The Advocate’s Guide

To Assistance Programs in North Carolina

A Complete Reference for the Professional to Help the Poor, Individuals over 60 and Persons with Disabilities Get the Benefits They Need

2009 Edition with 2012 updates
The Advocate’s Guide to Assistance Programs in North Carolina

A complete Reference for the Professional to Help the Poor, Individuals over 60, and the Persons with Disabilities Get the Benefits They Need

Originally By Jane R. Wettach

Wettach@law.duke.edu

2009 Edition

This book was reproduced and updated with the permission by Jane R. Wettach, May 11, 2009 by the Pitt Resource Connection Committee that represents the local Community Resource Connection statewide developing program.

If you see anything that needs correcting we would appreciate your input by emailing realcrisis@embarqmail.com as we will attempt to keep this publication up-to-date for as long as we can. We will post updates on the website that can be easily downloaded.

The publication of this book was made possible through the generous support of North Carolina Department of Health & Human Services, Office of Long Term Supports
Original support for the publication of this book was made possible through the generous support of:

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Legal Services of North Carolina, Inc.

The Advocate’s Guide is dedicated to Greg Malhoit, director of The North Carolina Legal Services Resource Center. Without his vision, commitment, persistence, and encouragement, the book would never have been published.
2009 Edition Acknowledgements: This is the third edition of The Advocate’s Guide to Assistance Programs in North Carolina and to quote my predecessor, we too must show our appreciation for all the hard work the committee put forth to update or review the information contained in this book and all the volunteers who took part in keying the information into the computer. The REAL Crisis Intervention Inc. has been a long-standing crisis center who has worked over the past 38 years to maintain an extensive Information & Referral service throughout the eastern part of North Carolina. Upon the encouragement of local individuals who work in the health and human services field, we applied and received a grant from the North Carolina Department of Health & Human Services, Office of Long Term Supports as an Aging and Disability Resource Center (ADRC) Developing Project, now called Community Resource Connection (CRC). As a developing CRC, we have the task to work on one of the seven components of the full CRC. Our group chose ACCESS since we felt it was most important to be able to connect individuals to services. One of the committee members had a book called "The Advocate’s Guide to Assistance Program in North Carolina" written in 1993 and wondered if this was what our committee was contemplating to achieve. We were very surprised to see it was; therefore, sought permission to reproduce the book. We want to thank Jane R. Wettach who gave us that permission. It has taken several months to reproduce this book and pleased to see it is now completed. We will host a PDF version on our website www.realcrisis.org and at www.pittresource.org for anyone who would like to download a copy of the book. We will also be distributing a hard copy until they run out.

I would like to thank all those who contributed to this project:

- Stephen Dickson. East Carolina University Public Administration graduate student who worked on the project all summer and into the fall;

- Cynthia Davis, Sallie Williamson & Edwina Fyle from the Mid East Commission Area Agency on Aging for all the encouragement to this project as well as updating and reviewing the information;

- And to the following individuals who saw to it that their respective sections were updated and reviewed: Sharon Edwards, Pitt Co. Department of Social Services, Brenda Simpson, Pitt County Public Health; Benita Hathaway, East Carolina Behavioral Health; Mary Hall, Senior Services at Pitt Co. Memorial Hospital; Christal Curran, Pitt Co. Council on Aging, Alan Roughton, Legal Aid of North Carolina; Teresa ball, Pitt Co. Veterans Affair Administration; and Connie Newton, Martin County Community Action.

Mary L. Smith, Executive Director
REAL Crisis Intervention Inc.
Acknowledgements

This second edition of The Advocate’s Guide to Assistance Programs in North Carolina, like its earlier counterpart, is a compilation of information gathered from many sources, primarily from people whose professional lives are dedicated to providing services to those who need them. I wish to express my appreciation to all those who provided or reviewed the information presented here. Among those who shared their knowledge and expertise were Debbie Jackson, Melinda Hamrick, Michael Aheron, Mary Bethel, Pam Silberman, Curtis Venable, Myron Smith, Jesse Sherrill, Andy Wilson, Margaret Matrone, Mary Pergerson and others.

A special thanks goes to Jennifer Graham, Duke University law student, who spent much of her summer internship at East Central Community Legal Services assisting with the revision of this book. Volunteers Jim Lye and Fawn Gielow also spent many hours checking facts, figures and phone numbers, and their work is greatly appreciated.

My colleagues at East Central Community Legal Services have been generously supportive of my work on The Advocate’s Guide. Johnsa Anderson deserves particular mention for her administrative skills in managing the distribution process of the book.

As with the first edition, Carol Majors and Ann Farmer of Publications Unlimited have been a joy to work with and have contributed immensely to the usability of the book. They are true professionals.

Finally, I wish to thank those of you who used the first edition of this book to assist your many needy clients in obtaining services. Many of you told me directly of how you were able to use The Advocate’s Guide to answer questions and guide clients in the right direction. I hope this current edition will allow you to continue to assist the poor, individuals over 60 and persons with disabilities get the benefits they need.

Jane R. Wettach

Raleigh, North Carolina

1993
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North Carolina Regional and County Agencies

Adult Day Care Services, [http://www.ncdhhs.gov/aging/adcadh.pdf](http://www.ncdhhs.gov/aging/adcadh.pdf)

Adult Day Health Services, [http://www.ncdhhs.gov/aging/adcadh.pdf](http://www.ncdhhs.gov/aging/adcadh.pdf)

Aging, Area Agencies on, [http://www.ncdhhs.gov/aging/aaa.htm](http://www.ncdhhs.gov/aging/aaa.htm)


Blind, Services for the (regional offices), [http://www.ncdhhs.gov/dsb/contacts/districtoffices.htm](http://www.ncdhhs.gov/dsb/contacts/districtoffices.htm)

Community Action Agencies, [http://www.nccaa.net/Member-Agencies.aspx](http://www.nccaa.net/Member-Agencies.aspx)

Community Alternatives Programs lead agencies, Disabled Adults, [http://www.ncdhhs.gov/dma/cap/CAPContactList.pdf](http://www.ncdhhs.gov/dma/cap/CAPContactList.pdf), Mental Retardation (see Mental Health LMEs), Children, [http://www.ncdhhs.gov/dma/cap/capcagency.htm](http://www.ncdhhs.gov/dma/cap/capcagency.htm)

Deaf and Hard of Hearing, Services for the (regional offices), [http://www.ncdhhs.gov/dsdhh/where.htm](http://www.ncdhhs.gov/dsdhh/where.htm)

Dental providers accepting Medicaid, [http://www.ncdhhs.gov/dma/dental/dentalprov.htm](http://www.ncdhhs.gov/dma/dental/dentalprov.htm)

Emergency Management Offices by county, [http://www.nccrimecontrol.org/Index2.cfm?a=000003,000010,000073,000513](http://www.nccrimecontrol.org/Index2.cfm?a=000003,000010,000073,000513)


Home and Community Care Block Grant (HCCBG) services: [http://www.ncdhhs.gov/aging/service.htm](http://www.ncdhhs.gov/aging/service.htm)

Homeless Shelters, [http://www.homelessshelterdirectory.org/northcarolina.html](http://www.homelessshelterdirectory.org/northcarolina.html)

Independent Living Programs, [http://www.ncdhhs.gov/dvrs/iloffices.htm](http://www.ncdhhs.gov/dvrs/iloffices.htm)


Legal Aid of North Carolina, local offices, [http://www.legalaidnc.org/public/Learn/Locations/County-Office_Index.aspx#Index_County-Office](http://www.legalaidnc.org/public/Learn/Locations/County-Office_Index.aspx#Index_County-Office)

Mental Health Local Management Entities (LMEs), [http://www.ncdhhs.gov/mhddsas/lmedirectory.htm](http://www.ncdhhs.gov/mhddsas/lmedirectory.htm)

Public Health Departments, [http://www.nchalhd.org/county.htm](http://www.nchalhd.org/county.htm)

Red Cross, [http://www.redcross.org/where](http://www.redcross.org/where) (look up by zip code)
Senior Centers, [http://www.ncdhhs.gov/aging/scenters/sccty.htm](http://www.ncdhhs.gov/aging/scenters/sccty.htm)
Seniors Health Insurance Information Program (SHIIP), [http://www.ncdoi.com/shiip/default.asp](http://www.ncdoi.com/shiip/default.asp)
Smart Start Programs, [http://ncchildcare.dhhs.state.nc.us/providers/pv_providercontacts.asp](http://ncchildcare.dhhs.state.nc.us/providers/pv_providercontacts.asp)
Social Services, County Departments, [http://www.ncdhhs.gov/dss/local/](http://www.ncdhhs.gov/dss/local/)
Veterans Affairs District Service Offices, [http://www.doa.state.nc.us/vets/locations/](http://www.doa.state.nc.us/vets/locations/)
Vision resources, [http://www.preventblindness.org/nc/nc_vision_resources.html](http://www.preventblindness.org/nc/nc_vision_resources.html)
Vocational Rehabilitation Services, [http://www.ncdhhs.gov/dvrs/vroffices.htm](http://www.ncdhhs.gov/dvrs/vroffices.htm)


Federal Departments

### 2012 HHS Poverty Guidelines at a Glance (Effective 1-26-2012)

<table>
<thead>
<tr>
<th>Persons in Family</th>
<th>100%</th>
<th>110%</th>
<th>125%</th>
<th>150%</th>
<th>185%</th>
<th>200%</th>
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<tbody>
<tr>
<td>1</td>
<td>$11,170</td>
<td>$12,287</td>
<td>$13,963</td>
<td>$16,755</td>
<td>$20,665</td>
<td>$22,340</td>
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<td>2</td>
<td>$15,130</td>
<td>$16,643</td>
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<td>$22,695</td>
<td>$27,991</td>
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<td>3</td>
<td>$19,090</td>
<td>$20,999</td>
<td>$23,863</td>
<td>$28,635</td>
<td>$35,317</td>
<td>$38,180</td>
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<td>4</td>
<td>$23,050</td>
<td>$25,355</td>
<td>$28,813</td>
<td>$34,575</td>
<td>$42,643</td>
<td>$46,100</td>
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<tr>
<td>5</td>
<td>$27,010</td>
<td>$29,711</td>
<td>$33,763</td>
<td>$40,515</td>
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<td>6</td>
<td>$30,970</td>
<td>$34,067</td>
<td>$38,713</td>
<td>$46,455</td>
<td>$57,295</td>
<td>$61,940</td>
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<td>7</td>
<td>$34,930</td>
<td>$38,423</td>
<td>$43,663</td>
<td>$52,395</td>
<td>$64,621</td>
<td>$69,860</td>
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<tr>
<td>8</td>
<td>$38,890</td>
<td>$42,779</td>
<td>$48,613</td>
<td>$58,335</td>
<td>$71,947</td>
<td>$77,780</td>
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For each additional person, add $3,960 $4,356 $4,950 $5,940 $7,326 $7,920

<table>
<thead>
<tr>
<th>Programs</th>
<th>LIEAP</th>
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For current guidelines, go to
http://aspe.hhs.gov/poverty/12poverty.shtml

**Medicare-Aid** (Assistance in paying Medicare premiums and deductibles for people with limited income) for individuals and families with the following maximum monthly income. (These figures current in April 2012.)

http://www.ncdhhs.gov/dma/medicaid/medicare.htm

<table>
<thead>
<tr>
<th>Program</th>
<th>Persons in family</th>
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<tr>
<td></td>
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</tr>
<tr>
<td>MQB-Q</td>
<td></td>
</tr>
<tr>
<td>MQB-B</td>
<td>1,089</td>
</tr>
<tr>
<td>MQB-E</td>
<td>1,228</td>
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**Comprehensive Medicare-Aid (MQB-Q)** covers:
1. Medicare Part B premium
2. Medicare Part A premiums (when applicable)
3. Medicare hospital deductible
4. Medicare annual deductible
5. 20% Medicare co-payment
6. If you go into a nursing home, Medicare-Aid only covers the first 20 days.

For more information, see Medicaid for long term care.

**Limited Medicare-Aid (MQB-B)** covers the Medicare Part B premium

**Limited Medicare-Aid Capped Enrollment (MQB-E)** also covers the Medicare Part B premium. Funds for this program may be limited.
Introduction

How to Use *The Advocate’s Guide*

*The Advocate’s Guide to Assistance Programs in North Carolina* is the human services professional’s reference to the programs and services offered in the state to the poor, individuals over 60, persons with disabilities, and children. Using this book as the first source of information, you can:

- Direct you clients to the programs most likely to provide them assistance, saving them hours of futile waiting in agency waiting rooms
- Assist your clients in making application for programs by reviewing the requirements and helping to provide needed information.
- Evaluate the problems your clients may be having in gaining access to programs and advise them of how to proceed
- Intervene on behalf of your clients with the appropriate staff to assure that communication difficulties are not hindering your clients’ participation in needed programs
- Advocate for your clients when they are denied services, helping to assure that all program rules are applied correctly

Format and Features

This book is set up to be used quickly and easily. If you’ll scan the Table of Contents, you’ll see the range of programs covered. Note that Parts I through V focus on the kind of benefit provided (cash, food, health care, housing, utility assistance), and Parts VI and VII focus on services provided to persons with certain characteristics (seniors, individuals with disabilities, children). Part VIII covers general services, and is followed by the Appendices. These are listings of all the local offices of the agencies that administer the programs described. Web addresses, phone numbers and street or mailing addresses are included, so that you may easily contact them.

The programs covered in *The Advocate’s Guide* are generally available statewide and administered by governmental agencies. There are many other programs providing benefits and services to the poor offered in local communities, either by the local government or private, non-profit agencies.
Although these are beyond the scope of this book, you may be able to obtain information about them from the sources listed in the chapter on Information and Referral Services.

Quick-Glance Reference

Each chapter begins with a quick-glance reference answering the questions, What Is It?, Who Is It For?, and Where Are Applications Taken? This section is designed to help you decide very quickly if there is even a possibility that your client will benefit from and qualify for the program. It will also allow you to direct your client to the right agency, even if you don’t have the time to assist further with an application.

Introduction

This section gives some background about the program, indicating how it is administered and the source of the funding. The overview provides the context for the program and an overall sense of its purpose and features.

Applications

Where and how to apply are reviewed here. If it is important that certain information be provided during the application process, for example, proof of income or proof of residence, that information will be specified in this section. Additionally, the length of time a client can expect to wait before receiving a decision on eligibility will be stated.

Benefits

This section details what an individual can get from the program. The nature and scope of the benefits or services are described. For example, if cash is provided, the amounts available to qualified people will be listed; if health care is provided, the scope of the services available will be listed.

Personal Eligibility

The Personal Eligibility section sets out the personal characteristics the applicant for the program must have to qualify. Examples are age, residency, disability, or family status requirements. If a program beneficiary must do certain things to retain eligibility, such as file a monthly report, these requirements will be discussed here.
Financial Eligibility

This section reviews the financial eligibility guidelines when they exist. (Not all programs are restricted to those of low income.) The limits for both income and resources (assets) are set out, along with the program rules about how those items are counted and evaluated.

Appeals

Many of the programs covered provide an avenue for an applicant or client to challenge a decision made by the agency through an appeal process. In most situations, these appeals have several stages, beginning with an informal “fair hearing.” Clients have the right to be represented at these hearings and representation by non-lawyer advocates is permitted. This section is designed to enable non-lawyer advocates to participate successfully in the hearing process on behalf of clients.

