment was initially discovered by, or reported to, an eligibility specialist.~~

Intentional Program Violation claims will be established or calculated back to the month that the fraudulent activity initially occurred unless that change occurred more than 72 months ~~six years~~ prior to the date it was initially discovery by or reported to, the Department ~~of discovery~~.

~~For client error, or inadvertent household error, a claim will be established when 30 months or less have elapsed between the month an overpayment occurred and the month the Department discovered the overpayment. No OP claim will be established for any month prior to June 1994.~~

3610.0306 Inadvertent or Agency Errors Not Requiring Referral (FS)

A BR ~~Benefit Recovery~~ referral will not be made, or a claim established on cases when agency or client errors results in overpayment of less than $400 in food stamps.

3610.0308 Suspected Fraud Definition (FS)

In addition to those examples of fraud listed in passage 3610.0307, fraud also exists if the assistance group or individual intentionally:

1. used ~~coupons or~~ benefits to buy nonfood items (such as alcohol or cartons of cigarettes);
2. used or possessed improperly obtained ~~coupons or~~ benefits;
3. traded or sold benefits ~~coupons~~; or
4. committed any act that constitutes a violation of the Food Stamp Act, the Food Stamp Program Regulations, or any state statute relating to the use, presentation,

transfer, acquisition, receipt, or possession of food stamp ~~coupons or~~ benefits.

3610.0309 Evidence Used to Substantiate Fraud (FS)

Written verification of the unreported income received by the assistance group may be used to substantiate intent. Wage and unearned income information supplied through Data Exchange to the eligibility specialist is not to be considered verified upon receipt, with the exception of SSA/SSI and BENDEX information.

Verification that the assistance group member understood their responsibility for reporting the information in question may be used to substantiate intent. This verification could include:

1. the signed application,
2. the acknowledgement of rights and responsibilities,
3. previously submitted change report form(s), or
4. recorded and/or verified instances of other changes reported by the assistance group which could or did affect the benefits received.

An application or change report form submitted during the period fraud is suspected which omits the information that resulted in the overpayment may be used to substantiate intent.

~~Recorded instances which indicate that the assistance group member visited the office during the period fraud is suspected and did not report the change which resulted in overpayment may be used to substantiate intent. These instances might include a record of the dates benefits were issued to the assistance group member, copies of signed food stamp receipts or Electronic Benefits Transfer (EBT) records, or reports of beneficial changes but not the adverse change.~~

Sworn testimony by the eligibility specialist or other individuals may also be used to substantiate intent. It is important that the eligibility specialist be able to identify the individual.

These examples are not all inclusive; other types of evidence may also be used.

3610.0312 Waiver of an Administrative Disqualification Hearing (FS)

The State agency shall provide written notification to the household member suspected of Intentional Program Violation that the member can waive his/her right to an administrative disqualification hearing. An Administrative Disqualification waiver provided to the household member which informs him/her of the possibility of waiving the administrative disqualification hearing shall include, at a minimum:

- An opportunity for the accused individual to specify whether or not he/she admits to the facts as presented by the State agency. This opportunity shall consist of the following statements, or statements developed by the State agency which have the same effect, and a method for the individual to designate his/her choice:

(1) I admit to the facts as presented, and understand that a disqualification penalty will be imposed if I sign this waiver; and

(2) I do not admit that the facts as presented are correct. However, I have chosen to sign this waiver and understand that a disqualification penalty will result; and

(3) I have read this notice and wish to exercise my rights to have an administrative hearing.

- The date that the signed waiver must be received by the State agency to avoid the holding of a hearing and a signature block for the accused individual, along with a statement that the head of household must also sign the waiver if the accused individual is not the head of household, with an appropriately designated signature block.

Each waiver packet sent to the household member will include a copy of the waiver, a cover letter, and a notification of Intent to Disqualify.

3610.0400 OVERPAYMENT AMOUNT (FS)

The eligibility specialist determines if an overpayment appears to exist, and~~. The supervisor is to review and ensure that the claim is valid prior to transmitting to Benefit Recovery (BR). If it is determined that potential overpayment occurred,~~ a referral is completed and transmitted to BR for all agency error and household error overpayments. All suspected fraud referrals are transmitted to DPAF for review and possible investigations. ~~The~~ BR ~~unit~~ will determine the overpayment based on the best available information. If there is no acceptable information available on which to establish a corrected benefit amount, then insufficient evidence exists and no claim can be established by BR. ~~Overpayment will be computed on the best information available to the BR unit.~~

3610.0401 Overpayment (FS)

~~If an individual fails to provide accurate or complete information regarding income, the income discrepancy must be $3 per month or more in order to cause a reportable overpayment.~~

The beginning date of overpayment is determined as follows:

If the overpayment resulted from information provided or withheld at the time of application or reapplication, any incorrect benefits received based on that application would be included as part of the overpayment.

If the assistance group member fails to report a change in the assistance group's circumstances, the first month affected by the failure to report will be the first month in which the change would have been effective had it been timely reported.

The beginning date of overpayment is determined by applying the "10-10-10 rule" to the date the change occurred. * The 10-10-10 rule allows the individual 10 calendar days from the date the change occurred to report the change to the agency. The agency then has 10 calendar days to act on the change and 10 calendar days to allow for "adverse" notice to the individual. In most instances, this procedure would result in overpayment beginning the second month after the month of change. The exception would be when the change falls on the 1st day of the month in a 31-day month.

Note: Date of change is defined as the date the actual circumstance occurred; for income, this is the date the first paycheck reflecting the change is received. For the Food Stamp Program, the date of change is defined as the date the individual began the job, not the date of the first paycheck; however, BR ~~Benefit Recovery~~ looks at the date of the first paycheck for determining the beginning date of overpayment.

~~**Example 1:** A food stamp recipient began receiving regular child support checks March 5, but failed to report this income until July. March 5 is the date of change. After applying the 10-10-10 rule, overpayment would begin in May.~~

~~**Example 2:** Using the same example, change the date of change to March 1. After allowing for the 10-10-10 rule, overpayment would begin with April.~~

3610.0402 Benefit Recovery Overpayment Calculation (FS)

To determine correct monthly benefit levels, the ~~Benefit Recovery~~ BR claims examiner ~~manager~~ will use the same budget month and actual or converted budgeting methods to determine gross earned or unearned income received during the month.

3610.0500 DEPARTMENT STAFF OVERPAYMENT RESPONSIBILITIES (FS)

Overpayment responsibilities of the eligibility specialist, ~~Supervisor,~~ Benefit Recovery ~~unit~~, Benefit Investigations ~~ACCESS Integrity unit~~, and the Division of Public Assistance Fraud are provided in passages 3610.0501 through 3610.0505.

3610.0501 Eligibility Specialist Responsibilities (FS)

The eligibility specialist must establish that overpayment has occurred by obtaining and recording the following facts in running record comments ~~or in the paper case file~~ prior to initiating a referral to ~~Benefit Recovery (~~BR~~)~~ on the FLORIDA BVBR screen:

1. how the overpayment was discovered,
2. the date of discovery,
3. who received the income/asset/status change,
4. the date the income or change started and/or stopped,
5. the cause of overpayment,
6. the estimated length,
7. any explanation given for failure to provide information accurately or in a timely manner,
8. corrective action taken and the date such action(s) was taken, and
9. instances involving misuse of food stamps (the dates and source of the referral must be recorded).

The eligibility specialist must take necessary action to ensure that correct payment will be made for the current situation or that cancellation of benefits is effective in accordance with policy prior to referral to BR. This step includes doing a partial eligibility review on the fraudulent factors when fraud is suspected except when the suspected fraud was identified during the complete eligibility review process. If overpayment was discovered as a result of Data Exchange, follow the policy in Chapter 3000 prior to referral to BR.

The eligibility specialist must then verify that the individual was actually receiving assistance during the time the suspected overpayment.

The eligibility specialist must:

1. adjust the current benefit if appropriate;
2. complete a referral via the FLORIDA AIFP to the Benefit Investigations ~~Office of Public Benefits Integrity (OPBI) unit~~ for cases in which an error/fraud prone profile match occurs at the application/reapplication;~~,~~ certification/recertification process;
3. complete the Benefit Recovery Referral (BVBR) if an overpayment is determined; and
4. respond to ~~the~~ BR ~~unit~~ requests for any additional information within 10 calendar days.~~;~~
5. ~~rerun the benefit calculation to implement an individual's disqualification within 10 working days of receipt of BR's alert to disqualify the individual.~~

~~**3610.0502 Supervisor Responsibilities (FS)**~~

~~The supervisor's responsibilities include:~~

1. ~~reviewing the case record for validity of referral to the Benefit Recovery (BR) unit, proper organization, Roberts vs. Austin compliance, corrective action, and completeness of information;~~
2. ~~transmitting the referral to the BR unit;~~
3. ~~providing case records to the BR unit within five working days after receipt of the list of cases to be reviewed, or by the date the BR unit has, with prior notice, scheduled cases for review;~~
4. ~~arranging for the case record to be available for review by the BR unit or Public Assistance Fraud at a scheduled time and place, or immediately informing the BR unit of the reason a case record cannot be made available;~~
5. ~~submitting additional information, when obtained, to the BR unit; and~~
6. ~~attending court or an administrative hearing as necessary and carrying and safeguarding the case record during the hearing if requested by BR.~~

3610.0503 Benefit Recovery Responsibilities (FS)

~~Benefit Recovery (~~BR~~)~~ is responsible for the establishment of all overpayment claims and the maintenance of all recoupment and recovery activities.

As the Department's liaison with ~~the Department of Financial Services, Public Assistance Fraud (~~DPAF~~)~~, ~~the~~ BR ~~units are~~ is responsible for the programming of the electronic submission of suspected fraud referrals to DPAF via FLORIDA BVBR. ~~routing appropriate referrals (i.e., those that involve suspected fraud) from the Department to PAF.~~ When the investigation results in sufficient evidence of suspected fraud ~~is found~~, DPAF completes a referral for prosecution to the appropriate State Attorney or to the OSIH ~~Office of the Secretary Inspector General Hearings is made by PAF.~~ This process is also completed on cases identified by PAF through independent program reviews.

~~The~~ BR ~~supervisor~~ is ~~usually~~ the "Custodian of the Case Record" for the overpayment claim from the date of request for an Administrative Disqualification Hearing or court hearing to final disposition.

3610.0504 Benefit Investigations ~~ACCESS Integrity~~ Responsibilities (FS)

The Department will conduct pre-eligibility fraud screening and investigation of suspected fraud cases at the application/reapplication, certification/recertification process and prior to benefit approval. The Department is responsible for referring appropriate cases to the OISH ~~Office of the Inspector General~~, Hearings for an Administrative Disqualification Hearing. Cases in which individuals have received benefits due to suspected fraud will be referred directly to DPAF by BI ~~Public Assistance Fraud by ACCESS Integrity~~ staff by completion of the FLORIDA BVBR screen.

3610.0505 Division of Public Assistance Fraud Responsibilities (FS)

~~Public Assistance Fraud (~~DPAF~~)~~ has the responsibility to handle investigations of suspected fraud in all programs covered in Chapter 409, Florida Statutes (FS). This includes the Food Stamp Program. The Department has a contract with DPAF to investigate fraud in the public assistance programs. Federal matching monies are utilized to fund this activity.

PAF has the responsibility for investigating and referring cases of suspected fraud for prosecution to the State Attorney and for referring cases to the OSIH ~~Office of the Secretary Inspector General Hearings~~ for Administrative Disqualification Hearings.

3610.0600 PERSONS RESPONSIBLE FOR REPAYMENT (FS)

All ~~assistance group~~ members who were adult members (18 years of age or older) of the assistance group at the time the overpayment occurred will be jointly and individually liable for the value of any overpayment of benefits.
~~The Benefit Recovery (~~BR~~) unit~~ may pursue recovery action against any assistance group which contains a member who was an adult member of the original assistance group at the time the overpayment occurred. This can include retention of restored benefits owed to the assistance group as an offset against the overpayment claim.

If a change in assistance group membership occurs, ~~the~~ BR ~~unit~~ will pursue recovery action against current assistance groups containing:

1. a majority of the individuals who were assistance group members at the time the overpayment occurred; and
2. any adult member of the assistance group or adult relative who received the overpayment.

3610.0700 REPAYMENT (FS)

Recovery of amounts of overpayment will be made by one or more of the following methods:

1. lottery intercepts,
2. lump sum and installment payments,
3. benefit reduction,
4. offset of lost benefits,
5. credit for community service hours completed (food stamps with court order only),
6. child support credit (AFDC only), and
7. federal benefits and tax intercepts.

~~Benefit Recovery (~~BR~~)~~ must notify the overpaid assistance group of the amount and cause of overpayment as well as the various repayment methods available.

BR must then allow a minimum of ~~10, 20 or~~ 30 calendar days for the assistance group to respond prior to initiating recovery activity. If the recipient is active, benefit reduction will begin immediately.

Passages 3610.0701 through 3610.0710 describe methods of repayment.

3610.0702.01 Benefit Reduction (FS)

~~The Benefit Recovery unit will determine the rate of allotment reduction and complete appropriate FLORIDA screens.~~ Recoupment percentages are automatically set by the claim type and will start automatically. EDBC will be run automatically to initiate recoupment.

The amount of the monthly payment will change if the assistance group's allotment changes. FLORIDA will automatically adjust the recoupment amount when the allotment changes.

~~**3610.0702.02 Eight Percent Allotment Minimum (FS)**~~

~~The eight percent of the maximum benefit for a one-person assistance group is not applicable when allotment reduction is applied.~~

3610.0702.03 Amount to be Recovered (FS)

The amount of food stamps to be recovered each month through allotment reduction will be determined as shown below:

1. For agency error and non-fraud client error claims, the amount of food stamps recovered each month will be 10 percent of the assistance group's monthly allotment or $10 per month, whichever is greater.

2. For cases involving fraud, the amount will be 20 percent~~%~~ of the assistance group's monthly allotment or $10, whichever is greater.

3610.0703 Offset of Claim (FS)

The Department is required to restore benefits to a household that has lost benefits because of an agency error.

Federal regulations stipulate that in the event a claim has been established against a household, any benefits to be restored to the household at a later date can be offset against the claim amount. If the amount of benefits to be restored exceeds the claim amount, the remaining balance will be restored to the household and the claim will be satisfied.

Exception: Retroactive benefits are not ~~to be~~ offset against outstanding claims.

3610.0707 Civil Action (FS)

All steps necessary to institute civil action are taken when ~~the Benefit Recovery (~~BR~~)~~ unit determines that such action is required to recover a TCA, AFDC, or Food Stamp Program overpayment from a former recipient or from individuals in Medical Assistance Only cases.

~~If a case is returned indicating that civil action cannot be taken against an individual, the BR unit will notify the referring eligibility specialist that there is an unpaid overpayment that cannot be collected at this time. If the former recipients receive benefits at a later date, appropriate recoupment action must be taken against their benefits.~~

3610.0710 Hearing Requested (FS)

When an individual requests a fair hearing regarding an overpayment, the request for hearing screen (CLFH) must be completed by the ~~Benefit Recovery (~~BR~~)~~ Hearing Specialist team ~~(BR) unit supervisor~~ within three working days of the date the request was received. When the request is in writing, a copy must be sent to the ~~Office of the Secretary Inspector General Hearings (~~OSIH~~)~~ along with a copy of the "statement of matters" form (i.e., a Notice of Decision, Intent to Recover, etc.).

When an individual requests a hearing in response to the Notice of Case Action regarding the amount of repayment, the BR unit is responsible for submitting the Request for Hearing to OSIH. If the individual requests a timely hearing ~~within ten calendar days~~ from the date of the Notice of Case Action, the benefit reduction will be stopped until the conclusion of the Hearing and a final decision has been made by OSIH.~~removed and a copy of the new notice to the individual must be sent to the BR unit.~~ BR must be notified of the hearing date, time and location. When the final order is received via Document Imaging to the dedicated workgroup box, b~~y the public assistance unit, a copy must be sent to~~ the BR staff member ~~will be~~ is notified via an alert and will take the appropriate actions. ~~unit.~~ If the individual contacts the eligibility specialist in response to a BR generated notice or action, the eligibility specialist should refer the individual to the BR unit for initiation of the Fair Hearing request.

3610.0711 Compromising Claims (FS)

A claim or any portion of a claim may be compromised ~~with the exception of~~ except for court ordered restitutions or intentional program violations. Individuals with an overpayment claim may request a compromise of their claim at any time after they are notified of the claim. The Department will determine the economic household circumstances reasonably demonstrate the overpayment claim will not be paid within three years of being notified of the overpayment claim and will compromise to zero dollars when at least one of the following is present:

1. The death or prognosis of death of any liable individual within three years of being notified;
2. Pending litigation in a court, including a bankruptcy court, that involves any liable individual's obligation to repay the overpayment within three years of being notified;
3. Any liable individual is sentenced to a period of incarceration that will expire after the three-year period the overpayment is expected to be paid; or
4. The liable individual(s) sole household's income is based only on either age or disability projecting a fixed, limited economic potential to repay the overpayment within three years.

Verification of the above criteria is required.

Note: Liable individual(s) can request a compromise even if they do not meet the above criteria. The request and any other related information provided must clearly show the overpayment claim will not be paid within the three-year period. The Department will not speculate about the liable individual's ability to repay the overpayment.

3610.0800 TRANSMITTAL OF REPAYMENT (FS)

All repayments must be ~~channeled~~ directed through ~~Benefit Recovery (~~BR~~)~~.

Repayments may be collected by the local office; however~~:~~, the repayment ~~eligibility specialist~~ must be forwarded ~~the repayment~~ to BR within 24 hours. ~~If no referral was previously submitted, complete the referral screen and forward the paper case file with the payment to the BR unit.~~

~~A receipt must be provided to the individual for cash or currency payments.~~

Note: The individual must be informed that future payments must be payable to DCF and mailed to:

P.O. Box 4069
Tallahassee, FL 32315-4069

3610.0901 Disqualification Notice (FS)

~~The Benefit Recovery (~~BR~~)~~ ~~unit~~ will disqualify only the individual found to have committed or attempted to commit fraud and not the entire assistance group. On an active case, ~~the~~ BR ~~unit~~ will inform the assigned BR claims examiner ~~eligibility specialist~~ of the disqualification penalties against the individual. Notification must be provided to the payee of the assistance group regarding the effect that the disqualification has on the assistance group's benefits.

3610.0902 Disqualification Periods and Implementation (FS)

The disqualification period for an eligible assistance group member will begin with the first month following the date the agency receives written notification of the hearing's decision, the date of the signed Waiver of Administrative Disqualification Hearing or within 45 calendar days from the

date of receipt of a state attorney/court disposition. There is no requirement for notification through certified mail. The ~~agency~~ Department is not required to give the assistance group notice of adverse action prior to imposing the disqualification.

Disqualification periods, when specified in a court order, must be followed as defined by the court. In the absence of court ordered specifications, use the following program specific policies to determine disqualification periods.

FS disqualification periods:

In the Food Stamp Program there are several program violations, which have very stringent disqualification periods; these include the sale of controlled substances (illegal drugs), firearms, ammunition and/or explosives.

For program violations related to the use or receipt of food stamps in a transaction involving the sale of a controlled substance, the disqualification periods are:

1. 24 months for the first violation, and
2. permanent disqualification for the second violation.

For program violations related to the use or receipt of food stamps in a transaction involving the sale of firearms, ammunition, or explosives, the disqualification period is permanent for the first violation.

For program violations involving trafficking of food stamps in the amount of $500 or more, the disqualification period is permanent for the first violation.

For program violations involving fraudulent statements or representations regarding identity or residence in order to receive multiple benefits, the disqualification period is 10 years for each violation.

In addition to these specific program violations there are two situations where an individual is automatically disqualified due to their status as a fleeing felon or probation violator or having a felony drug trafficking conviction.

An individual, who is a fleeing felon or probation violator, is disqualified from participation in the Food Stamp Program as long as they are a fleeing felon or probation violator.

An individual who was convicted of a drug trafficking felony including agreeing, conspiring, combining, or confederating with another person to commit the act committed after 8/22/1996 is permanently disqualified from participation in the Food Stamp Program. If the illegal behavior that led~~lead~~ to the conviction occurred on or before 8/22/96, the disqualification does not apply regardless of the date of the conviction. If a court expunges the felony drug trafficking conviction, the individual is not subject to the disqualification. The individual must provide proof of the expungement.

For all other Food Stamp Program violations, the disqualification periods are:

1. 12 months for the first violation,
2. 24 months for the second violation, and
3. permanent disqualification for the third violation

Note: In instances where the food stamp fraud occurred prior to April 1, 1983, a three-month disqualification period is applied, regardless of the type of violation.

3610.0903 Determining Benefits During Disqualification (FS)

The income, expenses, and assets of a disqualified individual will be counted in their entirety for determining benefits for the remainder of the assistance group. ~~Expenses will also be counted in their entirety.~~

The individual's needs will not be included when determining the benefit level of the remaining members.

In no event will the assistance group's benefits be increased as a result of a member's disqualification.

3610.0904 Administrative Disqualification Hearings (FS)

The OSIH ~~Office of the Secretary Inspector General Hearings (OSIH)~~ will send a written advance notice of administrative disqualification hearing by ~~certified~~ regular mail ~~- return receipt requested~~ to the assistance group member suspected of fraud at least 30 calendar days in advance of the scheduled hearing date. A waiver of administrative disqualification hearing form will be provided with the notice. ~~The receipt must be signed by said individual, or other proof of receipt must be obtained from said individual.~~

A disqualification hearing will not be held if the individual signs and returns the waiver of administrative disqualification hearing accepting the disqualification penalty for the specified time period on the waiver form. ~~In signing this waiver, the individual agrees to be disqualified for the time period specified on the waiver form.~~ If the individual does not return a signed waiver, or indicates they would like a hearing, an administrative disqualification hearing will be held.

A pending disqualification hearing will not affect the assistance group's or individual's right to be determined eligible and participate in the program. Eligibility and benefit levels will be calculated according to standard rules and procedures.

OSIH will base the determination of fraud on clear and convincing evidence which demonstrates that the assistance group member(s) intentionally committed, or attempted to commit, fraud. The OSIH decision must:

1. specify the reasons for the decision,
2. identify the supporting evidence,
3. identify the pertinent Code of Federal Regulations, and
4. respond to reasoned arguments made by the assistance group member or representative consistent with current policy.

If OSIH rules the assistance group member committed or attempted to commit fraud, the member will be disqualified in accordance with the established disqualification periods.

In addition to updating the disqualification hearings update screen on FLORIDA, OSIH will send a copy of the hearing decision to the dedicated BR workgroup in Document Imaging. ~~through the Region or Circuit Program Office to Benefit Recovery (BR)~~ Each Final Order will be sent to the Collections Unit, who will initiate disqualification action. ~~The~~ BR ~~unit~~ will initiate disqualification upon receipt of notification that the disqualification hearings update screen has been completed by OSIH to show a hearings decision.

~~The~~ BR ~~unit will contact the eligibility specialist who~~ will take the appropriate FLORIDA action to remove the member from the assistance group, recalculate the benefit level, and send the Notice of Case Action.

3610.1000 BENEFIT INVESTIGATIONS ~~ACCESS INTEGRITY~~ (FS)

Benefit Investigations (BI) ~~ACCESS Integrity (AI)~~ is an extension of the Department's public assistance eligibility process and operates within the purview of 7 CFR 273, 45 CFR 233, and Sections 414.095(16) and 414.39(10), Florida Statutes. It is a program designed to combat fraud and reduce misspent dollars in the Department's public assistance programs. Probable error prone cases are identified at the pre-eligibility (application/reapplication, certification/recertification) phase of the public assistance program. Once a case is identified as meeting error prone criteria, it is referred to the ~~AI~~ BI ~~unit within the Region or Circuit where the public assistance unit resides~~. ~~The AI~~ BI ~~unit then~~ reviews the information provided by the individual or the authorized representative and verifies and documents the finding of fact as it relates to the information provided by the individual and the eligibility factors used to determine the individual's level of participation. Once verification and documentation ~~is~~ are completed, the recipient is given an opportunity to explain contradictory information and an eligibility determination is made.

3620.0000 Temporary Cash Assistance

This chapter presents policy regarding referrals to Benefit Recovery (BR) for determination of overpayment, fraud, benefit recovery, and disqualification.

In this chapter:

1. "fraud" encompasses intentional program violation,
2. "suspected fraud" refers to client errors pending determination as the result of an administrative disqualification hearing or court decision,
3. "inadvertent household error" encompasses nonfraud client error,
4. "agency" refers to administrative error or Department errors,
5. "overpayment" will mean both overpayment and overissuance, and
6. "Benefit Investigations ~~ACCESS Integrity~~" refers to the Department's pre-eligibility fraud screening and investigation program.

3620.0100 BENEFIT RECOVERY/BENEFIT INVESTIGATIONS ~~ACCESS INTEGRITY~~ BACKGROUND (TCA)

Background information is provided in passage 3610.0100.

~~The need to recover improperly issued benefits and to identify and prosecute individuals who willfully and fraudulently obtained, or attempted to obtain, these benefits led to the development of a statewide system for the identification, investigation, determination, and collection of public assistance overpayments.~~

~~This system is comprised of:~~

~~1. the ACCESS Integrity Program at the Region or Circuit level;~~
~~2. the Benefit Recovery Policy Development Unit at Headquarters;~~
~~3. the Benefit Recovery (BR) units located in each Region or Circuit; and~~
~~4. Public Assistance Fraud (PAF).~~

~~The ACCESS Integrity (AI) units conduct pre-eligibility, fraud screening, investigations and refer appropriate cases of attempted fraud to Administrative Disqualification Hearings. Referrals from AI units to the Office of the Secretary Inspector General Hearings are no program loss cases~~

~~only. Cases suspected of past overpayment from suspected fraud are referred by the AI unit directly to PAF by using the BVBR screen.~~

~~The BR unit establishes the existence, circumstances and amount of public assistance overpayment and pursues recovery of overpayment from members of the overpaid assistance group or person responsible for causing the overpayment (i.e., authorized representative).~~

~~The PAF unit handles fraud investigations and referrals to the State Attorneys and administrative disqualification hearings where appropriate in all programs covered in Chapters 409 and 414, Florida Statutes.~~

3620.0101 Legal Basis (TCA)

The legal basis is provided in passage 3610.0101.

~~The legal bases for fraud and recovery of overpayments are established by:~~

~~1. Florida Statutes, Sections 409.325/414.41[1996], and 409.335/414.39[1996];~~
~~2. Section 7 CFR 273.18 of the Code of Federal Regulations;~~
~~3. Title IV-A of the Social Security Act;~~
~~4. Section 45 CFR 233; and~~
~~5. Florida Administrative Code Chapter 65A-1.~~

~~According to Section 409.325/414.41[1996], Florida Statutes, "Any person who knowingly fails by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose a material fact used in making a determination as to such person's qualification to receive aid or benefits under any state or federally funded assistance program, or fails to disclose a change in circumstances in order to obtain or continue to receive under such program aid or benefits to which he is not entitled, or who knowingly aids and abets another person in the commission of any such act is guilty of a crime and will be punished as provided in Subsection (5)." This subsection provides that assistance wrongfully sought or received which is valued at less than $200 in a 12 month period will be punishable as a misdemeanor of the first degree. Assistance of $200 or more in a 12 month period will be punishable as a third degree felony.~~

~~According to Section 409.335/414.39[1996], Florida Statutes, "Whenever it becomes apparent that any person has received any assistance or benefits under this chapter to which he is not entitled, through either simple mistake or fraud, the Department shall take all necessary steps to recover the overpayment".~~

~~According to Section 414.095(16), Florida Statutes, an applicant who meets an error prone profile, as determined by the Department, is subject to pre-eligibility fraud screening as a means of reducing misspent funds and preventing fraud. The Department created an error prone or fraud prone case profile within its public assistance information system and shall screen each application for the Temporary Cash Assistance Program against the profile to identify cases that have a potential for error or fraud. Each case so identified is subject to pre-eligibility fraud screening.~~

~~According to Section 414.39 (10), the Department shall create an error-prone case profile within its public assistance information system and shall screen each application for public assistance, including food stamps, Medicaid, and Temporary Cash Assistance, against the profile to identify cases that have a potential for error or fraud. Each case so identified shall be subjected to pre-eligibility fraud screening.~~

3620.0200 STATUTES OF LIMITATION FOR ESTABLISHING CLAIMS (TCA)

For ~~nonfraud (~~agency ~~or client)~~ error cases, a claim is limited to 12-months ~~four years~~ prior to the month the overpayment was initially discovered by, or reported to, an eligibility specialist.

For inadvertent household error cases, a claim is limited to 72 months prior to the month the overpayment was initially discovered by, or reported to, an eligibility specialist.

Intentional Program Violation (non-prosecution) claims will be established or calculated back to the month that the fraudulent activity initially occurred unless that change occurred more than 72 months prior to the date it was initially discovery by or reported to, the Department.

3620.0306 Inadvertent or Agency Errors Not Requiring Referral (TCA)

A BR ~~Benefit Recovery~~ referral will not be made, or a claim established on cases when agency error or client error results in overpayment of less than $400 in cash assistance.

3620.0309 Evidence Used to Substantiate Fraud (TCA)

Written verification of the unreported income received by the assistance group may be used to substantiate intent. Wage and unearned income information supplied through Data Exchange to the eligibility specialist is not to be considered verified upon receipt, with the exception of SSA/SSI and BENDEX information.

Verification that the assistance group member understood their responsibility for reporting the information in question may be used to substantiate intent. This verification could include:

1. the signed application,
2. acknowledgement of rights and responsibilities,
3. submitted change report form(s), or
4. recorded and/or verified instances of other changes reported by the assistance group which could or did affect the benefits received.

An application or change report form submitted during the period fraud is suspected which omits the information that resulted in the overpayment may be used to substantiate intent.

~~Recorded instances which indicate that the assistance group member visited the office during the period fraud is suspected and did not report the change which resulted in overpayment may be used to substantiate intent. These instances might include a record of the dates benefits were issued to the assistance group member, copies of signed food stamp receipts or Electronic Benefits Transfer (EBT) records, or reports of beneficial changes but not the adverse change.~~

Sworn testimony by the eligibility specialist or other individuals may also be used to substantiate intent. It is important that the eligibility specialist be able to identify the individual.

These examples are not all inclusive; other types of evidence may also be used.

3620.0400 OVERPAYMENT AMOUNT (TCA)

The eligibility specialist determines if overpayment appears to exist, and a referral is completed and transmitted to BR for all agency error and household error overpayments. All suspected fraud referrals are transmitted to DPAF for review and possible investigations. BR will determine the overpayment based on the best available information. If there is no acceptable information available on which to establish a corrected benefit amount, then insufficient evidence exists, and no claim can be established by BR.

~~The eligibility specialist determines if overpayment appears to exist. The supervisor is to review and ensure that the claim is valid prior to transmitting to Benefit Recovery (BR). If it is determined that potential overpayment occurred, a referral is completed and transmitted to BR. The BR unit will determine overpayment based on the best available information. If there is no acceptable information available on which to establish a corrected benefit amount, then insufficient evidence exists and no claim can be established by BR. Overpayment will be computed on the best information available to the BR unit.~~

3620.0404 Overpayment (TCA)

The amount of TCA ~~Temporary Cash Assistance~~ overpayment for a given month is the difference between the amount an individual received and the amount the individual should have received.

3620.0405 Reportable Overpayment (TCA)

Reportable TCA ~~Temporary Cash Assistance~~ overpayment occurs whenever the assistance group is ineligible for assistance received or the amount of payment was more than the assistance group should have received. Reportable overpayment does not always result in actual overpayment. For changes other than income, reportable overpayment begins the first month of ineligibility for an entire month.

Policy on the application of the penalty of non-disregard as presented in Chapter 2400 of this manual must be followed. The penalty of non-disregard policy in effect at the time of the OP occurred must be followed.