Legal Authority

The citations to the laws, regulations, and policy governing the program are set out in this section. An example of a federal statute citation is 42 U.S.C. §601 et seq. This means the federal law (the one passed by the U.S. Congress) is located in Title 42 of the United States Code in section 601 and the following sections. The United States code can be found in all law libraries and many local public libraries. Federal regulations, which are promulgated by the federal agency administering the program to implement the statute, are found in the Code of Federal Regulations, abbreviated C.F.R. The number preceding C.F.R is the title; the number following is the section or part. The code of Federal Regulations is found at law libraries and some public libraries.

State statutes, passed by the N.C General Assembly, are located in the North Carolina General Statutes, abbreviated N.C Gen. Stat. The number following N.C Gen. Stat. is the chapter or section. These laws are likewise located at law libraries and many public libraries. Some state agencies have promulgated regulations, much like the federal ones. They are set out in the North Carolina Administrative Code, or N.C.A.C. This code, too, is divided into titles and chapters, with the title number preceding the abbreviation and the chapter number following it. In addition to being in law libraries, one copy of the N.C.A.C. is located in every county, at a site designated by the County Commissioners. To find out where it is in a particular county, you can call the Rules Division of the
Most agencies have developed policies, which detail how a program is administered. These policies are usually compiled in manuals and issued to the staff people who carry out the program operations. Although these policies are not technically law, they carry a fair amount of weight as long as they are not in conflict with the relevant statute or regulations. The manuals are generally available for review at the agency administering the program, and agency staff is often willing to copy and provide relevant parts to advocates or client representatives. Some of the manuals are available at Legal Services offices as well.

**Sources and Related Resources**

Here you will find the name, address, phone number, and web address of the agency that administers the program. In addition, if there are other sources of information about the program, they will be listed. If a particular Legal Services office has expertise in the program, that office name, address, and contact information will also appear. Finally, if there are resources that may help a client with a problem if the topic program does not, they will also be listed.

**Please Write In This Book!**

As most people who work in the human services field know, the programs providing benefits to their clients change with some frequency. Wide margins and blank pages have been left to allow you to make notes of changes or additions to the text. With any luck, most of the information in the book will remain current, until the next edition is published. But before you rely on information contained here, particularly in an appeal procedure, it would be wise to check with agency personnel to make sure the information is still up-to-date, using the names, addresses, and contact information included.
## 2011 HHS Poverty Guidelines at a Glance

<table>
<thead>
<tr>
<th>Persons in Family</th>
<th>100%</th>
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<th>150%</th>
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<td>56,445</td>
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For each additional person, add:

<table>
<thead>
<tr>
<th>Persons in family</th>
<th>MQB-Q</th>
<th>MQB-B</th>
<th>MQB-E</th>
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</table>

### Comprehensive Medicare-Aid (MQB-Q)
- Medicare Part B premium
- Medicare Part A premiums (when applicable)
- Medicare hospital deductible
- Medicare annual deductible
- 20% Medicare co-payment
- If you go into a nursing home, Medicare-Aid only covers the first 20 days.

### Limited Medicare-Aid (MQB-B)
- Covers the Medicare Part B premium.

### Limited Medicare-Aid Capped Enrollment (MQB-E)
- Covers the Medicare Part B premium. Funds for this program may be limited.


**Medicare-Aid** (Assistance in paying Medicare premiums and deductibles for people with limited income) for individuals and families with the following maximum monthly income.

[http://www.ncdhhs.gov/dma/medicaid/medicare.htm](http://www.ncdhhs.gov/dma/medicaid/medicare.htm)
Part 1: Cash Assistance Programs

Work First Family Assistance………………………………………..1
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Social Security………………………………………………….19
Special Assistance for Adults……………………………………30
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Work First Family Assistance (WFFA)

Program Specifics

Quick Lookup

What is it?

A joint national-state program that provides monthly cash payment to supplement family income. This program also provides medical assistance to families in need. Established 1935

Who is it for?

Households that have at least one minor child, meet income guidelines, or is a caretaker relative.

Where are the applications taken?

At county Departments of Social Services. Decisions on applications should be made in 45 days.

Introduction

Work First Family Assistance (WFFA) is the basic cash welfare program for low income families. It is a joint federal-state program in which the federal government sets the basic eligibility criteria and the states determine the level of benefits. At the national level, it is administered by the U.S. Department of Health and Human Services. At the state level it is supervised by the Public Assistance Section in the Division of Social Services, N.C. Department of Human Resources. It is administered locally by the county Departments of Social Services. The federal government provides about two-thirds of the funding for the program; the remainder is divided equally between the state and the counties.

Applications

Applications are taken at county Departments of Social Services. (See Appendix D for a listing of addresses and phone numbers.) An applicant has the right to apply the day he/she appears at the county office. This is important because benefits will be prorated from the date of the application.
An application must be processed within 45 days unless there is some good cause for delay.

**Standard Filing Unit**

Applications are taken for “assistance units.” Certain people must be included in the assistance unit; they are the standard filing unit members.

The standard filing unit includes:

- A minor child
- any parents of that child living in the household
- any minor brothers or minor sisters (including half brothers and sisters or step brothers and sisters) of that child who live in the same household

Optional assistance unit members may be first cousins, or others who meet the eligibility requirements. The significance of inclusion is that the income and assets of every one in the unit will be counted to determine eligibility.

**Program Benefits**

WFFA recipients receive a monthly check, the amount of which is determined by the number of persons in the family and the amount of other countable income they have. If the family has no other countable income, it is entitled to the maximum benefit. The maximum benefits as of 2009 are as follows:

<table>
<thead>
<tr>
<th>Number in Household</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
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<td>Maximum Benefit</td>
<td>181</td>
<td>236</td>
<td>272</td>
<td>297</td>
<td>324</td>
<td>349</td>
<td>373</td>
<td>386</td>
</tr>
</tbody>
</table>

There are no restrictions on how a WFFA check may be spent. The payee (usually the caretaker in the household) may spend it as he/she sees fit.
Standard of Need

WFFA benefits are calculated on the basis of the Standard of Need. This is a figure set by the N.C. General Assembly, ostensibly to represent the amount it takes for a family to live at a subsistence level. It was based on a study of actual needs for a family in 1974. Although it has been periodically raised, it is generally recognized that it has not kept pace with actual need. The maximum WFFA benefit, payable when the family has no other income, is one-half of the Standard of Need.

When a family has wages, the countable portion is subtracted from the Standard of Need and the WFFA benefit is half of the remainder. This works out so that a family loses only 50 cents from the WFFA benefit for every dollar it earns. (The Standard of Need amounts follow in the Income section.)

Child Support

WFFA recipients do not receive any child support collected by the state, all they is collected is retained by the state. All recipients must allow the state to collect any child support due to them. Any child support that is received by the recipient is used in the budget to determine their eligibility.

Medicaid

All WFFA recipients are automatically eligible for Medicaid. This is comprehensive health care coverage for all family members. Transitional Medicaid benefits are available for up to twelve months for families who become ineligible for WFFA due to increased earnings. (See chapter on Medicaid for more details.)

Program Eligibility

Many of the eligibility factors involved in WFFA case must be verified through documents or otherwise. To enhance the county worker’s ability to process the application on time, the applicant should try to bring the following items when applying:

- Proof of income, such as wage stubs, government check stubs or award letters, etc.
- Proof of assets, such as bank books, deeds, etc.
- Social security cards for all members or proof that applications have been made
- Birth certificates
• **Immigration papers** for anyone not a U.S. citizen
• The names, addresses and phone numbers of *one person who can verify the unit’s living circumstances*

**Personal Eligibility**

The requirements for WFFA eligibility depend on what category the recipient is in. Certain requirements apply to everyone, and additional requirements apply to different categories. Below are the universal requirements, followed by the special requirements for each category. Certain technical concepts are discussed more fully following the lists.

**Any WFDC recipient** must:

• Live in North Carolina voluntarily with the intent to remain (this can include homeless families)
• Be a citizen of the U.S., a permanent resident alien or an alien permanently residing in the U.S., under color of law
• Not be an inmate in a public institution
• Not receive Supplemental Security Income (SSI)
• Meet the financial eligibility requirements
• Unless exempt, register for work
• Provide his/her Social Security number or prove that an application for one has been made

**A child** who receives WFFA must be:

• Age 17 or younger or
• Age 18 and a full-time student who is reasonably expected to finish high school (or its equivalent) before reaching age 19
• Living with a “specified relative” who is providing a home and care for him/her

**A specified relative** who receives WFFA must:

• Be related, either by blood or marriage, to an eligible child
• Live with and provide care for an eligible child
• Assign to the state any rights to collect child support on behalf of the child
• Cooperate with the child support agency in establishing and securing support, unless there is good cause for not cooperating
• Unless exempt, file a quarterly report to the Department of Social Services
Work Registration

Unless exempt, WFFA recipients must register for work. Failure to do so can lead to penalties. Generally, the application is denied, if ongoing case is transferred to Medicaid.

Once registered, a recipient must accept any offer of employment. Once employed, a mandatory registrant may not voluntarily reduce his/her earnings or voluntarily quit the job. There are good cause exceptions for failing to meet these requirements. Without a showing of good cause, however, the WFFA benefits will be terminated.

A recipient is exempt from work registration if he/she is:

- Applicant or Recipient has a child six months or younger.

Work First Employment Services

Certain WFFA recipients are required to participate in Employment Services activities. These are activities that are used to help the family to become self-sufficient.

These activities could include: Job Search, Job Readiness Training, Volunteer Work, and Educational Activities along with other activities.

Some clients are exempt for employment services activities. Those exemptions could include parents with a child under the age of 6 months, an applicant/recipient who is disabled or an applicant/recipient that is needed in the home to care for another family member.

Supportive services are offered to assist recipient in participating including child care, transportation, adult day care, and work-related expenses.

A WFFA recipient’s failure to participate if required can result in a sanction of the WFFA benefits unless good cause for the failure can be shown.

Quarterly Reporting

Certain WFFA households are required to fill in and return to the local DSS office a quarterly report of income received and any other changes that occurred during the month.

The reports facilitate the system known as retrospective budgeting, which allows the amount of the WFFA check to be based on actual income received. For example, income earned in January is reported in
February and forms the basis for the March WFFA allotment. *Note: When an income source is terminated, retrospective budgeting can leave a recipient with neither other income nor a full WFFA check.*

The household is required to return the report by a given deadline, printed on the report. If it is not completed and returned by that date, a second deadline is set. If it is not returned by the second deadline, WFFA benefits are terminated.

**Advocate Tip:** *If a recipient’s check is stopped due to a failure to meet the quarterly reporting deadline, the recipient should request reopening by the 10th of the month following termination.*

**Assignment of Support**

The specified relative receiving the WFFA on behalf of the children must assign to the state Department of Human Resources the right to collect support for the children and must cooperate with the Child Support Enforcement Agency in establishing paternity and obtaining support. Failure to do so without good cause can result in termination or reduction of the check. Good cause may be established if it can be shown that emotional or physical harm would result if the absent parent were named or pursued for support. See chapter on Child Support Enforcement for additional information.

**Financial Eligibility**

WFFA recipients must meet both income and reserve tests to be eligible.

**Income**

The family must meet the standard of needs table below.

<table>
<thead>
<tr>
<th>Number in Unit</th>
<th>Standard of Need</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>$362</td>
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<tr>
<td>2</td>
<td>$472</td>
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<td>3</td>
<td>$544</td>
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<td>4</td>
<td>$594</td>
</tr>
<tr>
<td>5</td>
<td>$648</td>
</tr>
</tbody>
</table>
Reserve means cash or assets that are available to the assistance unit to meet its needs. **If the assistance unit’s reserve exceeds $3,000, the unit is ineligible.**

**Excluded Reserve**

Not all assets are included toward to $3,000 limit. The following items are **not counted:**

- Personal effects and household goods
- Principal place of residence
- Real property, for up to six months while the recipient makes an effort to sell it
- Non-salable partial interests in real property
- Equity value in one motor vehicle.
- Burial insurance
- One burial space for each unit member
- Irrevocable burial trusts.
- Inaccessible retirement funds
- Trust funds established for minor children
- Agent Orange payments
- Relocation payments

**Countable Reserve**

Virtually **all other assets with value are counted.** Some of the most common items **counted in the reserve** are as follows:

- Cash

---

Figures obtained from NC DSS website: [http://www.dhhs.state.nc.us/dss/workfirst/income.htm](http://www.dhhs.state.nc.us/dss/workfirst/income.htm)
• The balance in any bank accounts, excluding the amount deposited monthly to meet monthly needs
• Cash value of life insurance policies
• Stocks, bonds, mutual funds, etc.
• Accessible trust funds
• Equity in real property, except as noted above
• Income tax refunds (but not the Earned Income Credit)

**Lump Sum Rule**

If a WFFA unit receives a lump sum of money, it is counted as income in the month of receipt and reserve for the subsequent month. The receipt of a large lump sum can cause a household to be **ineligible** for several months.

A lump sum is any **one-time payment, not expected to recur**, made to a member of the assistance unit. An example is a personal injury award or a Social Security retroactive award. A few lump sums are **not affected by this rule**. They are:

• SSI retroactive awards
• Payments received as compensation for the loss of an asset (like an insurance payment to pay for a damaged house) or earmarked for a specific purpose
• Payments received from the sale of an asset
• Income tax refunds

The lump sum rule requires that the amount received be divided by the Standard of Need for that size unit. The result is the number of months the family will be ineligible to receive WFFA. Any remainder is counted as income in the month following the period of ineligibility. For example, assume a family of four received a $5,000 would be divided by the Standard of Need of $544, with the result of nine. The family would be ineligible for nine months. In the tenth month, the $104 remainder would be considered unearned income.

**Advocate Tip:** If a WFFA family anticipates the receipt of a large lump sum, they might want to consider withdrawing from the WFFA program before the month of receipt. They will then not be recipients when they receive it, and thus not affected by the lump sum rule. This will allow them to spend the money as needed and reapply when they are again within the $3,000 reserve amount. Another possibility is to have portions of the money paid directly to
vendors. For example, an insurance company making the payment might pay it directly to the landlord, utility company, Furniture Company or the like. The amount paid as a vendor payment will not be counted. Finally, the period of ineligibility can be reduced or terminated upon a showing of emergency circumstances (an unexpected death or illness, destruction of the home, or other disaster that required the expenditure of money).

Program Appeals

Any decision regarding WFFA—whether it be an approval, denial, termination, modification, or some other action or inaction by the county DSS—may be appealed. An appeal must be requested, either orally or in writing, within 60 calendar days of the written notice of decision, or within 90 calendar days if good cause is shown for the delay. If the request is made within 10 work days of the notice of termination or suspension, benefits can continue until the first decision is made. (If the family loses the appeal, the continued benefits are overpayments and will be recouped.)

Advocate Tip: Before appealing, if time permits, it is often helpful to try to discuss the case with the caseworker or her supervisor. Sometimes problems can be resolved informally without the necessity of a hearing. Factual misunderstandings or clear misapplications of the rules can often be corrected by an advocate with a conciliatory approach.

Local Hearing

The first level of appeal is a local hearing, in all cases except when the issue is whether a parent is incapacitated. The local hearing should be scheduled within five calendar days after it is requested, although the person appealing has the right to request that it be postponed for an additional 10 days. It will be held at the Department of Social Services, unless the person appealing is bedridden.