3620.0406 Beginning Date of Overpayment/Change in Income/Assets (TCA)

For TCA ~~Temporary Cash Assistance~~, if the change involves unreported or under reported income, the month in which the income is first received is considered to be the month in which the change occurred.

If the budget shows that the case was ineligible and the TCA ~~Temporary Cash Assistance~~ was not canceled appropriately, a referral must be made to BR ~~Benefit Recovery~~. The eligibility specialist must also determine the first month of eligibility for extended Medicaid and earned income disregards, if applicable.

TCA ~~Temporary Cash Assistance~~ overpayment begins after applying the 10-10-10 rule on cases from 10/1/96 forward. Prior to 10/1/96, overpayment began the month after the month of change.

~~**3620.0406.02 Example of Beginning Date of Overpayment (TCA)**~~

~~The following example illustrates when reportable overpayment begins.~~

~~**Example:** Ms. Brown, an active TCA individual, began receiving unemployment compensation benefits on February 15, 1996, and reported her income on February 22, 1996. The eligibility specialist completed a budget for March and determined that Ms. Brown is ineligible. The eligibility specialist canceled Ms. Brown's TCA effective April 1996, and completed an ex parte determination for the Medically Needy (MN) Program. The eligibility specialist determined that Ms. Brown should have been enrolled with a share of cost (SOC) in the MN Program during March 1996, the first month of ineligibility. A TCA overpayment referral is to be submitted to the Benefit Recovery unit for the month of March 1996, (the month following the month of the receipt of income). Possible Medicaid overpayment for March 1996, (first month of ineligibility for Family-Related Medicaid) should also be referred. Note that the most the Medicaid overpayment could be is the adjusted SOC for any month of MN eligibility.~~

3620.0406.03 Overpayment - Household Composition Changes (TCA)

Overpayment that occurs as a result of changes other than income will begin with the first month in which the individual or assistance group is ineligible for the entire month.

~~**Example of Beginning Date of Overpayment - Household Composition Changes:** Ms. Hodges, a Temporary Cash Assistance (TCA) individual, reported on June 30, 1996, that her husband returned home on June 3, 1996. The eligibility specialist determined that the Hodges were ineligible for TCA and canceled Ms. Hodges' TCA effective August 1996. The eligibility specialist completed a referral to the BR unit for the month of July 1996, the first month the assistance group was ineligible for an entire month.~~

3620.0408 Changes in Income that Occur in Application Months (TCA)

When an unreported or under reported change in income occurs during the application month, reportable overpayment begins with the first incorrectly issued warrant.

~~**Example:** Ms. Jones applied for Temporary Cash Assistance (TCA) on June 2 and reported that she works part-time. The eligibility specialist budgeted the wages for June and July based on past wages received and approved Ms. Jones for TCA on June 23. The eligibility specialist learned in July that the employer had provided net, not gross, wage information. The eligibility specialist determined that Ms. Jones was overpaid for June and July and completed a referral to the Benefit Recovery unit.~~

3620.0500 DEPARTMENT STAFF OVERPAYMENT RESPONSIBILITIES (TCA)

Overpayment responsibilities of the eligibility specialist, ~~Supervisor,~~ Benefit Recovery ~~unit~~, Benefit Investigations ~~ACCESS Integrity unit~~, and the Division of Public Assistance Fraud are provided in passages 3620.0501 through 3620.0505.

3620.0501 Eligibility Specialist Responsibilities (TCA)

The eligibility specialist must establish that overpayment has occurred by obtaining and recording the following facts in running record comments or in the paper case file prior to initiating a referral to ~~Benefit Recovery (~~BR~~)~~ on the FLORIDA BVBR screen:

1. how the overpayment was discovered,
2. the date of discovery,
3. who received the income/asset/status change,
4. the date the income or change started and/or stopped,
5. the cause of overpayment,
6. the estimated length and amount of overpayment,
7. any explanation given for failure to provide information accurately or in a timely manner, and
8. corrective action taken and the date such action(s) was taken. ~~, and~~
9. ~~instances involving misuse of food stamps (the dates and source of the referral must be recorded).~~

The eligibility specialist must take necessary action to ensure that correct payment will be made for the current situation or that cancellation of benefits is effective in accordance with policy prior to referral to BR. This step includes doing a partial eligibility review on the fraudulent factors when fraud is suspected except when the suspected fraud was identified during the complete eligibility review process. If overpayment was discovered as a result of Data Exchange, follow the policy in Chapter 3000 prior to referral to BR.

The eligibility specialist must then verify that the individual was actually receiving assistance during the time the suspected overpayment.

The eligibility specialist must:

1. adjust the current benefit if appropriate;
2. complete a referral via the FLORIDA AIFP to the Benefit Investigations ~~Office of Public Benefits Integrity (OBPI) unit~~ for cases in which an error/fraud prone profile match occurs at the application/reapplication, certification/recertification process;
3. complete the BR ~~Benefit Recovery~~ Referral (BVBR) screen if an overpayment is determined;
4. respond to ~~the~~ BR ~~unit~~ requests for any additional information within 10 calendar days;
5. ~~rerun the benefit calculation to implement an individual's disqualification within 10 working days of receipt of BR's alert to disqualify the individual.~~

~~3620.0502 Supervisor Responsibilities (TCA)~~

~~The supervisor's responsibilities include:~~

1. ~~reviewing the case record for validity of referral to the Benefit Recovery (BR) unit, proper organization, Roberts vs. Austin compliance, corrective action, and completeness of information;~~
2. ~~transmitting the referral to the BR unit;~~
3. ~~providing case records to the BR unit within five working days after receipt of the list of cases to be reviewed, or by the date the BR unit has, with prior notice, scheduled cases for review;~~
4. ~~arranging for the case record to be available for review by the BR unit or Public Assistance Fraud at a scheduled time and place, or immediately informing the BR unit of the reason a case record cannot be made available;~~
5. ~~submitting additional information, when obtained, to the BR unit; and~~
6. ~~attending court or an administrative hearing as necessary and carrying and safeguarding the case record during the hearing if requested by BR.~~

3620.0503 Benefit Recovery Responsibilities (TCA)

BR ~~Benefit Recovery (BR)~~ is responsible for the establishment of all overpayment claims and the maintenance of all recoupment and recovery activities.

As the Department's liaison with the DPAF, BR is responsible for the programing of electronic submission of suspected fraud referrals to DPAF via FLORIDA BVBR. When the investigation results in sufficient evidence of suspected fraud, DPAF completes a referral for prosecution to the appropriate State Attorney or to the Office of the Secretary Inspector General Hearings. This process is also completed on cases identified by DPAF through independent program reviews.

The BR is the "Custodian of the Case Record" for the overpayment claim from the date of request for an Administrative Disqualification Hearing or court hearing to final disposition.

~~As the Department's liaison with the Department of Financial Services, Public Assistance Fraud (PAF), the BR units are responsible for routing appropriate referrals (i.e., those that involve suspected fraud) from the Department to PAF. When sufficient evidence of suspected fraud is found, referral for prosecution to the appropriate State Attorney or to the Office of the Secretary Inspector General Hearings is made by PAF. This process is also completed on cases identified by PAF through independent program reviews.~~

~~The BR supervisor is usually the "Custodian of the Case Record" from the date of request for an Administrative Disqualification Hearing or court hearing to final disposition.~~

3620.0504 Benefit Investigations ~~ACCESS Integrity~~ Responsibilities (TCA)

The Department will conduct pre-eligibility fraud screening and investigation of suspected fraud cases at the application/reapplication, certification/recertification process and prior to benefit approval. The Department is responsible for referring appropriate cases to OSIH ~~the Office of the Inspector General~~, Hearings for an Administrative Disqualification Hearing. Cases in which individuals have received benefits due to suspected fraud will be referred directly to DPAF ~~Public Assistance Fraud~~ by Benefit Investigations ~~ACCESS Integrity~~ staff by completion of the FLORIDA BVBR screen.

3620.0505 Division of Public Assistance Fraud Responsibilities (TCA)

DPAF ~~Public Assistance Fraud (PAF)~~ has the responsibility to handle investigations of suspected fraud in all programs covered in Chapter 409, Florida Statutes (FS). This includes the TCA ~~Temporary Cash Assistance Program~~. The Department has a contract with DPAF to investigate fraud in the public assistance programs. Federal matching monies are utilized to fund this activity.

DPAF has the responsibility for investigating and referring cases of suspected fraud for prosecution to the State Attorney and for referring cases to the OSIH ~~Office of the Secretary Inspector General Hearings~~ for Administrative Disqualification Hearings.

3620.0600 PERSONS RESPONSIBLE FOR REPAYMENT (TCA)

All assistance group (AG) members who were adult members of the AG at the time the overpayment occurred will be jointly and individually liable for the value of any overpayment of the benefits. This includes:

1. any adult member included in the AG at the time the overpayment occurred;
2. any adult relative who applied for or received assistance on behalf of the AG at the time the overpayment occurred;
3. teen parents receiving assistance as an eligible adult in their own AG.

BR ~~The Benefit Recovery (BR)~~ ~~unit~~ may pursue recovery action against any open cash AG containing a member who was an adult member of the original AG at the time the overpayment occurred. This can include retention of restored benefits owed to the AG as an offset against the overpayment claim.

~~The~~ BR ~~unit~~ may pursue recovery action against an alternative/protective payee if this individual was the cause of the overpayment. Adults who apply for and receive benefits on behalf of the AG will be responsible for the value of any overpayment of benefits received.

3620.0700 REPAYMENT (TCA)

Recovery of amounts of overpayment will be made by one or more of the following methods:

1. lottery intercepts,
2. lump sum and installment payments,
3. benefit reduction,
4. offset of lost benefits, and
5. child support credit.

BR ~~Benefit Recovery (BR)~~ must notify the overpaid assistance group of the amount and cause of overpayment as well as the various repayment methods available.

BR must then allow a minimum of 30 calendar days for the assistance group to respond prior to initiating recovery activity. If the recipient is active, benefit reduction will begin immediately.

Passages 3620.0701 through 3620.0710 describe methods of repayment.

3620.0702 Benefit Reduction (TCA)

~~The Benefit Recovery unit will determine the rate of allotment reduction and complete appropriate FLORIDA screens.~~ Recoupment percentages are automatically set by the claim type and will start automatically. EDBC will be run automatically to initiate recoupment.

The amount of the monthly payment for TCA ~~Temporary Cash Assistance~~ always is five percent of the Consolidated Need Standard unless the recipient agrees to more. FLORIDA will automatically adjust the recoupment amount when the allotment changes.

3620.0705 Child Support Credit (TCA)

BR ~~The Benefit Recovery unit~~ will apply child support credit in cases where child support was paid during a month of overpayment. The amount of child support paid must exceed the amount of benefits that the individual remained eligible for after overpayment was calculated before credit can occur. Credit can be applied up to the total amount of overpayment only in those instances where a non-custodial parent has repaid to the state the full amount of benefits received by the overpaid assistance group.

3620.0707 Civil Action (TCA)

All steps necessary to institute civil action are taken when the BR ~~Benefit Recovery (BR) unit~~ determines that such action is required to recover a TCA Program overpayment from a former recipient.

~~If a case is returned indicating that civil action cannot be taken against an individual, the BR unit will notify the referring eligibility specialist that there is an unpaid overpayment that cannot be collected at this time. If the former recipients receive benefits at a later date, appropriate recoupment action must be taken against their benefits.~~

3620.0710 Hearing Requested (TCA)

When an individual requests a fair hearing regarding an overpayment, the request for hearing screen (CLFH) must be completed by the BR Hearing Specialist team ~~Benefit Recovery (BR) unit supervisor~~ within three working days of the date the request was received. When the request is in writing, a copy must be sent to the OSIH ~~Office of the Secretary Inspector General Hearings (OSIH)~~ along with a copy of the "statement of matters" form (i.e., a Notice of Decision, Intent to Recover, etc.).

When an individual requests a hearing in response to the Notice of Case Action regarding the amount of repayment, the BR unit is responsible for submitting the Request for Hearing to OSIH. If the individual requests a timely hearing from the date of the Notice of Case Action, the benefit reduction will be stopped until the conclusion of the Hearing and a fnal decision has been made by OSIH. BR must be notified of the hearing date, time and location. When the final order is received via Document Imaging to the dedicated workgroup box, the BR staff member will be notified via an alert and will take the appropriate actions. If the individual contacts the eligibility specialist in response to a BR generated notice or action, the eligibility specialist should refer the individual to the BR unit for initiation of the Fair Hearing request.

~~When an individual requests a hearing in response to the Notice of Case Action regarding the amount of repayment, the BR unit is responsible for submitting the Request for Hearing to OSIH. If the individual requests a hearing within ten calendar days from the date of the Notice of Case~~

~~Action, the benefit reduction will be removed and a copy of the new notice to the individual must be sent to the BR unit. BR must be notified of the hearing date, time and location. When the final order is received by the public assistance unit, a copy must be sent to the BR unit. If the individual contacts the eligibility specialist in response to a BR generated notice or action, the eligibility specialist should refer the individual to the BR unit for initiation of the Fair Hearing request.~~

3620.0800 TRANSMITTAL OF REPAYMENT (TCA)

All repayments must be directed ~~channeled~~ through BR. ~~Benefit Recovery (BR).~~

Repayments may be collected by the local office; however, the repayment ~~eligibility specialist~~ must forward the repayment to BR within 24 hours. ~~If no referral was previously submitted, complete the referral screen and forward the paper case file with the payment to the BR unit.~~

~~A receipt must be provided to the individual for cash or currency payments.~~

Note: The individual must be informed that future payments must be payable to DCF and mailed to:
P.O. Box 4069
Tallahassee, FL 32315-4069

3620.0900 DISQUALIFICATION DUE TO COURT/HEARING DECISION (TCA)

Individuals found to have committed fraud by a court will be disqualified for the length of time addressed by the court.

In addition to disqualification periods, the court may impose fines up to $10,000, imprisonment up to five years, or both. The individual may also be subject to further prosecution under other applicable state and federal laws.

If the court makes an adjudication of guilt but fails to impose a disqualification period, or if adjudication of guilt is withheld or the individual enters the pre-trial intervention or diversion program and signs a disqualification consent agreement, BR ~~the Benefit Recovery unit~~ will impose disqualification penalties in accordance with the policy presented in passage 3620.0902.

Individuals found to have committed fraud by a hearings official through the administrative disqualification hearing process or who sign a waiver of administrative disqualification hearing will be disqualified in accordance with the policy presented in passage 3620.0902.

3620.0901 Disqualification Notice (TCA)

BR ~~The Benefit Recovery (BR) unit~~ will disqualify only the individual found to have committed or attempted to commit fraud and not the entire assistance group. On an active case, the BR unit will inform the assigned BR claims examiner ~~eligibility specialist~~ of disqualification penalties against the individual. Notification must be provided to the payee of the assistance group regarding the effect that the disqualification has on the AG's benefits.

3620.0902 Disqualification Periods and Implementation (TCA)

The disqualification period for an eligible assistance group member must begin no later that the first day of the second month, which follows the date of the decision. There is no requirement for notification through certified mail. The agency is not required to give the assistance group notice of adverse action prior to imposing the disqualification.

Disqualification periods, when specified in a court order, must be followed as defined by the court. In the absence of court ordered specifications, use the following program specific policies to determine disqualification periods:

TCA disqualification periods:

1. 12 months for the first violation,
2. 24 months for the second violation, and
3. permanent disqualification for the third violation.

For program violations involving trafficking of Temporary Cash Assistance benefits in the amount of $500 or more, the disqualification period is permanent for the first violation.

For program violations involving fraudulent statements or representations regarding identity or residence in order to receive multiple benefits, the disqualification period is 10 years for each violation.

In addition to these specific program violations there are two situations where an individual is automatically disqualified due to their status as a fleeing felon or probation violator or having a felony drug trafficking conviction.
An individual, who is a fleeing felon or probation violator, is disqualified from participation in the TCA ~~Temporary Cash Assistance~~ Program as long as they are a fleeing felon or probation violator.

An individual, who was convicted of a drug trafficking felony after 8/22/96, is permanently disqualified from participation in the Temporary Cash Assistance Program. If the illegal behavior that led ~~lead~~ to the conviction occurred on or before 8/22/96, the disqualification does not apply regardless of the date of the conviction. If a court expunges the felony drug trafficking conviction, the individual is not subject to the disqualification. The individual must provide proof of the expungement.

For all other Temporary Cash Assistance Program violations, the disqualification periods are:

1. 12 months for the first violation,
2. 24 months for the second violation, and
3. permanent disqualification for the third violation.

3620.0903 Determining Benefits During Disqualification (TCA)

The income, expenses, and assets of a disqualified individual will be counted in their entirety for determining benefits for the remainder of the assistance group. ~~Expenses will also be counted in their entirety.~~ The individual's needs will not be included when determining the benefit level of the remaining members.

In no event will the assistance group's benefits be increased as a result of a member's disqualification.

3620.0904 Administrative Disqualification Hearings (TCA)

The OSIH ~~Office of the Secretary Inspector General Hearings (OSIH)~~ will send a written advance notice of administrative disqualification hearing by regular ~~certified~~ mail ~~- return receipt requested~~ to the assistance group member suspected of fraud at least 30 calendar days in advance of the scheduled hearing date. A waiver of administrative disqualification hearing form will be provided with the notice. ~~The receipt must be signed by said individual, or other proof of receipt must be obtained from said individual.~~

A disqualification hearing will not be held if the individual signs and returns the waiver of administrative disqualification hearing accepting the penalty. In signing this waiver, the individual agrees to be disqualified for the time period specified on the waiver form. If the individual does not return a signed waiver, or indicates they would like a hearing, an administrative disqualification hearing will be held.

A pending disqualification hearing will not affect the assistance group's or individual's right to be determined eligible and participate in the program. Eligibility and benefit levels will be calculated according to standard rules and procedures.

OSIH will base the determination of fraud on clear and convincing evidence which demonstrates that the assistance group member(s) intentionally or attempted to commit, fraud. The OSIH decision must:

1. specify the reasons for the decision,
2. identify the supporting evidence,
3. identify the pertinent Code of Federal Regulations, and
4. respond to reasoned arguments made by the assistance group member or representative consistent with current policy.

If OSIH rules the assistance group member committed or attempted to commit fraud, the member will be disqualified in accordance with the established disqualification periods.

In addition to updating the disqualification hearings update screen on FLORIDA, OSIH will send a copy of the hearing decision to the dedicated BR workgroup in Document Imaging. ~~through the Region or Circuit Program Office to Benefit Recovery (BR) who will initiate disqualification action. The BR unit will initiate disqualification upon receipt of notification that the disqualification hearings update screen has been completed by OSIH to show a hearings decision.~~ Each Final Order will be sent to the Collections Unit, who will initiate disqualification action. BR will initiate disqualification upon receipt of notification that the disqualification hearings update screen has been completed by OSIH to show a hearings decision.

BR will take the appropriate FLORIDA action to remove the member from the assistance group, recalculate the benefit level, and send the Notice of Case Action.

~~The BR unit will contact the eligibility specialist who will take the appropriate FLORIDA action to remove the member from the assistance group, recalculate the benefit level, perform an ex parte to determine eligibility for the appropriate Medicaid group and notify the AG.~~

3620.0905 Waiver of an Administrative Disqualification Hearing (TCA)

The State agency shall provide written notification to the household member suspected of Intentional Program Violation that the member can waive his/her right to an administrative disqualification hearing. An Administrative Disqualification waiver provided to the household member which informs him/her of the possibility of waiving the administrative disqualification hearing shall include, at a minimum:

- An opportunity for the accused individual to specify whether or not he/she admits to the facts as presented by the State agency. This opportunity shall consist of the following statements, or statements developed by the State agency which have the same effect, and a method for the individual to designate his/her choice:

(1) I admit to the facts as presented, and understand that a disqualification penalty will be imposed if I sign this waiver; and

(2) I do not admit that the facts as presented are correct. However, I have chosen to sign this waiver and understand that a disqualification penalty will result; and

(3) I have read this notice and wish to exercise my rights to have an administrative hearing.

- The date that the signed waiver must be received by the State agency to avoid the holding of a hearing and a signature block for the accused individual, along with a statement that the head of household must also sign the waiver if the accused individual is not the head of household, with an appropriately designated signature block.

Each waiver packet sent to the household member will include a copy of the waiver, a cover letter, and a notification of Intent to Disqualify.

3620.1000 BENEFIT INVESTIGATIONS ~~ACCESS INTEGRITY~~ (TCA)

BI ~~ACCESS Integrity (AI)~~ is an extension of the Department's public assistance eligibility process and operates within the purview of 7 CFR 273, 45 CFR 233, and Sections 414.095(16) and 414.39(10), Florida Statutes. It is a program designed to combat fraud and reduce misspent dollars in the Department's public assistance programs. Probable error prone cases are identified at the pre-eligibility (application/reapplication, certification/recertification) phase of the public assistance program. Once a case is identified as meeting error prone criteria, it is referred to the BI ~~AI unit within the Region or Circuit where the public assistance unit resides~~. The BI ~~AI unit then~~ reviews the information provided by the individual or the authorized representative and verifies and documents the finding of fact as it relates to the information provided by the individual and the eligibility factors used to determine the individual's level of participation. Once verification and documentation are ~~is~~ completed, the recipient is given an opportunity to explain contradictory information and an eligibility determination is made.

3630.0000 Family-Related Medicaid

This chapter presents policy regarding referrals to BR ~~Benefit Recovery~~ for determination of overpayment, fraud, and Benefit Recovery ~~benefit recovery, and disqualification~~.

In this chapter:

~~1.~~ 1. "fraud" encompasses intentional program violation,
~~2.~~ 2. "suspected fraud" refers to client errors pending determination as the result of an ~~administrative disqualification hearing or~~ court decision, and
~~3. "inadvertent assistant group error" encompasses non-fraud client error,~~
~~4. "agency" refers to administrative error or Department errors, and~~
~~5.~~ 3. "Benefit Investigations ~~ACCESS Integrity~~" refers to the Department's pre-eligibility fraud screening and investigation program.

3630.0100 BENEFIT RECOVERY/BENEFIT INVESTIGATIONS ~~ACCESS INTEGRITY~~ BACKGROUND (MFAM)

Background information is provided in passage 3610.0100.

~~The need to recover improperly determined benefits and to identify and prosecute individuals who willfully and fraudulently obtained, or attempted to obtain, these benefits led to the development of a statewide system for the identification, investigation, determination, and collection of public assistance overpayments.~~

~~This system is comprised of:~~

~~1. the ACCESS Integrity Program at the Region or Circuit level,~~
~~2. the Benefit Recovery Policy Development Unit at Headquarters,~~
~~3. the Benefit Recovery (BR) units located in each Region or Circuit,~~
~~4. Public Assistance Fraud (PAF).~~

~~The ACCESS Integrity (AI) units conduct pre-eligibility, fraud screening, investigations, and refer appropriate cases of attempted fraud to Administrative Disqualification Hearings. Referrals from AI units to the Office of the Secretary Inspector General Hearings are no program loss cases only. Cases suspected of past overpayment from suspected fraud are referred by the AI unit directly to PAF by using the BVBR screen.~~

~~The BR unit establishes the existence, circumstances, and amount of public assistance overpayment and pursues recovery of overpayment from members of the overpaid assistance group or person responsible for causing the overpayment (i.e., designated representative).~~

~~The PAF unit handles fraud investigations and referrals to the State Attorneys and administrative disqualification hearings where appropriate in all programs covered in Chapters 409 and 414, Florida Statutes.~~

3630.0101 Legal Basis (MFAM)

The legal basis is provided in passage 3610.0101.

~~The legal bases for fraud and recovery of overpayments are established by:~~

~~1. Florida Statutes, Sections 409.325/414.41[1996], and 409.335/414.39[1996];~~
~~2. Section 7 CFR 273.18 of the Code of Federal Regulations;~~
~~3. Title IV-A of the Social Security Act;~~
~~4. Section 45 CFR 233; and~~
~~5. Florida Administrative Code Chapter 65A-1.~~

~~According to Section 409.325/414.41[1996], Florida Statutes, "Any person who knowingly fails by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose a material fact used in making a determination as to such person's qualification to receive aid or benefits under any state or federally funded assistance program, or fails to disclose a change in circumstances in order to obtain or continue to receive under such program aid or benefits to which he is not entitled, or who knowingly aids and abets another person in the commission of any such act is guilty of a crime and will be punished as provided in Subsection (5)." This subsection provides that assistance wrongfully sought or received which is valued at less than $200 in a 12 month period will be punishable as a misdemeanor of the first degree. Assistance of $200 or more in a 12 month period will be punishable as a third degree felony.~~

~~According to Section 409.335/414.39[1996], Florida Statutes, "Whenever it becomes apparent that any person has received any assistance or benefits under this chapter to which he is not entitled, through either simple mistake or fraud, the Department shall take all necessary steps to recover the overpayment".~~

~~According to Section 414.095(16), Florida Statutes, an applicant who meets an error prone profile, as determined by the Department, is subject to pre-eligibility fraud screening as a means of reducing misspent funds and preventing fraud. The Department created an error prone or fraud prone case profile within its public assistance information system and shall screen each application against the profile to identify cases that have a potential for error or fraud. Each case so identified is subject to pre-eligibility fraud screening.~~

~~According to Section 414.39 (10), the Department shall create an error-prone case profile within its public assistance information system and shall screen each application for public assistance, including food stamps, Medicaid, and Temporary Cash Assistance, against the profile to identify cases that have a potential for error or fraud. Each case so identified shall be subjected to pre-eligibility fraud screening.~~

3630.0200 STATUTES OF LIMITATION FOR ESTABLISHING CLAIMS (MFAM)

For non-fraud (agency or client) error cases, a claim will not be established in the Medicaid Program.~~is limited to four years prior to the month the overpayment was initially discovered by, or reported to, an eligibility specialist.~~

3630.0300 DEFINITION~~S~~ AND TYPE~~S~~ OF OVERPAYMENT (MFAM)

An overpayment exists when an individual receives benefits in an amount greater than the amount the individual was eligible to receive.

An overpayment may be the result of:

~~1. agency error,~~
~~2. client error, or inadvertent household error,~~
1. fraud~~,~~ or intentional program violation~~, or~~
~~4. any combination of the above.~~

Medicaid, overpayment may also result from an error made by the provider.

~~**3630.0301 Agency Error Definition (MFAM)**~~

~~Agency error occurs when an incorrect benefit is received by or paid on behalf of an individual due to an error made on the part of the agency.~~

~~Agency error overpayment can occur as a result of:~~

~~1. a misapplication of policy,~~
~~2. a calculator error,~~
~~3. computer processing error (for example, an interception and/or cancellation that did not take place),~~
~~4. failure to take prompt action on available information,~~
~~5. insufficient time to give adverse action notice to the assistance group,~~
~~6. more income received in a prospective month than was anticipated, or~~
~~7. some other error over which the Department has control.~~

~~**3630.0302 Agency Errors Not Requiring a Referral (MFAM)**~~

~~A claim will not be established for the sole reason that the Department failed to ensure that an assistance group or individual:~~

~~1. signed the application form,~~
~~2. completed a timely review,~~
~~3. failed to provide a required form for completion, or~~
~~4. failed to provide a written Declaration of Citizenship.~~

~~**3630.0304 Inadvertent Assistance Group Error Definition (MFAM)**~~

~~Inadvertent assistance group error, also known as client error, is an overpayment caused by a misunderstanding or an unintended error on the part of the assistance group or individual.~~

~~Inadvertent assistance group (client) error overpayment can occur as a result of individual:~~

~~1. failure to provide the Department with correct or complete information,~~
~~2. failure to report to the Department changes in the filing unit circumstances, and~~
~~3. receipt of benefits (or more benefits than were entitled to be received) pending a fair hearing decision because the assistance group requested a continuation of benefits based on the mistaken belief that it was entitled to such benefits.~~

~~**3630.0306 Inadvertent or Agency Errors Not Requiring Referral (MFAM)**~~

~~A Benefit Recovery referral will not be made or a claim established on cases when client error results in overpayment of less than $400.~~

3630.0307 Suspected Fraud and Intentional Program Violation Definition (MFAM)

Fraud exists if:

1. overpayment was caused by an intentional action on the part of the assistance group or individual in an attempt to receive additional benefits for which they are not entitled, or
2. there was an intent to defraud that does not result in an overpayment.

Fraud, or attempted fraud, can only be determined by a court ~~or hearings official~~. Situations pending such a determination are considered suspected fraud.

Fraud overpayment can occur as a result of the assistance group:

1. misrepresenting information,
2. concealing information,
3. withholding information pertinent to determining eligibility including untimely reporting,
4. failing to report a change in order to continue to receive benefits for which they are not entitled, or
5. intentionally altered or changed documents to obtain benefits to which the assistance group was not entitled.

3630.0309 Evidence Used to Substantiate Fraud (MFAM)

Written verification of the unreported income received by the assistance group may be used to substantiate intent. Wage and unearned income information supplied through Data Exchange to the eligibility specialist is not to be considered verified upon receipt, with the exception of SSA/SSI and BENDEX information.

Verification that the assistance group member understood their responsibility for reporting the information in question may be used to substantiate intent. This verification could include:

1. the signed application,
2. acknowledgement of rights and responsibilities,
3. submitted change report form(s), or

4. recorded and/or verified instances of other changes reported by the assistance group which could or did affect the benefits received.

An application or change report form submitted during the period fraud is suspected, which omits the information that resulted in the overpayment, may be used to substantiate intent.

~~Recorded instances which indicate that the assistance group member visited the office during the period fraud is suspected and did not report the change which resulted in overpayment may be used to substantiate intent.~~

Sworn testimony by the eligibility specialist or other individuals may also be used to substantiate intent. It is important that the eligibility specialist be able to identify the individual.

These examples are not all inclusive; other types of evidence may also be used.

3630.0310 Court Determination of Fraud (MFAM)

A court of appropriate jurisdiction must determine fraud. The determination must be an adjudication of guilt~~ or adjudication withheld and the individual charged with fraud must have signed a Disqualification Consent Agreement~~.

3630.0400 OVERPAYMENT AMOUNT (MFAM)

The eligibility specialist determines if overpayment appears to exist. ~~The supervisor is to review and ensure that the claim is valid prior to transmitting to Benefit Recovery (BR).~~ If it is determined that potential overpayment occurred, a referral is completed and transmitted to BR. ~~The~~ BR ~~unit~~ will determine the overpayment based on the best available information. If there is no acceptable information available on which to establish a corrected benefit amount, then insufficient evidence exists, and no claim can be established by BR. Overpayment will be computed on the best information available to ~~the~~ BR ~~unit~~.

Reportable Medicaid overpayment exists when funds may have been expended on behalf of an assistance group who were not eligible for Medicaid coverage or who were only eligible for coverage after meeting a share of cost.

If ineligibility is due to income, overpayment occurs for any month in which the assistance group is ineligible; including the first month income is received. If ineligibility is due to a reason other than income, it occurs for any month that the individual or assistance group was ineligible during the entire month. The assistance group must be ex parted into any other coverage group the assistance group may be eligible for. If still not eligible, the case is referred to BR.

3630.0410.01 Determination of Medicaid Overpayment (MFAM)

Possible Medicaid overpayment begins with the month of the unreported change. The following must be considered to determine the actual amount of overpayment:

1. When an individual is found to have been ineligible for 1931 Medicaid, BR ~~the Benefit Recovery (BR) unit~~ will assess the case to determine whether or not the individual might have been eligible for another Medicaid coverage group if all case situations had been reported appropriately.
2. If the individual would have been eligible for Medicaid under another coverage group, no Medicaid overpayment exists unless the individual or assistance group would have had to meet a share of cost for Medically Needy.
3. If the individual were ineligible for any of the Medicaid coverage groups, Medicaid overpayment would exist if funds were expended. The individual would be ineligible for any Medicaid benefits received during those months of ineligibility.