The person appealing has the right to be represented. The representative does not need to be an attorney, but may be. (See chapter on Legal Services regarding obtaining representation.) Either the person appealing or his/her representative has the right to see and have free copies of the file at DSS prior to the hearing. (The county worker will require a representative to have a release of information signed by the client.)
The local hearing will be conducted and the decision made, by an employee of the county Department of Social Services who is not familiar with the particular facts of the case. The hearing is informal. The worker involved in the decision will have prepared a summary of the case, and will read it. Copies of the documents relied on by the county will be attached to the summary and a copy provided to all parties. The person appealing or his/her representative can ask questions of the worker to establish or clarify certain facts. The person appealing will have the opportunity to produce evidence (both documents and witnesses) and testify, and may need to answer questions posed by either the hearing officer or the DSS worker. Court rules of evidence do not apply. Closing statements will be allowed.

The local hearing officer will make a decision within five calendar days of hearing and mail it to the person who appealed.

**Advocate Tip:** The local hearing is frequently unproductive, especially if a legal interpretation is involved. It is best used to establish facts and clarify misunderstandings. Nevertheless, it may not be waived. It is a prerequisite to a state level hearing. Losing a local hearing is no indication of the results of the state level hearing. Even when the county’s actions are consistent with the policy manual, it is possible to win a state level hearing or win in court. An appealing party would be well advised to get legal advice early in the appeals process.

**State Level Hearing**

If the local hearing decision is not satisfactory, a **state level hearing** may be requested. It must be requested, either orally or in writing, within **15 calendar days** of the date of the local hearing decision.

The state level hearing is conducted by a hearing officer based in Raleigh with the Hearings and Appeals Section of the Division of Social Services, N.C. Department of Human Resources. The hearing will be held, however, at the county Department of Social Services. It will be scheduled by the hearing officer, and usually will be held within three to six weeks after the request. The hearing officer will be familiar with the program, but not with the facts in the particular case.

The state level hearing is similar in format to the local hearing. Again, the person appealing may be represented, may have access to county files ahead of time, may submit evidence, etc. (An appealing party should strongly consider obtaining the services of a lawyer, paralegal or other person...
knowledgeable about WFDC at this level. See chapter on Legal Services.)

The hearing will be taped, and any witnesses will be requires to testify under oath.

The county worker will begin by reading the appeals summary, and reviewing the attached documents. The county may, but rarely does, present additional witnesses. The person appealing or his/her representative may ask questions of the county worker to try to establish facts or clarify issues. The person appealing can testify and present additional documentary evidence or witnesses. Either the county worker or the hearing officer may ask questions of any witness. Closing statements will be allowed. The hearing officer, may, upon request, leave the case open to receive additional documentary evidence if a good reason is presented as to why it could not be made available at the hearing.

Advocate Tip: The state level hearing is, for all practical purposes, the last opportunity a person has to introduce evidence. Generally, no additional testimony will be taken, nor will any documents (other than written legal arguments) be accepted at later appeal stages. Consequently, it is very important to establish all necessary facts at this level. If the case is appealed further, a transcript of this hearing together with the documents submitted will be the official record of the case.

The state hearing officer will issue a written decision and mail it to all parties. The decision is initially tentative. Either party has ten days to request that it be reviewed by the Chief Hearing Officer. If neither party requests a review, the hearing officer’s decision becomes the final agency decision.

If either party requests it, the Chief Hearing Officer will accept additional written or oral arguments supporting or attacking the decision. The Chief Hearing Officer will then issue a final decision in writing and mail it to all parties. The final decision should be issued within 90 days of the initial request for an appeal.

Judicial Review

The final agency decision can be appealed to Superior Court by filing a Petition for Judicial Review within 30 days of the receipt of the final decision. As a practical matter, this can rarely be accomplished successfully without the services of an attorney. Free legal help may be available from the local Legal Services program. (See chapter on Legal Services.)

**LEGAL AUTHORITY**


Federal Regulations: 45 C.F.R. §201 *et seq.*


State Regulations: 10 N.C.A.C. Chapter 49A & B

State Policy: WFDC Manual (Available at county Departments of Social Services)

**SOURCES AND RELATED RESOURCES**

N.C. Department of Human Resources  
Division of Social Services  
Public Assistance Section  
Assistance Payments Branch  
325 N. Salisbury Street  
Raleigh, NC 27601  
(919)733-3055

North Carolina Legal Services Resource Center  
224 S. Dawson Street  
P.O. Box 27343  
Raleigh, NC 27611  
(919)856-2564  
CARELINE 1-800-662-7030 (Department of Human Resources Information and Referral Service)
Emergency Assistance (EA)

Program Specifics

Quick Lookup

What Is It?

A program that provides a once-a-year allotment of up to $300 in short-term emergency assistance. Emergency Assistance is designed to assist with families’ sporadic emergency needs, such as a utility cut-off or an eviction notice. The procedures for determining eligibility for and providing Emergency Assistance are described in each county’s Work First Plan.

Who Is It For?

Families with children whose household incomes are under 200% of the poverty guidelines and who are experiencing a financial crisis.

Where Are Applications Taken?

At county Departments of Social Services. Decisions on applications should be made within 48 hours.

Introduction

A part of the overall WFFA program, Emergency Assistance (EA) is a joint federal-state effort to provide short-term assistance to families in crisis. There is a specific sum of money appropriated each year for the program, and when the money is exhausted, the program ends for the year.

At the federal level, the program is administered by the U.S. Department of Health and Human Services. At the state level, it is supervised by the Public Assistance Section, Division of Social Services within the N.C. Department of Human Resources. The program is administered locally by the county Departments of Social Services.

Applications

Applications are taken at county Departments of Social Services. (The addresses and phone numbers of the county departments are listed in Appendix D.) An applicant must be permitted to apply the day he/she appears at the department.
Applications should be processed immediately and payment authorized within 24 to 48 hours, depending on the specific circumstances. If the worker is unable to verify critical information, the application may take longer, but all decisions must be made within five workdays of the date of the application.

Applicants should try to bring to the county DSS office the following items:

- The most recent wage stub of anyone working
- Verification of other income, such as Social Security, Veterans benefits, child support, etc.
- Verification of the emergency, such as a Magistrate’s summons for eviction
- Verification of assets, such as bank books or financial statements

**Definition of Emergency**

The assistance unit must be facing an **emergency**. An emergency is defined as an unexpected or unforeseen situation that cannot be resolved without intervention. This includes unexpected expenses and/or decrease in household.

The county workers are given the discretion to use prudent judgment in determining whether to authorize EA. Assistance may be refused because the worker concludes that the household is trying to improve its standard of living rather than alleviate an emergency; the household has resources it could use toward resolving the crisis; or authorization of the assistance would delay, but not alleviate, the emergency. Nevertheless, the needs of the child must be considered in all cases.

**Advocate Tip:** Because the county worker has so much discretion in determining who is in an “emergency,” an advocate can play an important role in assisting a client with the application. If you refer a client to DSS to apply for EA, it’s a good idea to make contact with the DSS worker. You can help your client articulate the situation and help the worker see how the situation fits the emergency definition. The more sympathetic the client’s situation, the more likely he/she are to receive assistance.

**Program Benefits**

A maximum of $300 per assistance unit is available within any 30-day period in a year. (See definition of assistance unit in Personal Eligibility
After the 30-day period has elapsed, no additional assistance is available for the next twelve months. For example, a unit could receive $150 on the 15th of March and another $150 on the 7th of April (which is within 30 days of the first benefit.) No additional EA could be authorized until the following March.

There is no limit to the number of times a unit can be authorized to receive payment within the 30-day period, as long as the total amount authorized does not exceed $300. The actual payment to the vendor (i.e., the landlord) does not need to be made in the 30 days; only the authorization must be complete.

If more than $300 is needed to alleviate the emergency, the county worker is to explore whether there are other community resources which could be used or negotiate with the vendor so that the emergency can be averted with $300. If the worker determines that the emergency cannot be alleviated with the authorization of the $300 maximum, the application will be denied.

Assistance may be provided for:

- **Temporary shelter**, including rent and other shelter needs
- **Utilities**

Payments may be made directly to the unit, as two-party checks, as voucher payments, or as vendor payments.

**Program Eligibility**

**Personal Eligibility**

EA is available to **assistance units**. An assistance unit must:

- **Contain a child** under the age of 18
- **Contain a caretaker relative** of the child who will serve as the payee of the benefit, called the specified relative
- **Contain a U.S. citizen or an eligible alien**
- **Be in an emergency** situation that meets the EA requirements (see discussion below)
- **Not have received EA** within the past twelve consecutive months
- **Be financially eligible**

The assistance unit consists of the child, the specified relative, and any other individuals sharing the same household, with the exception of roomers/boarders.
Disqualifications

EA will *not* be authorized in the following situations:

- The family’s resources (readily convertible to cash) do not fall below $3000.00.
- Funds cannot be used to assist those individuals who have been terminated from Work First for failure to comply or who have been sanctioned for failure to comply.

Financial Eligibility

To be eligible for EA, the assistance unit must meet both an *income test* and a *reserve test*.

Income

An assistance unit must have *countable net monthly income which does not exceed 200% of the federal poverty guidelines*. The following figures became effective April 1, 2009.

<table>
<thead>
<tr>
<th>Number Eligible In Household</th>
<th>Maximum Countable Net Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$1,805</td>
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<tr>
<td>2</td>
<td>$2,428</td>
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<td>5</td>
<td>$4,298</td>
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<td>$4,922</td>
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<td>7</td>
<td>$5,545</td>
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<td>8</td>
<td>$6,168</td>
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Countable Income

The income of everyone in the assistance unit is counted. Income exclusions and inclusions are the same as for the regular WFFA program.
If the combined income of everyone is at or below the chart, the meet the income test.

**Reserve**

*Reserve* refers to assets owned by any of the household members. A family receiving Work First Family Assistance is allowed $3,000 in reserve or resources. Resources that can be readily converted to cash count toward the $3,000 limit. “Readily converted” means For EA purposes, assets are considered to be either liquid or non-liquid.

**Resources** include such things as the following:

- Cash on hand
- Balance in checking account, excluding any monthly income deposited
- Balance in savings account
- Stocks, bonds, mutual funds, etc.
- Revocable trust funds

**Excluded Reserve**

Not all assets are included as reserve for EA. The following are not counted:

- Household goods and personal belongings
- Automobiles
- Primary residence and contiguous property
- Income-producing property
- Insurance
- Value of pre-paid burial contracts
- Value of burial plots
- Savings of a student under age 21 who is saving the money for school expenses
- Heir property and non-saleable life estates and remainder interests
- Relocation assistance of HUD block grant funds

**Program Appeals**

Any applicant has the right to appeal a decision regarding EA. He/she can appeal any of the following actions by the count DSS:
• An application was not taken the day the applicant appeared at the DSS office.
• A decision was not made in a timely manner.
• The application was denied.
• The amount of assistance authorized was not correct.
• A replacement check was refused.

The applicant will get a written decision on his/her application. He/she must request an appeal \textbf{within 60 days} of the date of the notice. The request can be either oral or in writing.

The procedures for appeals are the same as for WFFA.

\textbf{Legal Authority}

Federal Statute: 42 U.S.C. §601(e)
Federal Regulations: 45 C.F.R. §233.120
State Regulations: 10 N.C.A.C. Chapter 49C
State Policy: AFDC Manual Section 2800

\textbf{Sources and Related Resources}

N.C. Department of Human Resources  
Division of Social Services  
Public Assistance Section  
Assistance Payments Branch  
325 N. Salisbury Street  
Raleigh, NC 27603  
(919) 733-7831

North Carolina Legal Services Resource Center  
224 S. Dawson Street  
P.O. Box 27343  
Raleigh, NC 27611  
(919) 856-2121

CARELINE 1-800-662-7030 (Department of Human Resources Information and Referral Service)
Social Security

PROGRAM SPECIFICS

Quick Lookup

What Is It?

A federal insurance program that provides monthly cash payments and lump sum death benefits.

Who Is It For?

Retired and disabled wage earners and their survivors and dependents.

Where Are Applications Taken?

At the Social Security Administration (SSA) applications may be filed several ways. Retirement and disability applications may be filed online at www.socialsecurity.gov, by telephone, or in-person. It is recommended that an applicant call 1-800-772-1213 before stopping by in person to make an appointment.

Introduction

Social Security, more formally titled Old Age, Survivors and Disability Insurance (OASDI), is a national insurance program that provides monthly cash payments to retired and disabled wage earners and their dependents or survivors. Payments are based on the earnings record of the wage earner. This is not a needs based program. The program is funded through the payment of taxes (FICA) by both employers and employees.

Applications

How and When to Apply

Applications may be filed online, by telephone or in-person. Follow-up may be initiated by the local SSA office. (The addresses and phone numbers of the local offices are listed in Appendix K.)

An application must be made in order to receive any type of benefit. An individual wishing to receive Social Security benefits upon reaching FRA should apply the month prior to FRA. Retirement applications are effective when filed. Disability applications may be retroactive up to 12...
months after completion of the 5 month waiting period which begins with the established date of onset.

What to Provide

The following proofs are requested when an application is filed:

- Proof of age
- Proof of relationship to the wage earner (such as marriage certificate, etc.)
- In the case of the death of wage earner, a death certificate
- In the case of a disability application, detailed medical information, including the names and addresses of doctors and hospitals and dates and reasons for medical treatments

**Advocate Tip:** While most people do not need the assistance of an advocate during the application process, applicants for disability benefits may benefit by having one. It is important to ensure that SSA has gathered all the pertinent medical information, and it is sometimes necessary to assist the applicant in obtaining needed evaluations of his/her medical condition.

Time Limits

There are **no time limits** within which applications for Social Security benefits must be processed. Applications in which all proofs are submitted and have no unusual circumstances may be processed on the date of receipt. Some applications, requiring additional evidence may take days or weeks to process. Disability applications usually take 3 to 4 months for a medical decision.

Program Benefits

A **monthly check** is sent to those eligible for benefits from the Social Security Administration. The checks usually arrive on the 2nd, 3rd, or 4th Wednesday of the month representing payment for the preceding month.

Benefit Amounts

The **amount of the check** is determined by a complex formula based on the earnings record of the retired, disabled, or deceased wage earner. A **primary insurance amount (PIA)** is calculated for each wage earner, based on average monthly earnings. Persons drawing on the record of a wage earner may receive the entire PIA or a percentage of it.
Retired wage earners who wait until Full Retirement Age (FRA) to receive benefits receive 100% of their PIA. Those who retire early (after reaching 62) receive a reduced benefit. The PIA is reduced by five-ninths of one percent for each month a check is received prior to the person reaching FRA.

A retired wage earner’s benefit may be reduced if he/she earns money in excess of the earnings limit. In 2009, the following limits apply:

| Wage Earners Age 62 to the year prior to FRA | $14,160 |
| Wage Earners in the year of FRA (From January up to the month of FRA) | $37,680 |
| Wage Earners in the month of FRA and forward | Unlimited |

A wage earner age 62 to the year prior to FRA looses $1.00 of benefits for each $2.00 earned over the limit; a wage earner in the year of FRA from January up to the month before FRA looses $1.00 of benefits for each $3.00 earned over the limit. The earnings limit applies to all other beneficiaries as cited above.