4. Medicaid Only budgets are computed using income, assets, and circumstances in months it was actually received or occurred.

Note: If an assistance group is not eligible for one Medicaid coverage group an ex parte determination and budget must be completed for other possible Medicaid coverage groups before a BR referral is made.

3630.0410.02 Ineligibility Due to Income (MFAM)

Ineligibility due to income can include the first month income is received, or a month when assistance could not be terminated even though the income was reported timely and action to close the case was taken immediately.

~~**Example:** Mrs. Jones and her son were receiving 1931 Medicaid only. She reported on August 10 that she received a pay raise in the paycheck she received on August 1. The eligibility specialist completes a budget for September and determines that Mrs. Jones and her son are no longer Medicaid eligible. They are expected to be Medically Needy (MN) with a share of cost (SOC). In order to determine if potential overpayment for Medicaid exists, the eligibility specialist must complete another budget for August. The eligibility specialist determines that Mrs. Jones was also ineligible for categorical Medicaid coverage for August, the month of change. She and her son should have been enrolled in the MN Program with a SOC and therefore Mrs. Jones must be referred to the Benefit Recovery unit for potential Medicaid overpayment in August. The Medicaid overpayment for August would be the amount of medical benefits paid on behalf of Mrs. Jones and her son, unless the, SOC for August is met by the household.~~

~~Mrs. Jones is ex parted to MN for September and sent a notice concerning the SOC she must meet in order to be Medicaid eligible again.~~

3630.0410.03 Reasons Other than Income (MFAM)

Prospective ineligibility due to a reason other than income occurs for any month in which the individual or assistance group is ineligible during the entire month.

~~**Example:** Mr. and Mrs. Steel and their child were receiving Medicaid under family-related Medically Needy with no share of cost. They reported on October 3 that their only child left the home on October 1. The eligibility specialist determined that the Steels were ineligible and canceled their Medicaid coverage effective November. The Steels must be referred to the Benefit Recovery unit for potential Medicaid overpayment in October, as there was full a month of ineligibility.~~

3630.0411 Understated Share of Cost (MFAM)

In Medically Needy cases, any Medicaid benefits expended for any portion of the month that the assistance group did not meet their share of cost (SOC) is considered overpayment not to exceed the corrected SOC.

A referral to the BR ~~Benefit Recovery (BR) unit~~ must be made whenever an assistance group receives benefits they are not entitled to due to an understated SOC. An understated SOC can occur whenever the following circumstances exist:

1. an undetected mathematical error occurs,
2. the individual fails to report an increase in income,
3. the individual misrepresents his situation, or
4. the Department fails to timely act on a report change.

~~The~~ BR ~~unit~~ will complete an ex parte to ensure that members of a potentially overpaid assistance group are ineligible for all other Medicaid coverage groups, prior to computing Medicaid overpayment.

The BR unit will then request the Medicaid benefit history printout for the months of potential overpayment to determine if Medicaid overpayment exists. If Medicaid funds were spent during these months, amount of overpayment would be the amount spent if the SOC was not met the household.

3630.0414 Provider Error (MFAM)

A provider may receive Medicaid payment to which the provider is not entitled. This may occur if:

1. the provider billed Medicaid for days that services were not provided or for days for which the provider was not entitled to payment (for example, unapproved paid bed reservation days or paid reservation days in excess of the established limit);
2. the provider received payment from another source (friends, family, insurance) as well as received full payment from Medicaid; (this includes payment received for services, supplies, and equipment which are already included in the Medicaid rate for care); or
3. the provider committed billing errors, such as a fiscal agent systems problem in the institutional billing system.

Any erroneous payment made to a provider as a result of provider error is considered countable overpayment. Overpayment due to provider error must be reported to the Headquarters ~~District~~ Medicaid Program Office.

Medicaid provider fraud should be referred to the Agency for Health Care Administration. Cases are then referred to Medicaid Fraud Control in the Attorney General's office.

3630.0500 DEPARTMENT STAFF OVERPAYMENT RESPONSIBILITIES (MFAM)

Overpayment responsibilities of the eligibility specialist, ~~Supervisor,~~ Benefit Recovery ~~unit~~, Benefit Investigations ~~ACCESS Integrity unit~~, and Division of Public Assistance Fraud are provided in passage 3630.0501 through 3630.0505.

3630.0501 Eligibility Specialist Responsibilities (MFAM)

The eligibility specialist must establish that overpayment has occurred by obtaining and recording the following facts in running record comments or in the paper case file prior to initiating a referral to BR ~~Benefit Recovery (BR)~~ on the BVBR screen:

1. how the overpayment was discovered,
2. the date of discovery,
3. who received the income/asset/status change,
4. the date the income or change started and/or stopped,
5. the cause of overpayment,
6. the estimated length and amount of overpayment,
7. any explanation given for failure to provide information accurately or in a timely manner, and
8. corrective action taken and the date such action(s) was taken.

The eligibility specialist must take necessary action to ensure that correct payment will be made for the current situation or that cancellation of benefits is effective in accordance with policy prior

to referral to BR. This step includes doing a partial eligibility review on the fraudulent factors when fraud is suspected except when the suspected fraud was identified during the complete eligibility review process. If overpayment was discovered as a result of Data Exchange, follow the policy in Chapter 3000 prior to referral to BR.

The eligibility specialist must then verify that the individual was actually receiving assistance during the time the suspected fraud.

The eligibility specialist must also obtain the verification necessary to determine the amount of overpayment when the circumstances causing the overpayment are still present at the time the overpayment is discovered.

The eligibility specialist must:

1. adjust the current benefit if appropriate,
2. complete a referral via the FLORIDA AIFP to the Benefit Investigations ~~Office of Public Benefits Integrity (OPBI) unit~~ for cases in which an error/fraud prone profile match occurs at the application/reapplication process;
3. complete the Benefit Recovery Referral (BVBR) screen; and
4. respond to the BR unit requests for any additional information within 10 calendar days.~~;~~
5. ~~rerun the benefit calculation to implement an individual's disqualification within 10 working days of receipt of BR's alert to disqualify the individual.~~

~~**3630.0502 Supervisor Responsibilities (MFAM)**~~

~~The supervisor's responsibilities include:~~

1. ~~reviewing the case record for validity of referral to the Benefit Recovery (BR) unit, proper organization, Roberts vs. Austin compliance, corrective action, and completeness of information;~~
2. ~~transmitting the referral to the BR unit;~~
3. ~~providing case records to the BR unit within five working days after receipt of the list of cases to be reviewed, or by the date the BR unit has, with prior notice, scheduled cases for review;~~
4. ~~arranging for the case record to be available for review by the BR unit or Public Assistance Fraud at a scheduled time and place, or immediately informing the BR unit of the reason a case record cannot be made available;~~
5. ~~submitting additional information, when obtained, to the BR unit; and~~
6. ~~attending court or an administrative hearing as necessary and carrying and safeguarding the case record during the hearing if requested by BR.~~

3630.0503 Benefit Recovery Responsibilities (MFAM)

Benefit Recovery (BR) is responsible for the establishment of all overpayment claims and the maintenance of all ~~recoupment and~~ recovery activities.

As the Department's liaison with the DPAF, BR is responsible for the programing of electronic submission of suspected fraud referrals to DPAF via FLORIDA BVBR. When the investigation results in sufficient evidence of suspected fraud, DPAF completes a referral for prosecution to the appropriate State Attorney or to the OSIH. This process is also completed on cases identified by DPAF through independent program reviews.

BR is the "Custodian of the Case Record" for the overpayment claim from the date of request for an Administrative Disqualification Hearing or court hearing to final disposition.

~~As the Department's liaison with the Department of Financial Services, Public Assistance Fraud (PAF), the BR units are responsible for routing appropriate referrals (i.e., those that involve suspected fraud) from the Department to PAF. When sufficient evidence of suspected fraud is found, referral for prosecution to the appropriate State Attorney or to the Office of the Secretary Inspector General Hearings is made by PAF. This process is also completed on cases identified by PAF through independent program reviews.~~

~~The BR supervisor is usually the "Custodian of the Case Record" from the date of request for an Administrative Disqualification Hearing or court hearing to final disposition.~~

3630.0504 Benefit Investigations ~~ACCESS Integrity~~ Responsibilities (MFAM)

The Department will conduct pre-eligibility fraud screening and investigation of suspected fraud cases at the application/reapplication process and prior to benefit approval. ~~The Department is responsible for referring appropriate cases to the Office of the Inspector General, Hearings for an Administrative Disqualification Hearing.~~ Cases in which individuals have received benefits due to suspected fraud will be referred directly to DPAF ~~Public Assistance Fraud~~ by ~~ACCESS Integrity~~ staff by completion of the FLORIDA BVBR screen.

3630.0505 Division of Public Assistance Fraud Responsibilities (MFAM)

DPAF ~~Public Assistance Fraud (PAF)~~ has the responsibility to handle investigations of suspected fraud in all programs covered in Chapter 409, Florida Statutes (FS). This includes the Medicaid Programs. The Department has a contract with DPAF to investigate fraud in these programs. Federal matching monies are utilized to fund this activity.

DPAF has the responsibility for investigating and referring cases of suspected fraud for prosecution to the State Attorney and for referring cases ~~to the Office of the Secretary Inspector General Hearings for Administrative Disqualification Hearings~~.

3630.0700 REPAYMENT (MFAM)

Recovery of amounts of overpayment will be made by one or more of the following methods:

1. lottery intercepts, and
2. lump sum and installment payments,

BR ~~Benefit Recovery (BR)~~ must notify the overpaid assistance group of the amount and cause of overpayment as well as the various repayment methods available.

BR must then allow a minimum of 30 calendar days for the assistance group to respond prior to initiating recovery activity.

Passages 3630.0706 through 3630.0710 describe methods of repayment.

3630.0707 Civil Action (MFAM)

All steps necessary to institute civil action are taken when the BR ~~Benefit Recovery (BR) unit~~ determines that such action is required to recover an overpayment from individuals in Medical Assistance Only cases.

~~If a case is returned indicating that civil action cannot be taken against an individual, the BR unit will notify the referring eligibility specialist that there is an unpaid overpayment that cannot be collected at this time.~~

3630.0708 Medicaid Recovery (MFAM)

Collection of Medicaid overpayment must be attempted in all cases~~, whether the overpayment was due to fraud or non-fraud,~~ by contacting the overpaid individual using the Notice of Overpayment/Intent to Recover notice. Benefit reduction cannot be used to recover Medicaid overpayment.

3630.0709 Amount to be Recovered (MFAM)

For Medical Assistance Only cases, the BR ~~Benefit Recovery (BR) unit~~ will attempt to verify current information regarding the income of ~~former individuals from~~ the ~~former~~ individuals involved. The BR unit may accept the individual's statement in some instances if no verification is available. Work related day-care costs may not be included unless verified by a source other than the individual's statement.

3630.0710 Hearing Requested (MFAM)

When an individual requests a fair hearing regarding an overpayment, the request for hearing screen (CLFH) must be completed by the BR Hearing Specialist team ~~Benefit Recovery (BR) unit supervisor~~ within three working days of the date the request was received. When the request is in writing, a copy must be sent to OSIH ~~the Office of the Secretary Inspector General Hearings (OSIH)~~ along with a copy of the "statement of matters" form (i.e., a Notice of Decision, Intent to Recover, etc.).

When an individual requests a hearing in response to the Notice of Case Action regarding the amount of repayment, the BR unit is responsible for submitting the Request for Hearing to OSIH. If the individual requests a timely hearing from the date of the Notice of Case Action, the benefit reduction will be stopped until the conclusion of the Hearing and a fnal decision has been made by OSIH. BR must be notified of the hearing date, time and location. When the final order is received via Document Imaging to the dedicated workgroup box, the BR staff member will be notified via an alert and will take the appropriate actions. If the individual contacts the eligibility specialist in response to a BR generated notice or action, the eligibility specialist should refer the individual to the BR unit for initiation of the Fair Hearing request.
~~When an individual requests a hearing in response to the Notice of Case Action regarding the amount of repayment, the BR unit is responsible for submitting the Request for Hearing to OSIH. If the individual requests a hearing within ten calendar days from the date of the Notice of Case Action, the benefit reduction will be removed and a copy of the new notice to the individual must be sent to the BR unit. BR must be notified of the hearing date, time and location. When the public assistance unit receives the final order, a copy must be sent to the BR unit. If the individual contacts the eligibility specialist in response to a BR generated notice or action, the eligibility specialist should refer the individual to the BR unit for initiation of the Fair Hearing request.~~

3630.0800 TRANSMITTAL OF REPAYMENT (MFAM)

All repayments must be directed ~~channeled~~ through BR. ~~Benefit Recovery (BR).~~

Repayments may be collected by the local office; however, the repayment must be forwarded to BR within 24 hours.

~~The local office may collect repayments; however, the eligibility specialist must forward the repayment to BR within 24 hours. If no referral was previously submitted, complete the referral screen and forward the paper case file with the payment to the BR unit.~~

~~A receipt must be provided to the individual for cash or currency payments.~~

Note: The individual must be informed that future payments must be payable to DCF and mailed to:
P.O. Box 4069
Tallahassee, FL 32315-4069

3630.1000 BENEFIT INVESTIGATIONS ~~ACCESS INTEGRITY~~ (MFAM)

Benefit Investigations (BI) ~~ACCESS Integrity (AI)~~ is an extension of the Department's public assistance eligibility process and operates within the purview of 7 CFR 273, 45 CFR 233, and Sections 414.095(16) and 414.39(10), Florida Statutes. It is a program designed to combat fraud and reduce misspent dollars in the Department's public assistance programs. Probable error prone cases are identified at the pre-eligibility (application/reapplication, certification/recertification) phase of the public assistance program. Once a case is identified as meeting error prone criteria, it is referred to the BI ~~AI unit within the Region or Circuit where the public assistance unit resides~~. BI ~~The AI unit~~ then reviews the information provided by the individual or the authorized representative and verifies and documents the finding of fact as it relates to the information provided by the individual and the eligibility factors used to determine the individual's level of participation. Once verification and documentation are ~~is~~ completed, the recipient is given an opportunity to explain contradictory information and an eligibility determination is made.

3640.0000 SSI-Related Medicaid, State Funded Programs

This chapter presents policy regarding referrals to Benefit Recovery for determination of overpayment, fraud, and ~~benefit~~ recovery activities. ~~, and disqualification.~~

In this chapter:

~~1.~~ 1. "fraud" encompasses intentional program violation,
~~2.~~ 2. "suspected fraud" refers to client errors pending determination as the result of an ~~administrative disqualification hearing or~~ court decision,
~~3. "inadvertent household error" encompasses non-fraud client error,~~
~~4. "agency" refers to administrative error or Department errors,~~
~~5.~~ 3. "overpayment" will mean both overpayment and overissuance, and
~~6.~~ 4. "Benefit Investigations ~~ACCESS Integrity~~" refers to the Department's preeligibility fraud screening and investigation program.

3640.0100 BENEFIT RECOVERY/BENEFIT INVESTIGATIONS ~~ACCESS INTEGRITY~~ BACKGROUND (MSSI, SFP)

Background information is provided in passage 3610.0100.

~~The need to recover improperly issued benefits and to identify and prosecute individuals who willfully and fraudulently obtained, or attempted to obtain, these benefits led to the development of a statewide system for the identification, investigation, determination, and collection of public assistance overpayments.~~

~~This system is comprised of:~~

~~1. the ACCESS Integrity Program at the Region or Circuit level;~~
~~2. the Benefit Recovery Policy Development Unit at Headquarters;~~
~~3. the Benefit Recovery (BR) units located in each Region or Circuit; and~~
~~4. Public Assistance Fraud (PAF).~~

~~The ACCESS Integrity (AI) units conduct pre-eligibility, fraud screening, investigations, and refer cases of attempted fraud to Administrative Disqualification Hearings. Referrals from the AI units to the Office of the Secretary Inspector General Hearings are no program loss cases only. Cases suspected of past overpayment from suspected fraud are referred by the AI unit directly to PAF by using the BVBR screen.~~

~~The BR unit establishes the existence, circumstances and amount of public assistance overpayment and pursues recovery of overpayment from members of the overpaid assistance group or person responsible for causing the overpayment (i.e., authorized representative).~~

~~The PAF unit handles fraud investigations and referrals to the State Attorneys and administrative disqualification hearings where appropriate in all programs covered in Chapters 409 and 414, Florida Statutes.~~

3640.0101 Legal Basis (MSSI, SFP)

The legal basis is provided in passage 3610.0101.

~~The legal bases for fraud and recovery of overpayments are established by:~~

~~1. Florida Statutes, Sections 409.325/414.41[1996], and 409.335/414.39[1996]; and~~
~~2. Florida Administrative Code Chapter 65A-1.~~

~~According to Section 409.325/414.41[1996], Florida Statutes, "Any person who knowingly fails by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose a material fact used in making a determination as to such person's qualification to receive aid or benefits under any state or federally funded assistance program, or fails to disclose a change in circumstances in order to obtain or continue to receive under such program aid or benefits to which he is not entitled, or who knowingly aids and abets another person in the commission of any such act is guilty of a crime and will be punished as provided in Subsection (5)." This subsection provides that assistance wrongfully sought or received which is valued at less than $200 in a 12 month period will be punishable as a misdemeanor of the first degree. Assistance of $200 or more in a 12 month period will be punishable as a third degree felony.~~

~~According to Section 409.335/414.39[1996], Florida Statutes, "Whenever it becomes apparent that any person has received any assistance or benefits under this chapter to which he is not entitled, through either simple mistake or fraud, the Department shall take all necessary steps to recover the overpayment".~~

~~According to Section 414.39 (10), the Department shall create an error-prone case profile within its public assistance information system and shall screen each application for public assistance, including food stamps, Medicaid, and Temporary Cash Assistance, against the profile to identify cases that have a potential for error or fraud. Each case so identified shall be subjected to pre-eligibility fraud screening.~~

3640.0200 STATUTES OF LIMITATION FOR ESTABLISHING CLAIMS (MSSI, SFP)

~~For client error (non-fraud) a claim will be established when less than 24 months have elapsed between the month an overpayment occurred and the month the overpayment was initially discovered by, or reported to, an eligibility specialist.~~

For client error (fraud), a claim will be established when less than 36 months have elapsed between the month an overpayment occurred and the month the overpayment was initially discovered by, or reported to, an eligibility specialist.

3640.0300 DEFINITION~~S~~ AND TYPE~~S~~ OF OVERPAYMENT (MSSI, SFP)

An overpayment exists when an individual receives benefits in an amount greater than the amount the individual was eligible to receive.

An overpayment may be the result of:

~~1. agency error;~~
~~2. client error, or inadvertent household error;~~
~~3.~~ 1. fraud~~,~~ or intentional program violation~~; or~~
~~4. any combination of the above.~~

For Medicaid, overpayment may also result from an error made by the provider.

~~**3640.0301 Agency Error Definition (MSSI, SFP)**~~

~~Agency error occurs when an incorrect benefit is received by or paid on behalf of an individual due to an error made on the part of the agency.~~

~~Agency error overpayment can occur as a result of:~~

~~1. a misapplication of policy,~~
~~2. a calculator error,~~
~~3. computer processing error (for example, an interception and/or cancellation that did not take place),~~
~~4. failure to take prompt action on available information,~~
~~5. insufficient time to give adverse action notice to the assistance group,~~
~~6. more income received in a prospective month than was anticipated, or~~
~~7. some other error over which the Department has control.~~

~~**3640.0302 Agency Errors Not Requiring a Referral (MSSI, SFP)**~~

~~A claim will not be established for the sole reason that the Department failed to ensure that an assistance group or individual:~~

~~1. failed to provide a required form for completion,~~
~~2. failed to provide a written Declaration of Citizenship,~~
~~3. signed the application form,~~
~~4. completed a current work registration form,~~
~~5. was certified in the correct project area, or~~
~~6. completed a timely review.~~

~~**3640.0304 Inadvertent Assistance Group Error Definition (MSSI, SFP)**~~

~~Inadvertent assistance group error, also known as client error, is an overpayment caused by a misunderstanding or an unintended error on the part of the assistance group or individual.~~

~~Inadvertent assistance group (client) error overpayment can occur as a result of individual:~~

~~1. failure to provide the Department with correct or complete information,~~
~~2. failure to report to the Department changes in the filing unit circumstances, and~~
~~3. receipt of benefits (or more benefits than were entitled to be received) pending a fair hearing decision because the assistance group requested a continuation of benefits based on the mistaken belief that it was entitled to such benefits.~~

~~3640.0306 Inadvertent or Agency Errors Not Requiring Referral (MSSI)~~

~~A Benefit Recovery referral will not be made or a claim established on cases when client error results in overpayment of less than $400.~~

3640.0307 Suspected Fraud and Intentional Program Violation Definition (MSSI, SFP)

Fraud exists if:

1. overpayment was caused by an intentional action on the part of the assistance group or individual in an attempt to receive additional benefits for which they are not entitled, or
2. there was an intent to defraud that does not result in an overpayment.

Fraud, or attempted fraud, can only be determined by a court ~~or hearings official~~. Situations pending such a determination are considered suspected fraud.

Fraud overpayment can occur as a result of the assistance group:

1. misrepresenting information,
2. concealing information,
3. withholding information pertinent to determining eligibility including untimely reporting,
4. failing to report a change in order to continue to receive benefits for which they are not entitled, or
5. intentionally altered or changed documents to obtain benefits to which the assistance group was not entitled.

3640.0309 Evidence Used to Substantiate Fraud (MSSI, SFP)

Written verification of the unreported income received by the assistance group may be used to substantiate intent. Wage and unearned income information supplied through Data Exchange to the eligibility specialist is not to be considered verified upon receipt, with the exception of SSA/SSI and BENDEX information.

Verification that the assistance group member understood their responsibility for reporting the information in question may be used to substantiate intent. This verification could include:

1. the signed application,
2. acknowledgement of rights and responsibilities,
3. submitted change report form(s), or
4. recorded and/or verified instances of other changes reported by the assistance group which could or did affect the benefits received.

An application or change report form submitted during the period fraud is suspected which omits the information that resulted in the overpayment may be used to substantiate intent.

~~Recorded instances which indicate that the assistance group member visited the office during the period fraud is suspected and did not report the change which resulted in overpayment may be~~

~~used to substantiate intent. These instances might include a record of the dates of reports of beneficial changes but not the adverse changes.~~

Sworn testimony by the eligibility specialist or other individuals may also be used to substantiate intent. It is important that the eligibility specialist be able to identify the individual.

These examples are not all inclusive; other types of evidence may also be used.

3640.0400 OVERPAYMENT AMOUNT (MSSI, SFP)

The eligibility specialist determines if overpayment appears to exist. ~~The supervisor is to review and ensure that the claim is valid prior to transmitting to Benefit Recovery (BR).~~ If it is determined that potential overpayment occurred, a referral is completed and transmitted to BR. ~~The~~ BR ~~unit~~ will determine the overpayment based on the best available information. If there is no acceptable information available on which to establish a corrected benefit amount, then insufficient evidence exists, and no claim can be established by BR. Overpayment will be computed on the best information available to the BR unit.

3640.0411 Understated Share of Cost (MSSI)

In Medically Needy cases, any Medicaid benefits expended for any portion of the month that the assistance group did not meet their share of cost (SOC) is considered overpayment not to exceed the corrected SOC.

A referral to the BR ~~Benefit Recovery (BR)~~ unit must be made whenever an assistance group receives benefits they are not entitled to due to an understated SOC. An understated SOC can occur whenever the following circumstances exist:

1. an undetected mathematical error occurs,
2. the individual fails to report an increase in income,
3. the individual misrepresents his situation, or
4. the Department fails to timely act on a report change.

The BR unit will complete an ex parte to ensure that members of a potentially overpaid assistance group are ineligible for all other Medicaid coverage groups.

~~The~~ BR ~~unit~~ will ~~then~~ request the Medicaid benefit history printout for the months of potential overpayment to determine if Medicaid overpayment exists. If Medicaid funds were spent during these months, amount of overpayment would be the amount spent up to the difference between the original SOC and the corrected SOC.

3640.0413 Determination of Overpayment (MSSI, SFP)

Whenever reportable overpayment due to individual or agency error is identified, a report of overpayment must be completed ~~and appropriately routed~~.

Reportable overpayment begins on the first day of the second month following the month in which the change occurred, or when the Department failed to take appropriate action.

In cases where overpayment or ineligibility occurred in the initial month of entitlement, reportable overpayment begins from the date of entitlement.

When reportable overpayment occurs in the Institutional Care Program, the report of overpayment is completed on the BVBR screen.

~~When reportable overpayment occurs in Optional State Supplementation, the Overpayment and Recovery Report Form must be completed and forwarded to the Office of General Accounting.~~

3640.0414 Provider Error (MSSI)

A provider may receive Medicaid payment to which the provider is not entitled. This may occur if:

1. the provider billed Medicaid for days that services were not provided or for days for which the provider was not entitled to payment (for example, unapproved paid bed reservation days or paid reservation days in excess of the established limit);
2. the provider received payment from another source (friends, family, insurance) as well as received full payment from Medicaid; (this includes payment received for services, supplies, and equipment which are already included in the Medicaid rate for care); or
3. the provider committed billing errors, such as a fiscal agent systems problem in the institutional billing system.

Any erroneous payment made to a provider as a result of provider error is considered countable overpayment. Overpayment due to provider error must be reported to the Headquarters ~~District~~ Medicaid Program Office.

3640.0500 DEPARTMENT STAFF OVERPAYMENT RESPONSIBILITIES (MSSI, SFP)

Overpayment responsibilities of the eligibility specialist, ~~Supervisor,~~ Benefit Recovery ~~unit~~, Benefit Investigations ~~ACCESS Integrity unit~~, and the Division of Public Assistance Fraud are provided in passages 3640.0501 through 3640.0505.

3640.0501 Eligibility Specialist Responsibilities (MSSI, SFP)

The eligibility specialist must establish that overpayment has occurred by obtaining and recording the following facts in running record comments ~~or in the paper case file~~ prior to initiating a referral to BR ~~Benefit Recovery (BR)~~ on the BVBR screen:

1. how the overpayment was discovered,
2. the date of discovery,
3. who received the income/asset/status change,
4. the date the income or change started and/or stopped,
5. the cause of overpayment,
6. the estimated length and amount of overpayment,
7. any explanation given for failure to provide information accurately or in a timely manner, and
8. corrective action taken and the date such action(s) was taken.

The eligibility specialist must take necessary action to ensure that correct payment will be made for the current situation or that cancellation of benefits is effective in accordance with policy prior to referral to BR. This step includes doing a partial eligibility review on the fraudulent factors when fraud is suspected except when the suspected fraud was identified during the complete eligibility review process. If overpayment was discovered as a result of Data Exchange, follow the policy in Chapter 3000 prior to referral to BR.

The eligibility specialist must then verify that the individual was actually receiving assistance during the time the suspected fraud.

The eligibility specialist must also obtain the verification necessary to determine the amount of overpayment when the circumstances causing the overpayment are still present at the time the overpayment is discovered.

The individual will be allowed 10 days to rebut the allegation prior to referral to BR. The eligibility specialist must allow the individual an opportunity to provide information that clarifies the situation.

The eligibility specialist must:

1. adjust the current benefit if appropriate,
2. complete a referral to ~~the~~ Benefit Investigations via the FLORIDA AIFP ~~Office of Public Benefits Integrity (OPBI) unit~~ for cases in which an error/fraud prone profile match occurs at the application/reapplication process;
3. complete the Benefit Recovery Referral (BVBR) screen; and
4. respond to the BR unit requests for any additional information within 10 calendar days.~~;~~
5. ~~rerun the benefit calculation to implement an individual's disqualification within 10 working days of receipt of BR's alert to disqualify the individual.~~

~~**3640.0502 Supervisor Responsibilities (MSSI, SFP)**~~

~~The supervisor's responsibilities include:~~

1. ~~reviewing the case record for validity of referral to the Benefit Recovery (BR) unit, proper organization, Roberts vs. Austin compliance, corrective action, and completeness of information;~~
2. ~~transmitting the referral to the BR unit;~~
3. ~~providing case records to the BR unit within five working days after receipt of the list of cases to be reviewed, or by the date the BR unit has, with prior notice, scheduled cases for review;~~
4. ~~arranging for the case record to be available for review by the BR unit or Public Assistance Fraud at a scheduled time and place, or immediately informing the BR unit of the reason a case record cannot be made available;~~
5. ~~submitting additional information, when obtained, to the BR unit; and~~
6. ~~attending court or an administrative hearing as necessary and carrying and safeguarding the case record during the hearing if requested by BR.~~

3640.0503 Benefit Recovery Responsibilities (MSSI, SFP)

BR ~~Benefit Recovery (BR)~~ is responsible for the establishment of all overpayment claims and the maintenance of all recoupment and recovery activities.

As the Department's liaison with the Department of Financial Services, Division of Public Assistance Fraud (DPAF), BR is responsible for the programing of electronic submission of suspected fraud referrals to DPAF via FLORIDA BVBR. When the investigation results in sufficient evidence of suspected fraud, DPAF completes a referral for prosecution to the appropriate State Attorney or to the Office of the Secretary Inspector General Hearings. This process is also completed on cases identified by DPAF through independent program reviews.

Medicaid provider fraud should be referred to the Agency for Health Care Administration. Cases are then referred to Medicaid Fraud Control in the Attorney General's office.

BR is the "Custodian of the Case Record" for the overpayment claim from the date of request for an Administrative Disqualification Hearing or court hearing to final disposition.

~~As the Department's liaison with Department of Financial Services, Public Assistance Fraud (PAF), the BR units are responsible for routing appropriate referrals (i.e., those that involve suspected fraud) from the Department to PAF. When sufficient evidence of suspected fraud is~~

~~found, referral for prosecution to the appropriate State Attorney or to the Office of the Secretary Inspector General Hearings is made by PAF. This process is also completed on cases identified by PAF through independent program reviews.~~

~~Medicaid provider fraud should be referred to the Agency for Health Care Administration. Cases are then referred to Medicaid Fraud Control in the Attorney General's office.~~

~~The BR supervisor is usually the "Custodian of the Case Record" from the date of request for an Administrative Disqualification Hearing or court hearing to final disposition.~~

3640.0504 Benefit Investigations ~~ACCESS Integrity~~ Responsibilities (MSSI, SFP)

The Department will conduct pre-eligibility fraud screening and investigation of suspected fraud cases at the application/reapplication, certification/recertification process and prior to benefit approval. ~~The Department is responsible for referring appropriate cases to the Office of the Inspector General, Hearings for an Administrative Disqualification Hearing.~~ Cases in which individuals have received benefits due to suspected fraud will be referred directly to DPAF ~~Public Assistance Fraud by ACCESS Integrity staff~~ by completion of the BVBR screen.

3640.0505 Division of Public Assistance Fraud Responsibilities (MSSI, SFP)

DPAF ~~Public Assistance Fraud (PAF)~~ has the responsibility to handle investigations of suspected fraud in all programs covered in Chapter 409, Florida Statutes (FS). This includes the following programs: Optional State Supplementation, and Medicaid. The Department has a contract with DPAF to investigate fraud in the public assistance programs. Federal matching monies are utilized to fund this activity.

DPAF has the responsibility for investigating and referring cases of suspected fraud for prosecution to the State Attorney~~ and for referring cases to the Office of the Secretary Inspector General Hearings for Administrative Disqualification Hearings~~.

3640.0700 REPAYMENT (MSSI, SFP)

Recovery of amounts of overpayment will be made by one or more of the following methods:

1. lottery intercepts,
2. lump sum and installment payments.~~, and~~
3. ~~federal benefits and tax intercepts.~~

BR ~~Benefit Recovery (BR)~~ must notify the overpaid assistance group of the amount and cause of overpayment as well as the various repayment methods available.

BR must then allow a minimum of ~~10, 20 or~~ 30 calendar days for the assistance group to respond prior to initiating recovery activity.