A disabled wage earner is entitled to 100% of the PIA after a five-month waiting period has elapsed from the time of the established onset of the disability. Workers’ Compensation and certain other disability benefits can reduce the amount.

An eligible widow, widower, or surviving divorced spouse of a deceased wage earner generally is entitled to 100% percent of the wage earner’s PIA if initially filing at FRA.

An eligible spouse or divorced spouse of a wage earner currently receiving benefits is generally entitled to 50% of the wage earner’s PIA. A spouse or divorced spouse with a child in care of the deceased wage earner is entitled to 75% of the PIA.

A minor child of the wage earner currently receiving benefits is generally entitled to 50% of the wage earner’s PIA. The surviving minor child of a deceased wage earner is generally entitled to 75% of the PIA.

Any amount listed above may be reduced by a family maximum, depending on how many persons are drawing on the wage earner’s account. The family maximum is usually between 150% and 200% of the wage earner’s PIA.
Death Benefit

Upon the death of an insured wage earner, a lump sum death benefit of $255 may be paid to the eligible widow or widower. If there is no eligible widow or widower, the benefit may be paid to an eligible child entitled on the record for the month of death. An application must be made within two years of the insured wage earner’s death.

Overpayments

It is not uncommon for Social Security recipients to receive benefits which are later determined to be overpayments because the individual was not eligible when the check was received or was due a lesser amount than paid. When Social Security discovers the overpayment, it will send a notice that the overpaid amount must be repaid.

The overpayment may be recovered by a reduction of future benefits over a period of time or by voluntary refund. The overpayment may be recovered from the overpaid person or from anyone else drawing benefits on the same wage earner's record.

Repayment may be waived by the Social Security Administration if two conditions are met:

- The recipient is found “without fault” in causing overpayment, and
- Recovery would “defeat the purpose of the Social Security Act or would be against equity and good conscience.” This generally means that the recipient would be without funds to sustain life.

There is no time limit within which an individual can request that an overpayment be waived. Denial of the request for waiver may be appealed. (See Appeals section.) Overpayments are dischargeable in bankruptcy as long as fraud was not involved.

Program Eligibility

Personal Eligibility

Four basic eligibility criteria must be met in order for an individual to receive Social Security benefits. They are:

- The wage earner must have worked long enough to be insured
- The wage earner must be at least age 62, disabled, or deceased
• The dependents or survivors must meet distinct eligibility requirements related to **age and relationship to the wage earner**
• The wage earner must be a **citizen or an alien permitted to work in the U.S.**

**Insured Status**

Wage earners and/or their dependents **cannot receive benefits unless the wage earner is**, at the time an application is made or in cases of disability at the time the wage earner became disabled, either

- Fully insured, or
- Currently insured or
- Insured for disability

Insured status is determined by examining whether the wage earner has enough **quarters of coverage**. A quarter of coverage is a set amount of money earned. For 2009, a wage earner must earn $1090 to earn a quarter of coverage. The amount can be earned at any time during the year, but no more than four quarters of coverage can be credited in a year.

**Fully Insured**

To be **fully insured**, most wage earners must have **40 quarters of coverage** which is 10 years of social security covered work. Fully insured status is required for the payment of benefits to most categories of Social Security recipients.

**Currently Insured**

To be **currently insured**, a wage earner must have at least **six quarters of coverage during the 13-quarter period** prior to the wage earner’s death or entitlement to disability or old age benefits. This test is used when the wage earner is under age 31 or when the beneficiary is a surviving child or a spouse caring for surviving children.

**Insured for Disability**

To be **insured for disability**, a wage earner must have earned at least 20 quarters of coverage within the 40 calendar quarters immediately preceding the onset of disability which means the wage earner must have worked under Social Security covered earnings 5 out of the last 10 years prior to becoming disabled.
If a wage earner is **under age 31** at the time of the onset of disability, he/she must have covered quarters in at least half of the quarters that have elapsed since he/she became age 21. A minimum of six quarters is required. (For example, a person who becomes disabled at age 25 must have at least eight covered quarters among the 16 quarters which have elapsed since he/she turned age 21.)

**Age, Death, Disability**

**Age**

A wage earner must be at least **age 62** before benefits can be paid, unless disabled.

**Death**

Benefits may also be paid on a wage earner’s record by his/her survivors after his/her death.

**Disability**

A wage earner and his/her dependents can obtain benefits if the wage earner is **disabled**. To be considered disabled for Social Security purposes, an individual must have a **severe mental or physical impairment** which:

- Is supported by medical evidence *and*
- Has lasted or is expected to last, a minimum of **twelve consecutive months** or result in death *and*
- **Prevents** the individual from doing his or her previous work or any other **substantial gainful activity** (defined as earning at least $980 per month in 2009, unless the individual is blind, in which case it is $1640).

*Advocate Tip:* The process of attempting to prove disability can be lengthy. Applicants who are initially denied should always consider appealing the decision.

**Eligibility for Dependents and Survivors**

Entitlement factors determine which dependents and survivors can receive benefits from a wage earner’s record. The categories and factors are briefly summarized here. In all cases, the potential beneficiary must apply
for the benefits and must not be otherwise entitled to a higher benefit on another record.

To qualify as a **spouse**, an individual must be:

- The **husband or wife of an insured wage earner**
- At least **62 years old**

To qualify as a **divorced spouse**, an individual must:

- Be **divorced from an insured wage earner**
- Have been **married for ten years**
- Be **unmarried** at the time of filing
- Be at least **62 years old**

To qualify as a **surviving spouse**, an individual must be:

- The **widow or widower** of a deceased wage earner
- At least **60 years old or 50 years old and disabled**
- **Unmarried** (unless an exception applies)

To qualify as a **surviving divorced spouse**, an individual must:

- Be **divorced from a deceased wage earner**
- Have been **married for at least ten years**
- Be at least **60 years old or 50 years old and disabled**
- **Unmarried** (unless an exception applies)

To qualify as a **mother or father**, an individual must be:

- The **widow or widower** of a deceased wage earner or divorced from the wage earner
- **Unmarried**
- **Caring for a child** of the deceased wage earner who is under 16 or disabled

To qualify as a **child**, an individual must be:

- The **child** of an insured wage earner who is deceased or entitled to retirement or disability benefits
- **Dependent** on the wage earner
- **Unmarried**
- **Under age 18** or 18 or older if disabled or still in elementary or secondary school
**Advocate Tip:** There are numerous ways to show that a child is the child of the wage earner even if paternity was not formally established during the wage earner’s lifetime, and numerous ways to show the child was dependent on the wage earner even if the child was not living with the wage earner at the time of death or disability. Such cases should be referred to an experienced advocate.

To qualify as a **parent**, an individual must:

- Be the **parent** of a deceased wage earner
- Be at least **age 62**
- **Not have married** since the wage earner’s death
- Have been receiving at least **half of his/her support from the wage earner** at the time of the death

**Citizenship or Alien Status**

A wage earner must either be a citizen or an alien permitted to work in the United States. If an alien worked in the U.S. long enough to obtain insured status, he/she does not need to live in the U.S. to receive payments.

**Financial Eligibility**

Social Security is not a needs-based program. Therefore, there are **no financial eligibility requirements**. If the personal eligibility requirements are met, an individual may receive the benefit regardless of other income or assets.

**Program Appeals**

Decisions by the Social Security Administration (SSA) regarding eligibility, payment, overpayment, and most other issues affecting Social Security benefits usually may be appealed. SSA provides written notification of its decision, and includes the individual's right to appeal. There are several levels in the appeals process: reconsideration, hearing, Appeals Council review, and judicial review.

An individual may be represented during the appeals process by a representative.

Legal Services offices represent certain clients without a fee. (See chapter on Legal Services.) Private attorneys and representatives who specialize in this area usually advertise in the yellow pages of the phone book. A referral
also can be obtained from the N.C. Bar Association Lawyer Referral Services at 1-800-662-7760.

Representatives usually accept cases on a “contingency fee” basis. This means there is no up-front payment, and there is no fee at all unless the case is successful. In that event, the representative’s fee is generally 25% or up to $6000 of the retroactive benefits awarded. The fee must be approved by the Social Security Administration.

Reconsideration

An applicant has 60 days from the receipt of the notice of the SSA decision to file a request for reconsideration. The request must be in writing. If the request is filed within 10 days of receipt of a notice of termination, reduction, or suspension of benefits, the benefits may continue pending the appeal up to the hearings level.

Reconsideration means that SSA will review the case and make a new decision. The appealing party can choose a case review (one worker reviews the file and considers any new evidence), or an informal conference (appealing party can present testimony of witnesses and SSA provides an informal summary). In the appeal of termination, suspension, or reduction of benefits, the appealing party has the additional option of requesting a formal conference (including witnesses, cross-examination, etc.).

There is no time limit within which SSA must issue a decision on reconsideration.

Hearing

If the individual disagrees with the decision after Reconsideration, he/she has 60 days from receipt of the notice of the decision to request a hearing before an Administrative Law Judge (ALJ). Benefits will continue pending the hearing if the issue is cessation of disability and the request is filed within 10 days of the notice.

The hearing is heard by the ALJ who decides the case. The appealing party or his/her legal representative may review and copy without charge the documents in the SSA file prior to the hearing. New evidence can be submitted at the hearing, and sometimes, at the discretion of the judge, the record can be held open for submission of documents after the hearing. The ALJ may question witnesses and listen to oral argument. The hearing is
recorded and, together with the documents in the file, is the official record of the case if it is appealed further.

The ALJ will issue a written decision after the hearing and mail it to the appealing party and his/her representative. There is no time limit within which the ALJ must decide the case.

**Appeals Council Review**

If the hearing decision is unfavorable, the individual has **60 days to request review by the Appeals Council**. The Appeals Council can also review the ALJ’s decision on its own motion. The Appeals Council is located in Arlington, Virginia. The review at this stage is done based on the record and written legal arguments.

The Appeals Council will issue a written decision and mail it to the parties involved. There is no time limit within which the Appeals Council must make a decision.

**Judicial Review**

If the Appeals Council decision is unfavorable, the individual may file an **appeal in Federal District Court within 60 days** of the notice of the Appeals Council decision. The case will be reviewed by a judge or federal magistrate based on the evidence already submitted during the agency appeals process. The court’s duty is to determine if the law was properly applied and if the SSA decision was based on “substantial evidence” in the record.

**Legal Authority**

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<td>Federal Regulations:</td>
<td>45 C.F.R. §401 et seq.</td>
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**Sources and Related Resources**

U.S Department of Health and Human Services  
Social Security Administration  
300 N. Green Street  
Baltimore, MD 21201

Technical information can be obtained by calling the Social Security Administration at 1-800-772-1213 from 7:00 a.m. to 7:00 p.m.
Disability Hotline 1-800-638-6810 (Statewide information and referral services for disabled people needing information about Social Security Disability benefits.)
Special Assistance for Adults

Program Specifics

Quick Lookup

What is it?
A State-County program that provides a cash supplement to help low-income individuals residing in adult care homes (such as rest homes) pay for their care.

Who is it For?
Individuals with low income in need of assistance paying for needed care.

Where are application Taken?
At local county Departments of Social Services.

Introduction
State-County Special Assistance for Adults (SA) provides a cash supplement to help low-income individuals residing in adult care homes (such as rest homes) pay for their care. Adult care homes are unlike nursing homes in that medical care is not provided by home staff. Designated staff may administer medications and provide personal care services such as assistance with bathing, eating, and dressing.

Applications
Apply for the Special Assistance Adult Care Home Program at your county department of social services. You may send someone to apply for you. When you apply, please provide the following items if you have them:

- Income information that includes recent pay stubs, Social Security, SSI, or Veteran's Administration (VA) award letters;
- Savings and checking account information that includes passbooks, checkbooks, bank statements, etc;
- Information on assets such as property, stocks, bonds, IRAs, annuities, and trust funds owned by you and or your spouse;
- Social Security card or other verification of Social Security number;
- Proof of age (birth certificate or other);
- Insurance information; and,
- State-issued proof of identity.

From the date of application, the eligibility determination process can take up to 45 days for applicants age 65 or older and up to 60 days for applicants 18 and older and under 65.

**Program Benefits**

The maximum Special Assistance payment an eligible individual can receive is tied to the maximum rate adult care homes can charge Special Assistance recipients for room and board. The maximum rate, set by the General Assembly is $1,207 effective January 1, 2009.

An individual’s Special Assistance check amount is determined by taking the maximum rate and subtracting net countable monthly income. A personal needs allowance of $46 is added to the maximum rate to allow spending money for clothes and other essentials each month. The remainder of the check is for payment to the adult care home for room and board.

Aged and disabled adults in adult care homes receive their supplement from State/County Special Assistance. Adults and children who are visually impaired receive their supplement from Special Assistance for the Blind. Individuals who have extensive needs may receive case management.

Benefit Formula:

\[
\begin{align*}
&\text{Maximum Home Care Rate} \\
+ &\text{Personal Needs Allowance} \\
= &\text{Maintenance Amount} \\
\text{Subtract} &\text{Net Countable Monthly Income} \\
= &\text{Monthly Special Assistance Payment Amount}
\end{align*}
\]

**Program Eligibility**

**Personal Eligibility**
Individuals with low income are potentially eligible if they are age 65 or older, or if they are 18 or older and under 65 and are disabled according to Social Security disability standards;

All applicants must also:

- Need adult care home level of care as verified by a doctor
- Be a U.S. citizen or qualified alien
- Meet income and asset eligibility requirements
- Be a resident of NC
- Meet all other Special Assistance eligibility requirements

**Financial Eligibility**

Special Assistance Adult Care Home is available to otherwise eligible applicants with a monthly income of $1,252.50 or less and who have savings and assets worth less than $2,000. When you apply for Special Assistance you will be assigned a DSS caseworker who will determine your eligibility.

**Examples of countable income** include wages, Social Security and Supplemental Security Income (SSI), other retirement income and Veteran’s Administration income. Your DSS caseworker can explain how income is budgeted for Special Assistance Adult Care Home eligibility.

**Examples of assets that are counted** are property, cash, savings, checking accounts, stocks, bonds, annuities, some IRAs, and the cash value of life insurance policies.

Some assets that are not counted are personal belongings, *irrevocable burial plans*, burial plots and burial insurance. **One vehicle** is excluded as a resource if it is the primary mode of transportation, and under certain conditions, a primary residence can be excluded. Your DSS caseworker can also explain how assets are verified and counted in the Special Assistance eligibility process.

**Program Appeals**

Program decisions are appealed through the county DSS, see Appendix D.
Sources and Related Resources

NC Division of Aging and Adult Services
693 Palmer Drive, Raleigh, NC
Mailing address: 2101 Mail Service Center
Raleigh, NC 27699-2101
The NC DHHS is an equal opportunity provider and employer.
Special Assistance In-Home Program

Program Specifics

Quick Lookup

What Is It?

A program that provides a small monthly cash payment to supplement an individual's income.

Who Is It For?

Disabled individuals at least 18 years old who need an income supplement to allow them to remain living independently.

Where Are Applications Taken?

At county Departments of Social Services.

Introduction

SA/IH provides a choice to those facing care in an adult care home. With sufficient income, adequate housing, necessary health and social services, reliable informal support from family and friends, and case management, some individuals may remain safely at home rather than move to an adult care home. SA/IH provides financial assistance and case management services to adults over 60 and adults with disabilities with income below the poverty level. The program goal is to allow individuals to remain in the community and live as independently as possible.

The purpose of the SA/IH payment is to help low income adults to meet their basic needs. It is a supplement to their income and is intended to cover daily necessities such food, shelter, clothing, utilities, transportation, in-home aide services and other services to enable them to live at home safely. SA/IH payments do not replace the formal and informal services and support already available to an individual. When the individual needs in-home or community-based services to enable them to continue to live at home, Medicaid, Social Service Block Grant (SSBG), Home and Community Care Block Grant (HCCBG), Mental Health and other funding sources should be used to the fullest extent possible to provide these services.

Applications
When an individual contacts the county department of social services regarding SA/ACH, the adult services intake worker or the SA income maintenance caseworker (IMC) must explain to the applicant about the SA In-Home (SA/IH) payment option that allows eligible individuals the opportunity to live in a private living arrangement (PLA) and receive assistance as an alternative to facility care. Explain that applicants for SA/IH must also qualify for Medicaid for Adults as categorically needy. Explain the Medicaid eligibility criteria.

Ask the individual if he/she is interested in this option. If the individual is not interested in SA/IH, document the individual’s choice to make application for SA/ACH and process the application using current Special Assistance for Adults policy.

Unlike SA for adult care home residents, the SA/IH payment begins the date the application is made (if all eligibility criteria are met) and is not tied to the date the FL-2 is signed. The FL-2 must not be dated more than 90 days prior to the date of SA/IH application and must be received during the application processing period.

The application cannot be approved until the signed FL-2 is received and the RAI-HC assessment is completed. The case manager uses the assessment and the FL-2 to validate that the applicant meets the requirements for adult care home level of care but can stay at home safely with the SA/IH payments and services.

**Married Applicants**

It is important to note that in the determination of eligibility for Medicaid, a married applicant who lives with a spouse is budgeted differently than in the SA programs. In Medicaid there is always spouse-for-spouse financial responsibility when spouses live together. The spouse’s income and resources are considered when determining the individual’s financial eligibility.

Even though an individual’s income/resources alone may be within the SA/IH limits, the spouse’s income/resources may make the individual ineligible for Medicaid. In these situations, the applicant is ineligible for SA/IH because he/she does not meet the requirement to be eligible for Medicaid (see personal eligibility section below)

**Involved Parties**
The key people in SA/IH program are the client, the client's family and friends, the client's Adult Services case manager, the SA caseworker, and community agencies or individuals that provide care and services.

- The county DSS oversees the operation of the SA/IH program in the county and assures that the policies and procedures for SA/IH are followed. The county DSS is responsible for client assessment and case management and authorization of the SA/IH payment and Medicaid.
- The Medicaid providers that provide regular community services according to Medicaid guidelines.
- Other in-home and community service providers that provide services, including home repairs, to the client and his/her family.

**Program Benefits**

When a person is considered for SA/IH, Adult Services case manager assesses the individual's strengths and needs. After the assessment, the case manager develops a service plan with the client and his/her family which builds on the client's strength and needs. In addition to the SA/IH payment and case management, the client may also receive regular Medicaid community services under the guidelines for those services, or may receive services funded by SSBG, HCCBG or other sources. If the individual is receiving services from an LME program, the Adult Services case manager and the LME will work together in developing a service plan with the client.

**Program Eligibility**

**Personal Eligibility**

To be eligible for SA/IH, the individual must meet the following criteria:

1. Be at least 18 years old.
2. Need adult care home level of care in a facility licensed (under G.S. 131D, 122C, or 131E) but desires to live in their own home or other private living arrangement.
3. Live in or desire to live in a private living arrangement in a county that offers SA/IH.
4. Be eligible for Medicaid as a categorically needy aged, blind, or disabled individual living in a private living arrangement.
5. Meet SA/IH eligibility requirements.
6. Need SA/IH payment to live safely at home.
7. Request SA/IH payments and appropriate in-home or community-based services.
8. With appropriate services, can have his/her health, safety, and well being maintained at home.

Participating counties will serve as many individuals as possible. Their resources as well as an annual limit of 1500 statewide slots affect how many recipients they can serve. The Division allocates to each county DSS a specified number of slots that may be utilized at any one time. The county DSS is responsible for the appropriate use of their slot allocations.

Eligibility for SA/IH requires a need for adult care home level of care as documented on the FL-2 and signed by a licensed physician.

Requirement to Be Eligible For Medicaid

To qualify for the SA In-Home Program, the applicant/recipient (a/r) must be eligible for Medicaid for the Aged, Blind and Disabled (MAABD) as categorically needy (Medicaid class N, C or Q).

Eligibility for Medicaid for SA/IH recipients is not automatic as it is for SA/ACH recipients. Recipients in private living arrangements must be determined eligible for Medicaid separately. Medicaid is an essential component for SA/IH recipients to live at home safely.

**Advocate Tip:** If the person is NOT on Medicaid, refer the person to the SA/Adult Medicaid intake caseworker who is the contact for SA/IH.

*If the person RECEIVES Medicaid, notify the SA/Adult Medicaid caseworker that the individual wants to be considered for SA/IH.*

Financial Eligibility

Setting the need standard for SA/IH at 100% of the federal poverty level (FPL) is consistent with Medicaid and is required to enable SA/IH recipients to remain eligible for Medicaid.

The need standard for Medicaid changes each year in April when the FPL changes. The resource limit remains constant.


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<tr>
<th></th>
<th>Individual</th>
<th>Couple</th>
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<tr>
<td>Income</td>
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<tr>
<td>Resources</td>
<td>$2,000</td>
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(2009 Income Figures)

The SA/IH payment is not countable income when determining financial eligibility for Medicaid.

Because the SA/IH recipients are already eligible for Medicaid as categorically needy aged, blind, and disabled individuals living in private living arrangements, they receive the same reimbursable medical services as other Medicaid recipients. This is different from SA/ACH where SA eligibility provides a link to Medicaid eligibility and services that might otherwise be unavailable.

**Program Appeals**

Any decision regarding Special Assistance-whether it be an approval, denial, termination, modification or some other action or inaction by the county-**may be appealed**. An appeal must be requested, either orally or in writing, within **60 days** of the written notice of decision, or within 90 days if good cause is shown for the delay. If the request is made within 10 days of the notice, **benefits can continue** until the first decision is made. There is no local hearing when the issue is disability. Especially when the issue is disability, the appealing party should strongly consider obtaining the services of an experienced advocate to represent him/her.

**Legal Authority**


State Regulations: 10 N.C.A.C. Chapter 47

State Policy: State County Special Assistance for Adults Manual (available at county Departments of Social Services)

**Legal Basis for Program**

Session Laws 1999-237 and 2000-67 originally authorized the SA In-Home Program as a Department of Health and Human Services demonstration project within the State/County Special Assistance for
Adults program. The legislation allowed county departments of social services to provide Special Assistance payments for up to 400 individuals in in-home living arrangements. The purpose of this demonstration project was to determine the feasibility of providing Special Assistance payments to enable adults over 60 and adults with disabilities who are at risk of entering an adult care home (facilities licensed under 131D, 122C or 131E) to live at home in the community when that is what they prefer to do.

Session Law 2003-284 extended the program through June 2005 and expanded the number of participants to 800. The program is now called the SA In-Home Program.

The 2006 General Assembly expanded the SA In-Home Program in Session Law 2005-276, increasing the number of allowable recipients to 1000 statewide. The General Assembly expanded the SA/IH Program again during the 2006 Session. Session Law 2006-156 increased the number of allowable recipients to 1500.

**Sources and Related Resources**

North Carolina Department of Human Resources
Division of Social Services
Public Assistance Section
Albemarle Building 8th Floor
325 N. Salisbury St.
Raleigh, NC 27601
(919) 733-3055

North Carolina Legal Services Resource Center
224 S. Dawson Street
P.O. Box 27343
Raleigh, NC 27611
(919) 856-2121

CARELINE 1-800-662-7030 (N.C. Department of Human Resources Information and Referral Service)
Supplemental Security Income (SSI)

Program Specifics

Quick Lookup

What Is It?

A federal program that provides a monthly cash payment to supplement the income of those eligible.

Who Is It For?

Aged, blind, or disabled individuals who meet the financial and other eligibility requirements.

Where Are Applications Taken?

At local Social Security Administration offices. It is recommended that an applicant call 1-800-772-1231 first to make an appointment. There are no time limits within which applications must be processed.

Introduction

The Supplemental Security Income (SSI) program was begun in 1974 as a national program to provide a subsistence level income to aged, blind, and disabled persons with limited income and resources. It replaced state aid programs in the 50 states and is now uniform throughout the country.

The program is administered both nationally and locally by the Social Security Administration within the U.S. Department of Health and Human Services. SSI should be distinguished from Social Security benefits, also administered by the Social Security Administration. Social Security benefits, which are more technically known as OASDI (Old Age, Survivors, and Disability Insurance), are not based on financial need, but upon employment and the payment of Social Security taxes. SSI recipients are not required to have paid Social Security taxes to be eligible. Children can receive checks if they are disabled.

Applications

To apply for SSI, an applicant should call the Social Security Administration at 1-800-772-1213. A follow-up interview will be scheduled either in person at
the district office of the Social Security Administration, or by telephone. The addresses and phone numbers of the district offices are listed in Appendix K.

The date of the initial phone call is the application date, also known as the “protected filing date.” This date is important because benefits are prorated back to the date of application, if eligibility is eventually established. An applicant is wise to make a record of this date and confirm it in writing if there is reason to believe that Social Security is using some other date.

There are no time standards for processing SSI applications.

Advocate Tip: Depending on the complexity of the case, processing can take months. It is worth a call to the district office to determine if the application is being delayed because the applicant has not provided certain information. Unfortunately, applications often are not assigned to a particular claims representative and what you tell one representative may not be accurately conveyed to the next. Frequent checking can help. Make written notes of your phone calls.

Program Benefits

SSI recipients receive a monthly check. The check supplements any other income available to the recipient, up to a monthly maximum. The specific monthly maximums are adjusted annually, usually in January, and can be found out through a SSI Representative.

Program Eligibility

Personal Eligibility

To receive SSI benefits, an applicant must be:

- Aged, or
- Blind, or
- Disabled, and
- A U.S. citizen residing in the United States, or
- An alien lawfully admitted with permanent residency status, or
- A child living overseas with a parent in the armed services
Age

An individual who is age 65 or over.

Blindness

For SSI purposes, blindness is:

- Best corrected vision of no better than 20/200 in the better eye, or
- Tunnel vision in the better eye with a field of vision restricted to less than 20 degrees, or
- A combination of poor visual acuity and tunnel vision, or
- Eligibility for and receipt of benefits under a state plan of assistance for the blind for a month of 12/73, as long as the definition of blindness under that state plan is still met

Disability

To be considered “disabled” for SSI purposes, an individual must have a severe mental or physical impairment that:

- Can be verified by a doctor on the basis of lab test, physical examination, or other objective medical procedures, and
- Has lasted, or is expected to last a minimum of twelve consecutive months or result in death, and
- Prevents the individual from doing his or her previous work or any other substantial gainful activity (defined as earning at least $500 per month in 1993). In determining whether a person can engage in substantial gainful activity, factors such as age, education, and work experience may also taken into account.

Children may be eligible for SSI based on somewhat different standards. A child’s disability is not related to his/her ability to work, but rather to his/her ability to walk, eat, dress, and perform other age-appropriate daily activities. In 1990, the U.S. Supreme Court ruled that the Social Security Administration’s rules for determining the eligibility of children too strict, and it ordered the SSA to issue new regulations and rehear the cases of hundreds of thousands of children denied since 1974. Any child who was denied SSI from 1974 through 1990 should seek legal advice about whether he/she is eligible for a new hearing and possibly retroactive benefits.
Advocate Tip: The medical standards are very difficult for many disabled people both to understand and meet. They are written in terms of almost total dysfunction of some body system (respiratory, cardiovascular, musculoskeletal, neurological, etc.). Often people are disabled and unable to work due to a combination of less serious physical or mental problems. It is possible to prove that such a person is eligible, but this requires substantial preparation of specific medical and vocational data to counter the SSA bias against finding that such people meet their definition of “disability.” It is usually best to have a trained advocate (such as a lawyer, paralegal or other representative who specializes in Social Security law) assist in this preparation.

Financial Eligibility

Financial eligibility for SSI is met if the applicant meets both an income test and a resource test.

Income

In order to be “income eligible” for SSI, the individual or couple must have net countable income of less than the maximum monthly SSI benefit.

Income is defined as anything received in cash or in kind in a calendar month that can be used to meet food, shelter, or clothing needs. Not all income is counted, and certain deductions apply.

When determining benefits for a couple, the income of both members of the couple is combined, and is subject to only one set of exclusions and deductions.

Excluded Income

Payments and Services we do not count as income for the SSI program. They include but are not limited to:

- The first $20 of most income received in a month;
- The first $65 or earnings and one-half of earnings over $65 received in a month;
- The value of food stamps;
- Income tax refunds;
- Home energy assistance;
• Assistance based on need funded by a State or Local government;
• Small amounts of income received irregularly or infrequently;
• Interest or dividends earned on countable resources or resources excluded under other Federal laws;
• Grants, Scholarships, Fellowships or gifts used for tuition and educational expenses;
• Food or Shelter based on need provided by nonprofit agencies;
• Loans to you (cash or in-kind) that you have to repay;
• Money someone else spends to pay your expenses for items other than food or shelter (e.g., someone pays your telephone or medical bills);
• Income set aside under a Plan to Achieve Self-Support (PASS), See the SSI Website for Information on PASS opportunities
• Earnings up to $1,640 per month to a maximum of $6,660 per year (effective January 2009) for a student under age 22. See the SSI website for the Student Earned Income Exclusion;
• The value of impairment-related work expenses for items or services that a disabled person needs in order to work. See the SSI website for Impairment-Related Work Expenses;
• The value or work expenses that a blind person incurs in order to work. See the SSI Website for the Special SSI Rule for Blind People Who Work
• Disaster Assistance;
• And certain exclusions on Indian trust fund payments paid to American Indians who are members of a federally recognized tribe.

Earned Income

The following are the major sources of countable earned income:

• Gross wages, prior to any deductions
• Net earnings from self-employment (gross income minus operational expenses)
• Wages from work in a sheltered workshop
• In-kind payments in lieu of wages

**Unearned Income**

The following are the major sources of **countable unearned income**:

• Social Security benefits, Veterans benefits or any other type of public or private pension

• Annuities, payments from insurance companies that individuals receive based on policies for which they paid

• Workers’ compensation

• Unemployment insurance

• Railroad retirement benefits

• Proceeds from a life insurance policy payable as a result of another’s death, or other death benefit, minus the expenses of the deceased’s last illness and burial expenses if paid by the recipient

• Gifts, inheritances, prizes, or awards

• Child support (*except excluded portion listed above*) spousal support or alimony, received in cash or in-kind

• Rental income, minus operational expenses

• Dividends, interest, or royalties

**Deemed Income**

**Deemed income** is the income of certain persons which is considered available to the recipient. Income is deemed to an SSI recipient from the following people only:

• Ineligible spouse in the same household

• Parent of an eligible minor child in the same household

• Sponsor of an alien

• Essential person (applies only to those persons who had an essential person under the former state aid plan in effect through 12/73)

Not all of the income of these persons is deemed to the recipient. Different rules apply in each type of deeming situation. In general, there is a deduction for the needs of the spouse, parent, other minor children, sponsor and/or essential person. In addition, certain types of income are
excluded altogether. The remainder is deemed – that is, counted as available – to the SSI recipient.