Passages 3640.0708 through 3640.0710 describe methods of repayment.

3640.0708 Medicaid Recovery (MSSI)

Collection of Medicaid overpayment must be attempted in all cases, ~~whether the overpayment was due to fraud or non-fraud,~~ by contacting the overpaid individual using the Notice of Overpayment/Intent to Recover notice.

3640.0709 Amount to be Recovered (MSSI)

For Medical Assistance Only cases, the BR ~~Benefit Recovery (BR) unit~~ will attempt to verify current information regarding the income of former individuals from the former individuals involved. The BR unit may accept the individual's statement in some instances if no verification is available.

3640.0710 Hearing Requested (MSSI, SFP)

When an individual requests a fair hearing regarding an overpayment, the request for hearing screen (CLFH) must be completed by the BR Hearing Specialist team ~~Benefit Recovery (BR) unit supervisor~~ within three working days of the date the request was received. When the request is in writing, a copy must be sent to the OSIH ~~Office of the Secretary Inspector General Hearings (OSIH)~~ along with a copy of the "statement of matters" form (i.e., a Notice of Decision, Intent to Recover, etc.).

When an individual requests a hearing in response to the Notice of Case Action regarding the amount of repayment, the BR unit is responsible for submitting the Request for Hearing to OSIH. If the individual requests a timely hearing from the date of the Notice of Case Action, the benefit reduction will be stopped until the conclusion of the Hearing and a final decision has been made by OSIH. BR must be notified of the hearing date, time and location. When the final order is received via Document Imaging to the dedicated workgroup box, the BR staff member will be notified via an alert and will take the appropriate actions. If the individual contacts the eligibility specialist in response to a BR generated notice or action, the eligibility specialist should refer the individual to the BR unit for initiation of the Fair Hearing request.

~~When an individual requests a hearing in response to the Notice of Case Action regarding the amount of repayment, the BR unit is responsible for submitting the Request for Hearing to OSIH. If the individual requests a hearing within ten calendar days from the date of the Notice of Case Action, the benefit reduction will be removed and a copy of the new notice to the individual must be sent to the BR unit. BR must be notified of the hearing date, time and location. When the final order is received by the public assistance unit, a copy must be sent to the BR unit. If the individual contacts the eligibility specialist in response to a BR generated notice or action, the eligibility specialist should refer the individual to the BR unit for initiation of the Fair Hearing request.~~

3640.0800 TRANSMITTAL OF REPAYMENT (SFP)

For OSS cases, payments must be forwarded to the contracted vendor ~~GNP Joint Venture along with the appropriate overpayment report~~. Repayment should be made by check or money order. ~~and a receipt completed in duplicate (the original for the individual, the copy for the case record).~~

Individuals making payments directly to the contracted vendor ~~GNP Joint Venture~~ must be instructed to clearly identify the payment with the case name, program, and case number.

3640.1000 BENEFIT INVESTIGATIONS ~~ACCESS INTEGRITY~~ (MSSI, SFP)

BI ~~ACCESS Integrity (AI)~~ is an extension of the Department's public assistance eligibility process and operates within the purview of 7 CFR 273, 45 CFR 233, and Sections 414.095(16) and 414.39(10), Florida Statutes. It is a program designed to combat fraud and reduce misspent dollars in the Department's public assistance programs. Probable error prone cases are identified at the pre-eligibility (application/reapplication, certification/recertification) phase of the public assistance program. Once a case is identified as meeting error prone criteria, it is referred to the BI ~~AI unit within the Region or Circuit where the public assistance unit resides~~. BI ~~The AI unit~~ then reviews the information provided by the individual or the authorized representative and

verifies and documents the finding of fact as it relates to the information provided by the individual and the eligibility factors used to determine the individual's level of participation. Once verification and documentation are ~~is~~ completed, the recipient is given an opportunity to explain contradictory information and an eligibility determination is made.

3650.0000 Child In Care

This chapter presents policy regarding referrals to Benefit Recovery (BR) for determination of overpayment, fraud, benefit recovery, and disqualification.

In this chapter:

1. "fraud" encompasses intentional program violation,
2. "suspected fraud" refers to client errors pending determination as the result of an ~~administrative disqualification hearing or~~ court decision,
3. "inadvertent household error" encompasses non-fraud client error,
4. "agency" refers to administrative error or Department errors,
5. "overpayment" will mean both overpayment and over-issuance, and
6. "Benefit Investigations ~~ACCESS Integrity~~" refers to the Department's pre-eligibility fraud screening and investigation program.

3650.0100 BENEFIT RECOVERY/BENEFIT INVESTIGATIONS BACKGROUND (CIC)

Background information is provided in passage 3610.0100.

3650.0101 Legal Basis (CIC)

The legal basis is provided in passage 3610.0101.

3650.0306 Inadvertent or Agency Errors Not Requiring Referral (CIC)

A BR ~~Benefit Recovery~~ referral will not be made, or a claim established on cases when client error results in overpayment of less than $400.

3650.0309 Evidence Used to Substantiate Fraud (CIC)

Written verification of the unreported income received by the assistance group may be used to substantiate intent. Wage and unearned income information supplied through Data Exchange to the eligibility specialist is not to be considered verified upon receipt, with the exception of SSA/SSI and BENDEX information.

Verification that the assistance group member understood their responsibility for reporting the information in question may be used to substantiate intent. This verification could include:

1. the signed application,
2. acknowledgement of rights and responsibilities,
3. submitted change report form(s), or
4. recorded and/or verified instances of other changes reported by the assistance group which could or did affect the benefits received.

An application or change report form submitted during the period fraud is suspected which omits the information that resulted in the overpayment may be used to substantiate intent.

~~Recorded instances which indicate that the assistance group member visited the office during the period fraud is suspected and did not report the change which resulted in overpayment may be~~

~~used to substantiate intent. These instances might include a record of the dates benefits were issued to the assistance group member, copies of signed food stamp receipts or Electronic Benefits Transfer (EBT) records, or reports of beneficial changes but not the adverse change.~~

Sworn testimony by the eligibility specialist or other individuals may also be used to substantiate intent. It is important that the eligibility specialist be able to identify the individual.

These examples are not all inclusive; other types of evidence may also be used.

3650.0310 Court Determination of Fraud (CIC)

Fraud must be determined by a court of appropriate jurisdiction. The determination must be an adjudication of guilt~~ or adjudication withheld and a Disqualification Consent Agreement must have been signed by the individual charged with fraud~~.

3650.0400 OVERPAYMENT AMOUNT (CIC)

The eligibility specialist determines if overpayment appears to exist. ~~The supervisor is to review and ensure that the claim is valid prior to transmitting to Benefit Recovery (BR).~~ If it is determined that potential overpayment occurred, a referral is completed and transmitted to BR. ~~The~~ BR ~~unit~~ will determine the overpayment based on the best available information. If there is no acceptable information available on which to establish a corrected benefit amount, then insufficient evidence exists and no claim can be established by BR. Overpayment will be computed on the best information available to the BR unit.

3650.0414 Provider Error (CIC)

A provider may receive Medicaid payment to which the provider is not entitled. This may occur if:

1. the provider billed Medicaid for days that services were not provided or for days for which the provider was not entitled to payment (for example, unapproved paid bed reservation days or paid reservation days in excess of the established limit);
2. the provider received payment from another source (friends, family, insurance) as well as received full payment from Medicaid; (this includes payment received for services, supplies, and equipment which are already included in the Medicaid rate for care); or
3. the provider committed billing errors, such as a fiscal agent systems problem in the institutional billing system.

Any erroneous payment made to a provider as a result of provider error is considered countable overpayment. Overpayment due to provider error must be reported to the Headquarters ~~District~~ Medicaid Program Office.

3650.0700 REPAYMENT (CIC)

Recovery of amounts of overpayment will be made by one or more of the following methods:

~~1.~~ 1. lottery intercepts,
~~2.~~ 2. lump sum and installment payments,
~~3. benefit reduction RAP only,~~
~~4.~~ 3. offset of lost benefits, and
~~5.~~ 4. child support credit (TCA~~/RAP~~ only).

BR ~~Benefit Recovery (BR)~~ must notify the overpaid assistance group of the amount and cause of overpayment as well as the various repayment methods available.

BR must then allow a minimum of 30 calendar days for the assistance group to respond prior to initiating recovery activity.

Passages 3650.0701 through 3650.0710 describe methods of repayment.

Recoupment percentages are automatically set by the claim type and will start automatically. EDBC will be run automatically to initiate recoupment.

~~**3650.0701 Benefit Reduction/Recoupment (CIC)**~~

~~Benefit reduction is used to recover RAP overpayment from active RAP recipients. When a current recipient's court ordered amount is greater than the amount of benefit reduction, the excess must be paid by direct reimbursement.~~

3650.0710 Hearing Requested (CIC)

When an individual requests a fair hearing regarding an overpayment, the request for hearing screen (CLFH) must be completed by the BR Hearing Specialist team ~~Benefit Recovery (BR) unit supervisor~~ within three working days of the date the request was received. When the request is in writing, a copy must be sent to OSIH along with a copy of the "statement of matters" form (i.e., a Notice of Decision, Intent to Recover, etc.).

When an individual requests a hearing in response to the Notice of Case Action regarding the amount of repayment, the BR unit is responsible for submitting the Request for Hearing to OSIH. If the individual requests a timely hearing from the date of the Notice of Case Action, the benefit reduction will be stopped until the conclusion of the Hearing and a final decision has been made by OSIH. BR must be notified of the hearing date, time and location. When the final order is received via Document Imaging to the dedicated workgroup box, the BR staff member will be notified via an alert and will take the appropriate actions. If the individual contacts the eligibility specialist in response to a BR generated notice or action, the eligibility specialist should refer the individual to the BR unit for initiation of the Fair Hearing request.

~~When an individual requests a hearing in response to the Notice of Case Action regarding the amount of repayment, the BR unit is responsible for submitting the Request for Hearing to OSIH. If the individual requests a hearing within ten calendar days from the date of the Notice of Case Action, the benefit reduction will be removed and a copy of the new notice to the individual must be sent to the BR unit. BR must be notified of the hearing date, time and location. When the final order is received by the public assistance unit, a copy must be sent to the BR unit. If the individual contacts the eligibility specialist in response to a BR generated notice or action, the eligibility specialist should refer the individual to the BR unit for initiation of the Fair Hearing request.~~

3650.1000 BENEFIT INVESTIGATIONS ~~ACCESS INTEGRITY~~ (CIC)

BI ~~ACCESS Integrity (AI)~~ is an extension of the Department's public assistance eligibility process and operates within the purview of 7 CFR 273, 45 CFR 233, and Sections 414.095(16) and 414.39(10), Florida Statutes. It is a program designed to combat fraud and reduce misspent dollars in the Department's public assistance programs. Probable error prone cases are identified at the pre-eligibility (application/reapplication, certification/recertification) phase of the public assistance program. Once a case is identified as meeting error prone criteria, it is referred to the BI ~~AI unit within the Region or Circuit where the public assistance unit resides~~. BI ~~The AI unit~~ then reviews the information provided by the individual or the authorized representative and verifies and documents the finding of fact as it relates to the information provided by the individual and the eligibility factors used to determine the individual's level of participation. Once verification

and documentation are ~~is~~ completed, the recipient is given an opportunity to explain contradictory information and an eligibility determination is made.

3660.0000 Refugee Assistance Program

This chapter presents policy regarding referrals to Benefit Recovery for determination of overpayment, fraud, benefit recovery, and disqualification.

In this chapter:

1. "fraud" encompasses intentional program violation,
2. "suspected fraud" refers to client errors pending determination as the result of an administrative disqualification hearing or court decision,
3. "inadvertent household error" encompasses non-fraud client error,
4. "agency" refers to administrative error or Department errors,
5. "overpayment" will mean both overpayment and over-issuance, and
6. "Benefit Investigations ~~ACCESS Integrity~~" refers to the Department's pre-eligibility fraud screening and investigation program.

3660.0100 BENEFIT RECOVERY/BENEFIT INVESTIGATIONS ~~ACCESS INTEGRITY~~ BACKGROUND (RAP)

Background information is provided in passage 3610.0100.

~~The need to recover improperly issued benefits and to identify and prosecute individuals who willfully and fraudulently obtained, or attempted to obtain, these benefits led to the development of a statewide system for the identification, investigation, determination, and collection of public assistance overpayments.~~

~~This system is comprised of:~~

~~1. the ACCESS Integrity Program at the Region or Circuit level;~~
~~2. the Benefit Recovery Policy Development Unit at Headquarters;~~
~~3. the Benefit Recovery (BR) units located in each Region or Circuit; and~~
~~4. Public Assistance Fraud (PAF).~~

~~The ACCESS Integrity (AI) units conduct pre-eligibility, fraud screening, investigations and refer appropriate cases of attempted fraud to Administrative Disqualification Hearings. Referrals from AI units to the Office of the Secretary Inspector General Hearings are no program loss cases only. Cases suspected of past overpayment from suspected fraud are referred by the AI unit directly to PAF by using the BVBR screen.~~

~~The BR unit establishes the existence, circumstances and amount of public assistance overpayment and pursues recovery of overpayment from members of the overpaid assistance group or person responsible for causing the overpayment (i.e., authorized representative).~~

~~The PAF unit handles fraud investigations and referrals to the State Attorneys and administrative disqualification hearings where appropriate in all programs covered in Chapters 409 and 414, Florida Statutes.~~

3660.0101 Legal Basis (RAP)

The legal basis is provided in passage 3610.0101.

~~The legal bases for fraud and recovery of overpayments are established by:~~

~~1. Florida Statutes, Sections 409.325/414.41[1996], and 409.335/414.39[1996];~~
~~2. Section 7 CFR 273.18 of the Code of Federal Regulations;~~
~~3. Title IV-A of the Social Security Act;~~
~~4. Section 45 CFR 233; and~~
~~5. Florida Administrative Code Chapter 65A-1.~~

~~According to Section 409.325/414.41[1996], Florida Statutes, "Any person who knowingly fails by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose a material fact used in making a determination as to such person's qualification to receive aid or benefits under any state or federally funded assistance program, or fails to disclose a change in circumstances in order to obtain or continue to receive under such program aid or benefits to which he is not entitled, or who knowingly aids and abets another person in the commission of any such act is guilty of a crime and will be punished as provided in Subsection (5)." This subsection provides that assistance wrongfully sought or received which is valued at less than $200 in a 12 month period will be punishable as a misdemeanor of the first degree. Assistance of $200 or more in a 12 month period will be punishable as a third degree felony.~~

~~According to Section 409.335/414.39[1996], Florida Statutes, "Whenever it becomes apparent that any person has received any assistance or benefits under this chapter to which he is not entitled, through either simple mistake or fraud, the Department shall take all necessary steps to recover the overpayment".~~

~~According to Section 414.095(16), Florida Statutes, an applicant who meets an error prone profile, as determined by the Department, is subject to pre-eligibility fraud screening as a means of reducing misspent funds and preventing fraud. The Department created an error prone or fraud prone case profile within its public assistance information system and shall screen each application for Temporary Cash Assistance under the Welfare Transition Program against the profile to identify cases that have a potential for error or fraud. Each case so identified is subject to pre-eligibility fraud screening.~~

~~According to Section 414.39 (10), the Department shall create an error-prone case profile within its public assistance information system and shall screen each application for public assistance, including food stamps, Medicaid, and Temporary Cash Assistance, against the profile to identify cases that have a potential for error or fraud. Each case so identified shall be subjected to pre-eligibility fraud screening.~~

3660.0200 STATUTES OF LIMITATION FOR ESTABLISHING CLAIMS (RAP)

For agency error cases, claims are established when 12 months or less have elapsed between the month the overpayment occurred and the month the overpayment was initially discovered by, or reported to, the Department. ~~For non-fraud (agency or client) error cases, a claim is limited to four years prior to the month the overpayment was initially discovered by, or reported to, an eligibility specialist.~~

For client error, or inadvertent household error, a claim will be established when 72 months or less have elapsed between the month an overpayment occurred and the month the overpayment was initially discovered by, or reported to, the Department.