In-kind Income

In-kind income is support and maintenance received from another not in the form of cash. When an SSI recipient receives in-kind income, his/her check is usually reduced by one-third.

The one-third reduction applies when the recipient is living with another person, other than a spouse or minor child, who provides food and shelter, or when a non-household member buys food, clothing, or shelter for the recipient. The reduction will not apply if:

- The SSI recipient pays a pro rata share of the food and shelter expenses, or
- The SSI recipient has either rental liability or an ownership interest in the dwelling, or
- Everyone in the household is a recipient of public assistance, or
- The recipient can show that the value of the food, clothing or shelter provided is worth less than one third of the maximum benefit, in which case the reduction will be equal to the value of the items provided

Note that the check will never be reduced by more than one-third, even if the value of the food, clothing, or shelter exceeds that amount.

Income Deductions

After all countable income has been added up; the following deductions are subtracted in the following order:

- $20 from unearned cash income, unless the income is based on need, or from earned income if there is less than $20 in unearned income
- Up to $400 per month, but not more than $1,620 in a calendar year, from the earnings of a blind or disabled student child (under age 22)
- $65 plus half the remainder of any earned income
- The cost of any work expenses for a blind recipient

The result is the net countable income which must be subtracted from the maximum monthly benefit to determine the amount of the recipient’s check. For example, if a single individual has $234 in net countable
income, he/she would receive $200 in SSI. (Monthly maximum of $434 minus $234 equals $200.)

Resources

In addition to meeting the income test for SSI, a potential recipient must also meet a resource test. Resources are defined as personal or real property that an individual or spouse:

- Owns, and
- Has the right, authority or power to convert to cash (if it is not already cash), and
- Is not legally restricted from using his/her support and maintenance

An SSI recipient may not own more resources than the limit. If he/she does, he/she is not eligible. The SSI resource limits are as follows:

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<td>Single Individual</td>
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The one exception to that rule is that a person may receive conditional benefits during a period of time that he/she is attempting to sell excess resources. If the resource is sold, the benefits must be repaid from the proceeds of the sale. The limit on the period of conditional benefits is three months for personal property and nine months for real property. If personal property is not sold, the benefits are overpayments and the individual is not eligible. If real property is not sold, it can be excluded and benefits will continue for so long as the property remains on the market (see Excluded Resources on the next page).

Valuation of Resources

Resources are evaluated on the first day of the month. If the person is under the limit on the first day of the month, he/she is eligible for the entire month. Likewise, if he/she is over the limit on the first day of the month, he is ineligible for the entire month.

Resources are considered to be worth their equity value, which means the price the item can reasonably expect to sell for on the open market in
the particular geographic area (current market value), minus encumbrances (e.g., loan balances, taxes due). The Social Security office may assign a value to a resource based on the tax value, but the value can be rebutted with evidence of current market value and/or some kind of encumbrance against the property.

Excluded Resources

Not all of a person’s resources are countable for SSI purposes. The following are the main types of resources that are not counted:

- The home where the individual resides, together with all the land it sits on and related buildings
- Funds obtained from the sale of the home, if used within three months to buy another home
- Household goods and personal items, up to a limit of $2,000 in resale value
- One wedding ring and one engagement ring per person
- Medical or rehabilitation equipment
- Real property co-owned with others if the sale of the property would cause a loss of housing to a co-owner
- Real property that an individual has made a reasonable effort to sell during a nine-month period of conditional benefits, so long as the property remains on the market
- Certain Indian lands
- Any automobile necessary for employment, necessary to obtain medical care, modified for the transportation of a handicapped person, or necessary for the performance of essential daily activities. If no automobile is excluded under those circumstances, then one automobile is excluded up to a market value (regardless of encumbrances) of $4,500
- The cash surrender value of life insurance policies, if the total face value of all policies does not exceed $1,500 (but see following exclusion for burial policies)
- $1,500 each, for the recipient and spouse, in separately identifiable burial funds, which can include cash, revocable burial contracts or trusts, bank accounts, or other financial instruments
• One burial space (or agreement which represents the purchase of a burial space) for the recipient and each member of his/her immediate family

• Property essential to the recipient’s self-support, up to a value of $6,000 and a rate of return of at least six percent per year

• Resources set aside by a blind or disabled individual necessary for participation in a Plan for Achieving Self-Support

• Awards of retroactive SSI or Social Security benefits, for a period of six months following receipt

• Federal disaster assistance

• Cash or other resources received for the repair or replacement of lost, stolen, or damaged excluded resources for a period of nine months after receipt

  **Advocate Tip:** Problems with excess resources are quite common with SSI recipients. A frequent problem occurs when an applicant or recipient has legal title to a particular resource, but does not have the practical ability to convert it to cash. This may be because there are co-owners or because he/she is holding the title for someone else. One possible way to attack this problem is to find a knowledgeable source who can state that, due to the practical difficulties or legal impediments, the resource has a current market value of zero. This approach may be particularly useful when your client owns a partial share in real property. As a rule, real estate agencies will not list such shares of properties, and friendly agents will write statements saying they will not list the property interest because it has no current market value.

  **Countable Resources**

Any other property owned by the individual, spouse, parent of a minor, or sponsor of an alien is counted as a resource toward the limit.

The following are the most common types of countable resources:

• Real property not used as the home

• Cash or bank accounts

• Stocks, bonds, mutual funds, or other investments
• Promissory notes, loans, and property agreements

• Cash value of life insurance when the face value exceeds $1,500 (see above exclusions)

There is no penalty for transferring resources to become eligible for SSI, but before an individual gives away anything he/she should be thoroughly familiar with how the transfer could affect other benefits, such as Medicaid.

_Avocate Tip: If an SSI recipient expects to receive a sum of money or other resource over the limit, it will not affect eligibility if it is received after the first day of the month and spent on excluded resources or on bills before the first day of the next month._

**Program Appeals**

Decisions by the Social Security Administration (SSA) regarding eligibility, payment, overpayment, and most other issues affecting SSI may be appealed. SSA provides written notification of its decision and spells out the individual’s right to appeal.

The procedures for appeal are the same as for Social Security benefits. See Appeals section of the Social Security chapter on Part 1 - Page 26.

**Legal Authority**

Federal Statute: 42 U.S.C §1381 _et seq._

Federal Regulations: 20 C.F.R. §416 _et seq_

Federal Policy: Social Security Program

Operations Manual System (POMS)

**Sources and Related Resources**

U.S. Department of Health and Human Services
Social Security Administration
300 N. Greene Street
Baltimore, MD 21201

Technical information is available by calling the Social Security Administration at 1-800-772-1231 from 8:00 a.m. - 8:00 p.m.

North Carolina Legal Services Resource Center
Disability Hotline 1-800-638-6810 (Statewide information and referral service for disabled persons needing information about SSI.)

Lybarger and Onerheim, An Advocate’s Guide to Surviving the SSI System, (available from the Massachusetts Law Reform Institute, 69 Canal St., Boston, MA 02114)

SSI Website: http://www.ssa.gov/ssi/
Unemployment Insurance

Program Specifics

Quick Lookup

What Is It?
A program that provides a bi-weekly cash payment to partially replaced wages lost through unemployment.

Who Is It For?
Persons who are unemployed through no fault of their own, who have worked a sufficient period of time, are able and available for work, and are actively seeking work.

Where Are Applications Taken?
At local offices of the Employment Security Commission (ESC). The initial determination of eligibility should be made within 14 days.

Introduction
Unemployment Insurance (UI), also known as Unemployment Compensation, is a joint federal-state program designed to ease the burden of unemployment. Eligible unemployed persons receive bi-weekly checks which represent a percentage of their former wages. The program is funded with taxes collected from employers. The United States Department of Labor administers the program on a national level. At the state level, the program is administered by the North Carolina Employment Security Commission within the Department of Commerce. The ESC has local offices throughout the state, but not necessarily in every county.

Applications
Applications for Unemployment Insurance are taken at the local offices of Employment Security Commission. (The addresses and phone numbers of the local ESC offices are contained in Appendix E.) Making an application is known as filing a claim. To file an initial claim, an unemployed worker (called a claimant) must show up at the local ESC office and fill out the appropriate forms. To continue the claim, the person must either report back
in person to the ESC off as directed, or, more commonly, report back by mail through a card system on a bi-weekly basis.

At the same time an individual files an initial claim, he/she must register for work. The person will be interviewed by ESC staff about his/her job history and skills. This will allow the person to be referred for suitable jobs as listings come into the ESC.

In cases in which there are no questions of eligibility, a claimant will be notified immediately that he/she is qualified to receive benefits. When eligibility questions arise, the case referred to an adjudicator for a determination of eligibility. A written decision on eligibility will be mailed to the claimant within 14 days.

**Program Benefits**

An unemployed person who meets the other eligibility requirements will be entitled to a weekly amount calculated with a formula that takes into account previous wages paid. Checks are mailed every two weeks, containing two weeks' worth of benefits. There is a one-week waiting period for payment, which means that during the first week of eligibility, no benefit is paid.

**Benefit Amount**

The benefit amount is calculated as follows:

1. Wages from the person’s “base period” are computed. This period is the first four of the last five completed calendar quarters of work prior to the claim for unemployment. (Calendar quarters are periods of three months ending March 31, June 30, September 30, and December 31.)

2. Wages from the two highest paid quarters are added together.

3. The result is divided by 52.

If a person had steady wages during the year prior to the claim, the formula will work out so that he/she will receive approximately half of his/her gross weekly wage.

As of December, 2008, NC benefits ranged from $41 to $476. North Carolina state unemployment benefits are subject to Federal income taxes, and you may elect to have taxes withheld from your unemployment check.
Persons who are partially unemployed may receive benefits, but the amount will be reduced by the wages they are receiving. A portion of the current wages is disregarded when determining the weekly UI benefit (about ten percent of his/her previous weekly wage).

**Duration of Benefits**

The duration of benefits is also based on a mathematical formula taking into account the individual’s past wages, but it **not less than 13 weeks or more than 26 weeks**. In particularly poor economic times, extended benefits may be authorized.

**PROGRAM ELIGIBILITY**

**Personal Eligibility**

In order to receive Unemployment Insurance, the claimant must **meet certain affirmative requirements** and must not be disqualified for certain behaviors.

**Affirmative Requirements**

To meet the affirmative requirements, a claimant must:

- Be totally or partially **unemployed**
- Be **able and available** for work
- Be **registered for work** at the ESC and **actively seeking work**
- Have earned **sufficient wages in his/her base period**

**Unemployed**

Generally, a person’s unemployment status is determined by wages earned. A person is considered **totally unemployed** if his/her earnings are less than the amount disregarded in calculating his/her weekly unemployment benefit (*i.e.*, about ten percent of his/her previous weekly wage).

**Partial unemployment** occurs when an employee is still on a payroll but works fewer than three days in a week and his/her earnings are less than his/her weekly benefit minus the disregarded portion (which will work out to about 40% of his/her previous weekly wage). Likewise, a person is **part-totally unemployed** if he/she is not on a payroll, but is working odd
jobs and earning less than his/her weekly benefit minus the disregarded portion.

A claimant is **not unemployed** if he/she is receiving any kind of severance or separation pay or accrued vacation pay.

### Able and Available

A claimant for UI must be **physically and mentally able to work** to be eligible. He/she need not the able to do all work, but must be able to do work that he/she is qualified to do. An individual will **not be considered able** to work if he/she is **receiving or applying for any kind of disability benefits**. Nevertheless, if the individual who is applying for disability benefits also continues to meet all the other eligibility requirements for UI, and is ultimately determined **not** to be disabled, he/she can obtain a retroactive UI award.

To be **available for work**, a claimant must be **genuinely attached to the labor market**. This means that he/she can’t have such restrictions on him/herself that he/she is unlikely to be able to accept a job if offered. A claimant who substantially restricts the hours or days that he/she will work will be considered unavailable.

### Registered and Actively Seeking Work

Being **registered for work** simply means having signed up with the local Job Service (part of ESC and located at the same office) and having supplied information about the job history and skills.

**Actively seeking work** is defined as doing those things which an unemployed person who wants to work would normally do. A claimant will be considered to have actively sought work in any week in which he/she:

- Sought work on at least two different days, *and*
- Made a total of at least two in-person job contacts with different employers

Claimants are required to report to the ESC the contacts made and must follow through on job leads referred to the by the ESC.

### Sufficient Wages

Each individual must have earned a minimum amount of wages to qualify for UI. A mathematical formula, applied to base period wages, is used to
determine if sufficient wages were earned. Your weekly benefit amount and the number of weeks of entitlement to benefits are based on the wages you were paid and amount of time you worked during your base period. The exact amount of benefits and the duration of those benefits cannot be determined until you actually file your claim for benefits. Furthermore, the high-quarter wages must equal at least one and a half times the average weekly insured wage. The ESC office will notify and individual if he/she has insufficient wages to qualify. It is possible for certain wages to have been unrecorded, and the worker can get his/her wage record corrected and then qualify. More information can be found at their website: https://www.ncesc1.com/individual/UI/UiClaims2.asp.

Disqualifications

A claimant for benefits will be disqualifed if it is determined that he/she:

- Left work without good cause attributable to the employer
- Was discharged for misconduct connected with the work
- Was discharged for substantial fault connected with the work
- Lost a license, permit, certificate, bond or the like necessary for the employment
- Failed without good cause to apply for or accept an offer of suitable employment
- Failed to attend vocational school or training when so directed by the ESC
- Is unemployed as a result of a labor dispute or strike

Leaving Work

A person who chooses to leave a job is generally not qualified for UI, unless it can be shown that the conditions of work, created by the employer, were too burdensome. For example, if there were serious safety hazards on the job or if there was racial discrimination, UI should be granted.

An exception to the “leaving work” rule applies when the employee leaves due to health reasons. The employee will not be disqualified as long as the condition prevents the employee from doing his/her work or any alternative work that pays at least 85% of previous wages (or minimum wage, whichever is greater), and the employee gave reasonable notice of the condition to the employer.
Leaving as a result of a **cut in pay or hours** will cause a disqualification unless the cut in pay is more than 15% or the cut in hours more than 20%.

Leaving as a result of an **impending separation**, such as an upcoming layoff, will not be considered “attributable to the employer” unless the employee can show it would have been unduly burdensome to continue to work until the announced separation date. Otherwise, he/she will be disqualified.

**Misconduct Connected with the Work**

Misconduct is defined as:

Conduct evincing such a willful or wanton disregard of an employer’s interest as is found in deliberate violations or disregard of standards of behavior which the employer has the right to expect of his/her employee, or in carelessness or negligence of such degree or recurrence as to manifest equal culpability, wrongful intent or evil design, or to show an intentional and substantial disregard of the employer’s interest or of the employee’s duties and obligations to his/her employer.

A few specific behaviors will always be found to be misconduct: reporting to work significantly impaired by alcohol or illegal drugs, consuming alcohol or drugs on the employer's premises, or being convicted of certain drug offenses while employed.

**Advocate Tip:** Despite this definition, which seems to include only the most heinous behavior, the ESC has found relatively benign behavior to have met this definition and caused a disqualification. Employers will virtually always indicate that a discharge was for misconduct, and the ESC will usually accept the employer’s word. If the employee can show that there were good reasons for doing what he/she did, or that the acts were not deliberate, the ESC finding for disqualification is worth appealing.

**Substantial Fault**

Unlike a finding of leaving work without good cause or misconduct, a finding of **substantial fault** will result only in a **temporary disqualification**. Substantial fault is defined as:

Those acts or omissions of employees over which they exercised reasonable control and which violate reasonable requirements of the job
but shall not include (1) minor infractions of rules unless such infractions are repeated after a warning was received by the employee, (2) inadvertent mistakes made by the employee, nor (3) failures to perform work because of insufficient skill, ability or equipment.

A claimant is presumed to be disqualified for a period of **nine weeks** upon a finding of substantial fault. Nevertheless, the disqualification can be reduced to not less than four weeks as a result of mitigating circumstances or increased to not more than 13 weeks as a result of aggravating circumstances.

**Refusing Suitable Work**

A claimant for UI has an obligation to follow through on job leads, whether referred by the ESC or found independently, and to accept an offer of suitable work. **Suitable work** is not specifically defined. A person will not be expected to take a job that pays significantly less than his/her former job or is of a lower skill level than his/her previous job. The longer a claimant is unemployed, the stricter the ESC will be about requiring that he/she accept an offer of work.

**Financial Eligibility**

Unemployment Insurance is not a needs-based program. Consequently, there are no financial eligibility requirements. Anyone who meets the personal eligibility requirements can receive benefits, regardless of other income or assets.

**Program Appeals**

Decisions of the ESC regarding the payment of benefits can be appealed through an administrative appeal process and then to court.

When an initial claim is filed, an ESC staff person determines whether there are any questionable issues. These issues would include whether there is an allegation of misconduct, leaving work, failure to accept suitable work, failure to actively seek work, etc. When such an issue arises, there is adjudication.

**Adjudication**

Adjudication consists of an informal investigation and a determination of whether the employee is qualified for benefits. The adjudicator will interview both the employer and the employee separately, usually by phone and
review any written statements which have been submitted. From this information, the adjudicator will issue a **written decision** on eligibility.

Either the claimant or the employer may **appeal** the decision of the adjudicator. The appeal **must be filed** (which means *received*) at a local ESC office **within then calendar days** if the date of the adjudicator’s Notice of Decision (plus three days if adjudicator’s decision was mailed).

**Appeals Referee Hearing**

When an appeal is filed, a **hearing before an Appeals Referee** is scheduled. Advance written notice will be mailed to all parties at least ten days in advance. Hearings are generally scheduled to be heard in person at the ESC office where the initial claim was filed. **Telephone hearings** are sometimes scheduled. Any party may object to having the hearing held by telephone, and it will usually be scheduled as an in-person hearing.

The **Appeals Referee** is an employee of the ESC whose job it is to hear the evidence in appealed cases and make decisions on eligibility. The Appeals Referee regulates the course of the hearing and has the right to issue subpoenas, grants continuances, and otherwise make decisions on procedural matters.

Each party has the right to be represented (by a lawyer or a non-lawyer representative who is supervised by a lawyer), to review his/her file prior to the hearing, to present witnesses and documents on his/her behalf and cross-examine any witnesses who testify against him/her. The hearings are informal and court rules of evidence do not apply. Nevertheless, all testimony is taken under oath and the hearing is recorded. An appealing party would be well advised to have legal representation at this hearing.

The Appeals Referee will issue a written decision and mail it to the parties or the legal representatives within about two weeks of the hearing. If either party is dissatisfied with the decision, it may be **appeal to the Commission**.

**Advocate Tip:** The Appeals Referee hearing is, for all practical purposes, the last opportunity a party has to introduce evidence. Generally no additional testimony or documents will be accepted after this hearing. Thus, it is critical that the claimant present all necessary witnesses and documents to establish the facts. If the case is appealed further, a transcript or tape recording of the hearing, together with all the documents, will form the official record of the case.
Commission Hearing

Appeals to the Commission are generally heard by the Chief Deputy Commissioner of the ESC. The appeal must be received at the ESC office (P.O. Box 25903, Raleigh, NC 27611) within ten calendar days of the mailing of the Appeals Referee’s decision (plus three days if the Commissioner’s decision was mailed) and must state the grounds for the appeal. Statements that facts found by the Appeals Referee are not supported by the evidence or that the Appeals Referee erred in applying the law will be sufficient.

The Chief Deputy Commissioner will review each case appealed. He/she may or may not allow oral presentations, but will accept written legal arguments if submitted within the time allowed. (The acknowledgment of the appeal will contain a briefing schedule.) A tape recording of the proceedings before the Appeals Referee will be sent to each party unless a transcript is requested. If a transcript is requested, the request must contain either an assurance that it will be paid for or a special affidavit from the requesting party that he/she has insufficient funds to pay for the transcript but has a good cause to appeal.

The Chief Deputy Commissioner will issue a written decision on the case and mail it to interested parties, usually within a few weeks after any oral argument or written briefs are submitted. If either party is dissatisfied with the decision, it may be appealed to court.

Judicial Review

Within 30 calendar days of the mailing of the Commission’s decision, either party may file a Petition for Judicial Review in Superior Court. When the case is set, the judge will hear oral arguments and accept written legal arguments, but will not hear additional testimony. (In some counties, written arguments are required by the local rules of court.) The judge will decide whether there is evidence to support the Commission’s decision or whether the Commission made any legal errors. As a practical matter, such an appeal can rarely be accomplished successfully without the services of an attorney. Free legal help may be available from the local Legal Services program. (See chapter on Legal Services.)
**Legal Authority**

26 U.S.C. §3301 et seq.

Federal Regulations: 20 C.F.R. §640, 650


**Sources and Related Resources**

Employment Security Commission of North Carolina
Unemployment Insurance Division
700 Wade Avenue
P.O. Box 25903
Raleigh, NC 27611
(919) 733-2900

North Carolina Legal Services Resource Center
224 S. Dawson Street
P.O. Box 27343
Raleigh, NC 27611
(919) 856-2121
Veterans Nonservice-Connected Pension

Program Specifics

Quick Lookup

What Is It?

A needs-based program that provides a monthly check to supplement income.

Who Is It For?

Veterans who are over 65 years old or permanently and totally disabled, and/or the surviving spouses and children of eligible veterans.

Where Are Applications Taken?

At the regional office of the U.S. Department of Veterans Affairs (VA) in Winston-Salem, in person or through the mail. Forms are available at districts offices of the state Division of Veterans Affairs and through county veterans' service officers. There is no time limit on the eligibility determination process.

Introduction

The Veterans Nonservice-Connected Pension is a needs-based income supplement to veterans who are over 65 years old or permanently and totally disabled from a nonservice-connected condition. The program also provides benefits to the dependents and survivors of veterans. The amount of the benefit depends on other sources of income available to the veteran or his/her family; the pension supplements these amounts up to certain maximums. Depending on when the veteran files a claim, he/she might be covered by any one of three pension programs. Some veterans may be eligible for either a pension or service-connected compensation. (See following chapter.) The VA should assist the veteran in determining which program would provide the higher benefit.

The pension program is administered by the U.S. Department of Veterans Affairs (VA). The regional office of the VA serving North Carolina is located in Winston-Salem. Although the state is not involved in the administration of federal VA benefits, it does have a Division of Veterans Affairs with 15 district service offices throughout the state. Most counties have a county service
officer as well. The staffs at the district offices and the county service officers assist veterans in filing and pursuing claims for benefits. The District and County Offices are listed in Appendix L.

Applications

A veteran (or dependent or survivor) must apply for benefits with the U.S. Department of Veterans Affairs. The North Carolina office is in Winston-Salem. An applicant may appear at the office without an appointment to submit an application, or may obtain an application through the mail by calling the VA office. It may be returned by mail. The VA can be reached toll-free at 1-800-827-1000.

An “informal claim” can be submitted prior to filing a formal application. A veteran can write a letter stating that “I intend to apply for every benefit to which I may be entitled.” The date on this informal claim will be considered the filing date for purposes of awarding benefits. This allows the applicant to protect his/her benefits while having sufficient time to gather the evidence needed to support the formal application.

What to Provide

Applicants should be prepared to submit proof to support their claim for benefits. Medical records supporting the disability are required. A private physician’s statement may be satisfactory proof of being permanently and totally disabled. A private physician’s statement as to the need for regular aid and attendance and housebound benefits can also be satisfactory proof of the need for those additional benefits. These statements must be carefully worded to comply with VA requirements, and applicants would be well-advised to obtain advice at a veteran’s service office prior to submitting them.

For dependents and survivors, proof of relationship to the veteran is necessary, such as a birth certificate or marriage license.

Information about income and assets are also required.

Time Limits

There are no time limits within which an application must be filed or within which the decision on eligibility must be made. It is recommended that surviving spouses apply within one year from the veteran’s date of death, but there is no specified time limit.
Program Benefits

A Veterans Nonservice-Connected Pension is a supplemental check. The amount of the check is determined by subtracting the veteran’s (or survivor’s or dependent’s) other income from the maximum amount payable; with consideration given for annual medical expenses and/or funeral expenses. Veterans (or survivors) in need of the “regular aid and attendance” of another to help them are entitled to a higher benefit, as are veterans who are housebound or supporting a spouse and/or dependent children.

Three separate pension programs exist. The “Improved Pension” program went into effect on January 1, 1979. All those applying for benefits after that date are covered by this program. Prior to that was a pension program known as “Section 306” Pension. It was in effect from July 1, 1960 to December 31, 1978. Persons receiving benefits under Section 306 who remained eligible after the Improved Pension was introduced had their choice of staying on the older program or converting to the Improved Pension. The “Old Law” Pension program was in effect prior to July 1, 1960. (The rules regarding Section 306 and the old law are not covered in detail here, as they affect relatively few persons.)

The following are the maximum annual amounts payable to different classes of individuals under the Improved Pension program, effective 12/1/89. The amounts are increased annually by the same percentage that Social Security benefits are increased.

<table>
<thead>
<tr>
<th>Improved Pension Program (12/1/2008)</th>
<th>Maximum Annual Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veteran, no dependents</td>
<td>$11,830</td>
</tr>
<tr>
<td>Veteran, no dependents, House Bound</td>
<td>$14,457</td>
</tr>
<tr>
<td>Veteran, no dependents, Aid &amp; Attendance</td>
<td>$19,736</td>
</tr>
<tr>
<td>Veteran, one dependent</td>
<td>$15,493</td>
</tr>
<tr>
<td>Veteran, House Bound, one dependent</td>
<td>$18,120</td>
</tr>
<tr>
<td>Veteran, Needing Aid &amp; Attendance, one dependent</td>
<td>$23,396</td>
</tr>
</tbody>
</table>
Two Veterans, married both P&T | $15,493
---|---
Additional for each dependent Child | $2,020

<table>
<thead>
<tr>
<th>Surviving Spouse</th>
<th>Maximum Annual Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse, no children</td>
<td>$7,933</td>
</tr>
<tr>
<td>Spouse, no children, House Bound</td>
<td>$9,696</td>
</tr>
<tr>
<td>Spouse, no children, Aid &amp; Attendance</td>
<td>$12,681</td>
</tr>
<tr>
<td>Spouse, one child</td>
<td>$10,385</td>
</tr>
<tr>
<td>Spouse, one child, House Bound</td>
<td>$12,144</td>
</tr>
<tr>
<td>Spouse, one child, Aid &amp; Attendance</td>
<td>$15,128</td>
</tr>
<tr>
<td>Each additional child</td>
<td>$2,020</td>
</tr>
<tr>
<td>Surviving Child Only</td>
<td>$2,020</td>
</tr>
</tbody>
</table>

**Note:** A veteran without dependents who is in a nursing home and receiving Medicaid to assist in paying for the cost of his/her care is **limited to a benefit of $90 per month.** None of that money may be required to be used toward the cost of care.

**Overpayments**

There are occasions when the VA pays more benefits to a recipient that he/she is entitled to. This is called an overpayment. The overpaid individual can take several steps if charged with overpayment. These are discussed in detail in the following chapter on Veterans Service-Connected Compensation, Part 1 - Page 72.

**Denials**

If the VA denies a claim for benefits, they must provide a written notice of the denial. The notice should include a summary of the evidence considered and the reasons for the decision. Decisions of the VA regarding eligibility are appealable. See Appeals section on Part 1 - Page 60.
Personal Eligibility

Veterans

There are three basic eligibility requirements for a veteran:

• A discharge under “other than dishonorable conditions”

• A total and permanent disability from a nonservice-connected cause or be over 65 years old

• 90 days of service in the armed forces, at least one day must have been during wartime; or duty after 9-7-1980 requires 24 continuous months or full period for which called to active duty and at least one day must have been during wartime.

Discharge

The military discharges individuals under six categories. Those discharges that definitely will not affect a claim for pension benefits are either an honorable or a general discharge.

A discharge categorized as undesirable, under other than honorable conditions or uncharacterized may bar a claim for pension benefits, depending on a special determination made by the VA based on the facts of each case.

A bad conduct discharge from a general court martial or a dishonorable discharge will bar a claim for pension benefits.

It is sometimes possible to have a discharge upgraded. A Division of Veterans Affairs district service office can provide more information and assistance with that process.

Disability

For veterans under 65 years old their disability must be total and permanent to form the basis of eligibility for pension benefits. A total disability is an impairment of mind or body sufficient to make it impossible for the average person to follow a substantially gainful occupation. Permanent means that the impairment is reasonably certain to continue through lifetime.
Veterans are given percentage ratings of their disabilities (i.e., a 70% disability). **A veteran does not necessarily have to be rated at 100% to be considered permanently and totally disabled.**

The disability must **not be the result of the veteran’s “willful misconduct or vicious habits.”** Primary alcoholism and drug addiction are generally considered to be misconduct.

For veterans over 65 years old, the requirement of **permanent and total disability is waived**, effective 9-17-2001.

**Wartime Service**

A veteran must have served in the active military, naval or air service for at least 90 days, at least one day of which was in wartime, to qualify for benefits. Combat service is not required. Wartime includes the following periods:

- **World War I**: 4/6/17 – 11/11/18 (extended to 4/1/20 for those who served in Russia and to 7/1/21 for a few others)
- **World War II**: 12/7/41 – 12/31/46
- **Korean Conflict**: 6/27/50 – 1/31/55
- **Vietnam Ear**: 8/5/64 – 5/7/75 (2-28-61 for veterans who served in country before 8-5-1964)
- **Persian Gulf War**: 8/2/90 – no official end date established

**Dependents**

Eligible dependents are either the veteran’s spouse, children (legitimate, illegitimate, step, or adopted) who are under age 18 or full-time students between the ages of 18 and 23, or children suffering from a total disability that began before age 18. A later marriage by the widow(er) or child terminates eligibility. As of 11/1/90, eligibility will not be reinstated if that later marriage ends either by death or divorce.

**Survivors**

Survivors possibly entitled to a pension for a nonservice-connected death include spouses (married to veteran at time of death) and children of veterans:

Widow(er)s must also meet the following requirements:
• Have been married to the veteran for at least one year before the veteran’s death (less than one year if a child was born to the couple); married before or during veteran’s military service; or married to WWII veteran before 1-1-1957, Korean veteran before 2-1-1965, Vietnam Veteran before 5-8-1985, or Persian Gulf Veteran after 1-1-2001.