Intentional Program Violation claims will be established or calculated back to the month that the fraudulent activity initially occurred unless that change occurred more than 72 months years prior to the date it was initially discovery by or reported to, the Department.

3660.0306 Inadvertent or Agency Errors Not Requiring Referral (RAP)

A BR ~~Benefit Recovery~~ referral will not be made, or a claim established on cases when client error results in overpayment of less than $400.

3660.0309 Evidence Used to Substantiate Fraud (RAP)

Written verification of the unreported income received by the assistance group may be used to substantiate intent. Wage and unearned income information supplied through Data Exchange to the eligibility specialist is not to be considered verified upon receipt, with the exception of SSA/SSI and BENDEX information.

Verification that the assistance group member understood their responsibility for reporting the information in question may be used to substantiate intent. This verification could include:

1. the signed application,
2. acknowledgement of rights and responsibilities,
3. submitted change report form(s), or
4. recorded and/or verified instances of other changes reported by the assistance group which could or did affect the benefits received.

An application or change report form submitted during the period fraud is suspected which omits the information that resulted in the overpayment may be used to substantiate intent.

~~Recorded instances which indicate that the assistance group member visited the office during the period fraud is suspected and did not report the change which resulted in overpayment may be used to substantiate intent. These instances might include a record of the dates benefits were issued to the assistance group member, copies of signed food stamp receipts or Electronic Benefits Transfer (EBT) records, or reports of beneficial changes but not the adverse change.~~

Sworn testimony by the eligibility specialist or other individuals may also be used to substantiate intent. It is important that the eligibility specialist be able to identify the individual.

These examples are not all inclusive; other types of evidence may also be used.

3660.0400 OVERPAYMENT AMOUNT (RAP)

The eligibility specialist determines if overpayment appears to exist. ~~The supervisor is to review and ensure that the claim is valid prior to transmitting to Benefit Recovery (BR).~~ If it is determined that potential overpayment occurred, a referral is completed and transmitted to BR. The BR unit will determine overpayment based on the best available information. If there is no acceptable information available on which to establish a corrected benefit amount, then insufficient evidence exists, and no claim can be established by BR. Overpayment will be computed on the best information available ~~to the~~ BR ~~unit~~.

3660.0406.01 Beginning Date of Overpayment - Change in Income (RAP)

If the change involves unreported or under reported income, the month in which the income is first received is considered to be the month in which the change occurred.

If the budget shows that the case was ineligible and the direct assistance was not canceled appropriately, a referral must be made to BR ~~Benefit Recovery~~. The eligibility specialist must also determine the first month of eligibility for extended Medicaid and earned income disregards, if applicable.

Temporary Cash Assistance/Refugee Assistance Program overpayment begins after applying the 10-10-10 rule on cases from 10/1/96 forward. Prior to 10/1/96, overpayment began the month after the month of change.

~~**3660.0406.02 Example of Beginning Date of Overpayment (RAP)**~~

~~The following example illustrates when reportable overpayment begins.~~

~~**Example:** Ms. Brown, an active Temporary Cash Assistance (TCA) individual, began receiving unemployment compensation benefits on February 15, 1996, and reported her income on February 22, 1996. The eligibility specialist completed a budget for March and determined that Ms. Brown is ineligible. The eligibility specialist canceled Ms. Brown's direct assistance effective April 1996, and completed an ex parte determination for the Medically Needy (MN) Program. The eligibility specialist determined that Ms. Brown should have been enrolled with a share of cost in the MN Program during March 1996, the first month of ineligibility. A TCA overpayment referral is to be submitted to the Benefit Recovery (BR) unit for the month of March 1996, (the month following the month of the receipt of income). Possible Medicaid overpayment for March 1996, (first month of ineligibility for Family-Related Medicaid) should also be referred.~~

~~**Example:** Ms. Smith, an active TCA individual, began working on January 28, 1998 and received earnings beginning January 15, 1998. She did not report this to the Department until June 1998. The benefits were cancelled effective July 1998. Overpayment began March 1998 (10-10-10 to date of earnings). The eligibility specialist submitted a referral to BR.~~

3660.0406.03 Overpayment - Household Composition Changes (RAP)

Overpayment that occurs as a result of changes in the household composition will begin with the first month in which the individual or assistance group is ineligible for the entire month.

~~**Example of Beginning Date of Overpayment - Household Composition Changes:** Ms. Hodges, a Temporary Cash Assistance individual, reported on June 30, 1996, that her husband returned home on June 3, 1996. The eligibility specialist determined that the Hodges were ineligible for AFDC and canceled Ms. Hodges' AFDC effective August 1996. The eligibility specialist completed a referral to the Benefit Recovery unit for the month of July 1996, the first month the assistance group was ineligible for an entire month.~~

3660.0408 Changes in Income that Occur in Application Months (RAP)

When an unreported or under reported change occurs during the application month, reportable overpayment begins with the first incorrectly issued warrant.

~~**Example:** Ms. Jones applied for Temporary Cash Assistance (TCA) on June 2 and reported that she works part-time. The eligibility specialist budgeted the wages for June and July based on past wages received and approved Ms. Jones for TCA on June 23. The eligibility specialist learned in July that the employer had provided net, not gross, wage information. The eligibility specialist determined that Ms. Jones was overpaid for June and July and completed a referral to the Benefit Recovery unit.~~

3660.0500 DEPARTMENT STAFF OVERPAYMENT RESPONSIBILITIES (RAP)

Overpayment responsibilities of the eligibility specialist, ~~Supervisor,~~ Benefit Recovery ~~unit~~, Benefit Investigations ~~ACCESS Integrity unit~~, and Division of Public Assistance Fraud are provided in passages 3660.0501 through 3660.0505.

3660.0501 Eligibility Specialist Responsibilities (RAP)

The eligibility specialist must establish that overpayment has occurred by obtaining and recording the following facts in running record comments or in the paper case file prior to initiating a referral to BR ~~Benefit Recovery (BR)~~ on the FLORIDA BVBR screen:

1. how the overpayment was discovered,
2. the date of discovery,
3. who received the income/asset/status change,
4. the date the income or change started and/or stopped,
5. the cause of overpayment,
6. the estimated length and amount of overpayment,
7. any explanation given for failure to provide information accurately or in a timely manner, and
8. corrective action taken and the date such action(s) was taken.~~, and~~
9. ~~instances involving misuse of food stamps (the dates and source of the referral must be recorded).~~

The eligibility specialist must take necessary action to ensure that correct payment will be made for the current situation or that cancellation of benefits is effective in accordance with policy prior to referral to BR. This step includes doing a partial eligibility review on the fraudulent factors when fraud is suspected except when the suspected fraud was identified during the complete eligibility review process. If overpayment was discovered as a result of Data Exchange, follow the policy in Chapter 3000 prior to referral to BR.

The eligibility specialist must then verify that the individual was ~~actually~~ receiving assistance during the time the suspected overpayment.

The eligibility specialist must also obtain the verification necessary to determine the amount of overpayment when the circumstances causing the overpayment are still present at the time the overpayment is discovered.

The eligibility specialist must allow the individual an opportunity to provide information which clarifies the situation.

The eligibility specialist must:

1. adjust the current benefit if appropriate,
2. complete a referral via FLORIDA AIFP to BI t~~he Office of Public Benefits Integrity (OPBI) unit~~ for cases in which an error/fraud prone profile match occurs at the application/reapplication process;
3. complete the BR ~~Benefit Recovery~~ Referral (BVBR) screen; and
4. respond to the BR unit requests for any additional information within 10 calendar days.~~;~~
5. ~~rerun the benefit calculation to implement an individual's disqualification within 10 working days of receipt of BR's alert to disqualify the individual.~~

~~**3660.0502 Supervisor Responsibilities (RAP)**~~

~~The supervisor's responsibilities include:~~

1. ~~reviewing the case record for validity of referral to the Benefit Recovery (BR) unit, proper organization, Roberts vs. Austin compliance, corrective action, and completeness of information;~~
2. ~~transmitting the referral to the BR unit;~~

~~3. providing case records to the BR unit within five working days after receipt of the list of cases to be reviewed, or by the date the BR unit has, with prior notice, scheduled cases for review;~~
~~4. arranging for the case record to be available for review by the BR unit or Public Assistance Fraud at a scheduled time and place, or immediately informing the BR unit of the reason a case record cannot be made available;~~
~~5. submitting additional information, when obtained, to the BR unit; and~~
~~6. attending court or an administrative hearing as necessary and carrying and safeguarding the case record during the hearing if requested by BR.~~

3660.0503 Benefit Recovery Responsibilities (RAP)

BR ~~Benefit Recovery (BR)~~ is responsible for the establishment of all overpayment claims and the maintenance of all recoupment and recovery activities.

As the Department's liaison with the DPAF, BR is responsible for the programing of electronic submission of suspected fraud referrals to DPAF via FLORIDA BVBR. When the investigation results in sufficient evidence of suspected fraud, DPAF completes a referral for prosecution to the appropriate State Attorney or to the Office of the Secretary Inspector General Hearings. This process is also completed on cases identified by DPAF through independent program reviews.

Medicaid provider fraud should be referred to the Agency for Health Care Administration. Cases are then referred to Medicaid Fraud Control in the Attorney General's office.

The BR is the "Custodian of the Case Record" for the overpayment claim from the date of request for an Administrative Disqualification Hearing or court hearing to final disposition.

~~As the Department's liaison with the Department of Financial Services, Public Assistance Fraud (PAF), the BR units are responsible for routing appropriate referrals (i.e., those that involve suspected fraud) from the Department to PAF. When sufficient evidence of suspected fraud is found, referral for prosecution to the appropriate State Attorney or to the Office of the Secretary Inspector General Hearings is made by PAF. This process is also completed on cases identified by PAF through independent program reviews.~~

~~Medicaid provider fraud should be referred to the Agency for Health Care Administration. Cases are then referred to Medicaid Fraud Control in the Attorney General's office.~~

~~The BR supervisor is usually the "Custodian of the Case Record" from the date of request for an Administrative Disqualification Hearing or court hearing to final disposition.~~

3660.0504 Benefit Investigations ~~ACCESS Integrity~~ Responsibilities (RAP)

The Department will conduct pre-eligibility fraud screening and investigation of suspected fraud cases at the application/reapplication, certification/recertification process and prior to benefit approval. The Department is responsible for referring appropriate cases to the OSIH ~~Office of the Inspector General~~, Hearings for an Administrative Disqualification Hearing. Cases in which individuals have received benefits due to suspected fraud will be referred directly to Division of Public Assistance Fraud by Benefit Investigations ~~ACCESS Integrity~~ staff by completion of the FLORIDA BVBR screen.

3660.0505 Division of Public Assistance Fraud Responsibilities (RAP)

DPAF ~~Public Assistance Fraud (PAF)~~ has the responsibility to handle investigations of suspected fraud in all programs covered in Chapter 409, Florida Statutes (FS). This includes the following programs: RAP/RAP Medicaid and SSI. The Department has a contract with DPAF to investigate

fraud in the public assistance programs. Federal matching monies are utilized to fund this activity.

DPAF has the responsibility for investigating and referring cases of suspected fraud for prosecution to the State Attorney and for referring cases to the OSIH ~~Office of the Secretary Inspector General Hearings~~ for Administrative Disqualification Hearings.

3660.0700 REPAYMENT (RAP)

Recovery of amounts of overpayment will be made by one or more of the following methods:

1. lottery intercepts,
2. lump sum and installment payments,
3. benefit reduction RAP only,
4. offset of lost benefits, and
5. child support credit (TCA/RAP only).

BR ~~Benefit Recovery (BR)~~ must notify the overpaid assistance group of the amount and cause of overpayment as well as the various repayment methods available.

BR must then allow a minimum of 30 calendar days for the assistance group to respond prior to initiating recovery activity.

Passages 3660.0701 through 3660.0710 describe methods of repayment.

3660.0702 Benefit Reduction (RAP)

Recoupment percentages are automatically set by the claim type and will start automatically. EDBC will be run automatically to initiate recoupment. ~~The Benefit Recovery unit will determine the rate of allotment reduction and complete appropriate FLORIDA screens. EDBC will be run automatically to initiate recoupment which is always five percent of the Consolidated Need Standard.~~

The amount of the monthly payment will change if the assistance group's allotment changes. FLORIDA will automatically adjust the recoupment amount when the allotment changes.

3660.0707 Civil Action (RAP)

All steps necessary to institute civil action are taken when the BR ~~Benefit Recovery (BR) unit~~ determines that such action is required to recover a RAP or RAP Medicaid Program overpayment from a former recipient or from individuals in Medical Assistance Only cases.

~~If a case is returned indicating that civil action cannot be taken against an individual, the BR unit will notify the referring eligibility specialist that there is an unpaid overpayment that cannot be collected at this time. If the former recipients receive benefits at a later date, appropriate recoupment action must be taken against their benefits.~~

3660.0710 Hearing Requested (RAP)

When an individual requests a fair hearing regarding an overpayment, the request for hearing screen (CLFH) must be completed by the BR Hearing Specialist team ~~Benefit Recovery (BR) unit supervisor~~ within three working days of the date the request was received. When the request is in writing, a copy must be sent to the OSIH ~~Office of the Secretary Inspector General Hearings (OSIH)~~ along with a copy of the "statement of matters" form (i.e., a Notice of Decision, Intent to Recover, etc.).

When an individual requests a hearing in response to the Notice of Case Action regarding the amount of repayment, the BR unit is responsible for submitting the Request for Hearing to OSIH. If the individual requests a timely hearing from the date of the Notice of Case Action, the benefit reduction will be stopped until the conclusion of the Hearing and a final decision has been made by OSIH. BR must be notified of the hearing date, time and location. When the final order is received via Document Imaging to the dedicated workgroup box, the BR staff member will be notified via an alert and will take the appropriate actions. If the individual contacts the eligibility specialist in response to a BR generated notice or action, the eligibility specialist should refer the individual to the BR unit for initiation of the Fair Hearing request.

~~When an individual requests a hearing in response to the Notice of Case Action regarding the amount of repayment, the BR unit is responsible for submitting the Request for Hearing to OSIH. If the individual requests a hearing within ten calendar days from the date of the Notice of Case Action, the benefit reduction will be removed and a copy of the new notice to the individual must be sent to the BR unit. BR must be notified of the hearing date, time and location. When the final order is received by the public assistance unit, a copy must be sent to the BR unit. If the individual contacts the eligibility specialist in response to a BR generated notice or action, the eligibility specialist should refer the individual to the BR unit for initiation of the Fair Hearing request.~~

3660.0800 TRANSMITTAL OF REPAYMENT (RAP)

All repayments must be directed ~~channeled~~ through BR. ~~Benefit Recovery (BR).~~

~~Repayments may be collected by the local office; however, the eligibility specialist must forward the repayment to BR within 24 hours. If no referral was previously submitted, complete the referral screen and forward the paper case file with the payment to the BR unit.~~

Repayments may be collected by the local office; however, the repayment must be forwarded to BR within 24 hours.

~~A receipt must be provided to the individual for cash or currency payments.~~

3660.1000 BENEFIT INVESTIGATIONS ~~ACCESS INTEGRITY~~ (RAP)

BI ~~ACCESS Integrity (AI)~~ is an extension of the Department's public assistance eligibility process and operates within the purview of 7 CFR 273, 45 CFR 233, and Sections 414.095(16) and 414.39(10), Florida Statutes. It is a program designed to combat fraud and reduce misspent dollars in the Department's public assistance programs. Probable error prone cases are identified at the pre-eligibility (application/reapplication, certification/recertification) phase of the public assistance program. Once a case is identified as meeting error prone criteria, it is referred to the BI ~~AI unit within the Region or Circuit where the public assistance unit resides~~. BI ~~The AI unit~~ then reviews the information provided by the individual or the authorized representative and verifies and documents the finding of fact as it relates to the information provided by the individual and the eligibility factors used to determine the individual's level of participation. Once verification and documentation are ~~is~~ completed, the recipient is given an opportunity to explain contradictory information and an eligibility determination is made.