• Have lived with the veteran continuously from the date of marriage (or have been separated through no fault of his/her own)

• Not have remarried

Financial Eligibility

Improved Pension Program

Income

To receive a monthly check, a veteran and his/her dependents or his/her survivors may not have a combined family income in excess of the maximum amounts payable under this program (see limits listed in the Benefits section of this chapter). If the family has no other source of income, it receives the maximum. If it does have other income, that income is subtracted from the maximum to determine the benefit level. The following types of income, however, are not counted and therefore do not reduce the benefit:

• Public or private welfare benefits, including AFDC and SSI

• Value of maintenance payments if paid by someone other than the pension recipient

• A child’s income only if it can be shown that to count it would cause a hardship

  Advocate Tip: Unreimbursed medical expenses can be used to reduce countable income

Assets

There are no specific limits on assets, but the VA will disqualify an individual or family if, given the amount of assets owned, it is reasonable that some of the assets can be used for maintenance. As a general rule of thumb, the VA considers $80,000 to be the maximum amount of assets allowable, excluding the home and personal effects.

Section 306 Pension
Under this older program, the benefit levels are lower, but there are more income exclusions. Most significantly, a spouse’s earned income and children’s income are not counted when determining the veteran’s eligibility for benefits.

Program Appeals

Any actions by the VA to deny, reduce, suspend, terminate or otherwise adversely affect a veteran benefits may be appealed. A veteran may have a representative during this process. The district offices of the NC Divisions of Veterans Affairs and most counties have staff that may be available to represent veterans.

Notice

When any VA decision affecting a veteran’s benefits is made the VA must send a written notice explaining the decision. If the veteran is already receiving benefits and the VA actions will reduce or suspend them, the veteran is entitled to receive at least 60 days advance notice. The veteran is permitted to submit evidence showing why such adverse actions should not be taken. In addition the veteran may request a pre-termination hearing within 30 days of the writing notice. The adverse actions may not become effective until after the hearing decision is made.

Review

A veteran has one year from the date of notice of adverse action to file a notice of disagreement (NOD) at the Regional VA office. There is no specific form that must be used. It can be a simple statement, or it can be a more extended argument laying out the basis for the veteran’s position.

Upon receipt of the NOD, the VA must either allow the claim or prepare a “Statement of the Case” containing a summary of the evidence, applicable laws and reasons for the denial of the claim.

Regional Office Hearings

At any time, either before or after the filing of an NOD, a veteran can ask for a hearing before a hearing officer at the regional office. The hearing officer has the authority to amend, reverse, or affirm the decision in question. This hearing does not affect the deadlines for filing the Notice of Disagreement or the other appeal processes. They proceed simultaneously.
Appeals to the Board of Veterans Appeals

After the veteran receives the “Statement of the Case” (if he/she has not had the decision reversed at a regional hearing), he/she must file a **Form I-9**, which is an appeal to the Board of Veterans Appeals. The form is filed at the regional office.

The deadline for filing is **60 days** from the date on the Statement of the Case, or the remainder of the one year period that began with the date on the VA denial notice, whichever is later.

The Board of Veterans Appeals is located in Washington, D.C and has 60 members. Claimants can request a BVA hearing before a BVA member by requisitioning either: (1) In person in Washington, D.C., (2) In person, with a travel judge at their local Regional Office, or (3) Video hearing at their local Regional Office. Veterans may submit new evidence and witnesses at BVA hearings. The BVA will also consider whatever evidence was developed at the regional office when the original decision was made. **Note:** Unless the veteran personally appears at the hearing (which is not required and can delay the case for an extended period of time), new evidence must be submitted within 90 days of the day of notification that the case has been transferred from the regional office to the BVA. The 90-day rule also applies to requests to change counsel and requests for a personal hearing. **Exceptions for good cause may be allowed.**

The decision of the BVA is the final administrative decision. A request that the BVA reconsider its decision is allowed at anytime but is seldom successful.

Reopening

A claim can be reopened at the regional office if there is new and material evidence to be submitted. There is no time limit on when a reopened case may be filed.

Judicial Review

Claimants who are unsuccessful before the BVA may appeal to the **U.S. Court of Veterans Appeals**, located in Washington, D.C. The notice of appeal must be filed **within 120 days** of the final decision of the BVA. (Only veterans whose Notice of Disagreement was filed on or after November 18, 1988 are eligible to have claims reviewed in this court.) It is recommended
that claimants seek legal representation from an attorney accredited by the Court of Veterans’ Appeals if they wish to appeal a BVA decision.

**LEGAL AUTHORITY**


Federal Regulations: 38 C.F.R. §501 et seq.

**SOURCES AND RELATED RESOURCES**

U.S. Department of Veterans Affairs Regional Office
251 N. Main Street
Winston-Salem, NC 27155
Toll Free 1-800-827-1000

North Carolina Division of Veterans Affairs
1325 N. Salisbury Street
Raleigh, NC 27601
(919) 733-3851
(District offices of the N.C. Division of Veterans Affairs are listed in Appendix L.)

National Veterans Legal Services Project, Inc. (A non-profit law firm that serves as a national support center in the area of veterans’ law. Its services are available to veterans’ service organizations, state and county veterans offices, community-based veterans’ organizations, volunteer attorneys, private bar attorneys, Legal Services programs, and other veterans’ advocates.)
2001 S Street, NW
Suite 610
Washington, DC 20009
(202) 265-8305

*The Veterans Advocate* (A monthly newsletter, available free of charge to most veterans’ advocacy groups and service organizations, and for a small subscription fee to others. Available from the National Veterans Legal Services Project, Inc. at the above address.)

*Veterans Benefits Manual* (A comprehensive manual for advocates available from the National Veterans Legal Services Project, Inc. at the above address. Prices vary depending on the nature of the entity purchasing the book.)

*Federal Benefits for Veterans and Dependents* (80-page pamphlet published by the U.S. Department of Veterans Affairs, available free from the Regional Office in Winston-Salem and at most district offices of the Division of Veteran Affairs.)
Veterans Service-Connected Compensation

PROGRAM SPECIFICS

Quick Lookup

What Is It?

A monthly cash payment that compensates a veteran for a service-connected disability.

Who Is It For?

Any veteran who incurred or aggravated an illness or injury while in the military service or because of their military service, (i.e. Agent Orange related conditions) and his/her dependents and survivors. There are no financial eligibility requirements.

Where Are Applications Taken?

At the regional office of the U.S. Department of Veterans Affairs. District offices of the state Division of Veterans Affairs and county veteran service officers can assist in the filing of applications. There are no time limits on the eligibility determination process.

Introduction

Veterans Service-Connected Compensation is one of the two major disability-base programs operated by the U.S. Department of Veterans Affairs (VA). The purpose of the program is to provide regular compensation payments to veterans and their dependents and survivors for “service-connected” disabilities and deaths. It has two advantages over the other major VA program, Veterans Pensions, which provides benefits for “nonservice-connected” disabilities and deaths. First, it is available regardless of financial need. Second, it generally pays higher benefits than the pension program (although in particular circumstances this may not be true). Veterans may be eligible for both programs and may apply for both. The VA is obligated to rule on both claims and pay the higher of the two benefits if both are approved.

The U.S. Department of Veterans Affairs has one office in North Carolina, located in Winston-Salem. The state is not involved in the administration of veterans programs. It has established, however a Division of Veterans
Affairs, within the N.C Department of Administration. The Division, which has 15 district service offices throughout the state, provides assistance to veterans in filing and pursuing their claims for benefits. Most counties have a veterans service officer as well, who can assist veterans in pursuing their claims.

Applications

**Applications are received by the U.S. Department of Veterans Affairs.** North Carolina applicants should submit their applications to the regional office in Winston-Salem. An applicant may call to request an application by mail, and return it by mail, or may apply in person without an appointment at the Winston-Salem office.

Online applications can be found at [www.va.gov](http://www.va.gov)

District offices of the State Division of Veterans Affairs and county service officers have the application forms and can assist veterans in filling them out and including proper information. The district offices are listed in Appendix L.

An “informal claim” can be submitted prior to filing a formal application. A veteran can write a letter stating that “I intend to apply for every benefit to which I may be entitled.” The date on this informal claim will be considered the filing date for purposes of awarding benefits. This allows the applicant to protect his/her benefits while having sufficient time to gather the evidence needed to support the formal application.

What to Provide

Dependents and survivors need to provide proof of their relationship to the veteran. This can be done with birth certificates, marriage licenses, divorces, etc.

Veterans need to prove their disability and that it is service-connected. Medical records from private physicians should be provided, as well as information about when and where the veteran was treated while in the military. (The VA can obtain the military medical records, but the veteran need to lead the VA to the correct sources of information. The veteran may wish to obtain these records on his/her own, however, and review them before they are submitted). A veteran should be prepared to undergo a medical examination by a VA doctor.

**Program Benefits**
Veterans

Veterans eligible for this program receive a monthly non-taxable compensation check. The amount depends on the "percentage of disability" the veteran is experiencing. Ratings are assigned to reflect the average impairment of earning capacity. The rating may reflect the combination of two or more disabilities.

The following figures, effective 12/1/08, are basic amounts payable based on the rated disability:

<table>
<thead>
<tr>
<th>Disability</th>
<th>Monthly Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 Percent</td>
<td>$123</td>
</tr>
<tr>
<td>20 Percent</td>
<td>$243</td>
</tr>
<tr>
<td>30 Percent</td>
<td>$376</td>
</tr>
<tr>
<td>40 Percent</td>
<td>$541</td>
</tr>
<tr>
<td>50 Percent</td>
<td>$770</td>
</tr>
<tr>
<td>60 Percent</td>
<td>$974</td>
</tr>
<tr>
<td>70 Percent</td>
<td>$1,228</td>
</tr>
<tr>
<td>80 Percent</td>
<td>$1,427</td>
</tr>
<tr>
<td>90 Percent</td>
<td>$1,604</td>
</tr>
<tr>
<td>100 Percent</td>
<td>$2,673</td>
</tr>
</tbody>
</table>

Additional allowances are paid to persons with certain severe disabilities, those who require the aid and attendance of another, or those who are housebound.

If a disability that is rated at least 60% precludes a veteran from working, he/she can be paid as if he/she were rated at 100% disability.

Dependents
If the veteran’s disability is 30% or greater, the **basic amounts are increased for each eligible dependent**. The amount of increase is related to the number of dependents and the percentage of disability. The maximum monthly increases to a veteran who is 100% disabled are:

<table>
<thead>
<tr>
<th>Dependent</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse Only</td>
<td>add $150</td>
</tr>
<tr>
<td>Child only</td>
<td>add $101</td>
</tr>
<tr>
<td>Spouse, 1 child</td>
<td>add $259</td>
</tr>
<tr>
<td>Each Additional Child</td>
<td>add $75</td>
</tr>
</tbody>
</table>

To obtain the figures for veterans who are rated at less than 100%, multiply the above figures by the percentage disability. For example, a veteran with a spouse and no children who is rated at 50% would receive an addition of 50% of $150, or $75 a month.

A veteran may receive additional benefits for **dependent parents**, depending on the circumstances. An advocate should check with the VA for more information.

**Survivors**

If a veteran dies as a result of a service connected disability, **eligible survivors may receive either Death Compensation** (if the veteran died before 1/1/57) or **Death and Indemnity Compensation (DIC)**. Anyone eligible for Death Compensation can choose DIC. Generally, DIC is a higher benefit for widow(er) s and children; it varies for dependant parents depending on the circumstances.

**Remarriage** by the spouse before age 57 entitled to DIC benefits **terminates entitlement to benefits**. Likewise, marriage by a dependent child ends entitlement. If remarriage is after age 57, or if remarriage ends, the surviving spouse retains DIC benefits.

**Burial Benefits**

The VA will pay an amount up to $2,000 for the burial expenses of a veteran who dies from service-connected causes. (Some servicemen and military retirees are eligible for a federal death benefit that may be higher.) Families of certain veterans who die from nonservice-connected causes may receive up to $300 in burial expenses and $300 for a burial plot.
Overpayments

Occasionally, the VA pays a veteran or his/her dependents or survivors more benefits than they were entitled to. In those instances, the VA will attempt to collect the amount of the overpayment either by reducing current monthly benefits or requiring a refund.

In these situations, the veteran (or other recipient) has several options. He/she can:

- Dispute that the overpayment actually exists
- Pay it back, either in full or at some lower, negotiated level
- Ask that repayment be waived

Waiver

If it cannot be shown that the debt does not exist, waiver can relieve the veteran of having to reimburse the VA. A request for a waiver must be requested within six months following the date of the notice of the overpayment. If the VA determines there was fraud, misrepresentation, or bad faith on the part of the debtor, no waiver will be granted. If none of those factors is involved, the VA may waive the debt if collection would be against equity and good conscience. Factors involved are:

- Fault of the debtor in creating debt
- Fault of the VA in creating debt
- Whether collection of the debt would create undue hardship on the part of the debtor
- Whether collection would defeat the purpose of the benefit
- Whether failure to collect the debt would result in the unjust enrichment of the debtor
- Whether the debtor has changed his/her position for the worse in reliance on the VA benefits

There is no particular formula to be used in considering these factors; each case is looked at individually.

Advocate Tip: There is no deadline to dispute the existence of the debt, but there is a six-month deadline to request a waiver. If both arguments are possible, the debtor should pursue both
avenues simultaneously. That way, if the existence of the debt is affirmed after the six-month time period for requesting a waiver had passed, the waiver avenue is not foreclosed.

**Program Eligibility**

**Personal Eligibility**

**Veterans**

A veteran must meet two basic eligibility requirements to be entitled to service-connected compensation. He/she must:

- Have been **discharged** under “other than dishonorable conditions” (see further explanation in Personal Eligibility section of Veterans Nonservice-connected Pension Part 1 – Page 69).
- Have a **total or partial disability caused by an illness or injury incurred or aggravated during a period of military service**

**Disability**

The injury or illness that led to the disability does not have to have been incurred in combat, or even while engaged in military duties. As long as it was **incurred or aggravated while the veteran was active in service**, and was **not the result of willful misconduct**, it meets the requirements.

**Advocate Tip:** A complex system of procedures is involved in establishing the disability and the rating percentage. A veteran would be well-advised to obtain advice from a knowledgeable source, such as a staff member at a district office of the N.C. Division of Veterans Affairs or a county veteran service officer, before submitting evidence to the VA.

**Dependents**

In order for an allowance to be added for a dependent, the veteran must be at least 30% disabled. In addition, children must be under age 18 or between 18 and 23 and enrolled full-time in school, or suffering from a total disability that began before age 18. Parents can qualify as dependents if they actually rely on the veteran for their necessary expenses.
If a veteran’s spouse or children are not living with the veteran and the veteran is not providing support, the dependents can apply to the VA for direct payments of a portion of the veteran’s benefits. There is no specific application form to use for filing for an “apportionment.” Any or all of a veteran’s benefits can be apportioned; the amount is not limited to the minimal dependents’ allowance. The standard for determining how much to apportion is the dependents’ financial needs balanced against the needs of the veteran.

**Survivors**

To receive Death Compensation or DIC benefits, a widow(er) must:

- Have been married to the veteran for at least one year before the veteran’s death, unless a child was born to the couple, or married to veteran within 15 years of discharge
- Have lived with the veteran continuously from the date of marriage, or have been separated through no fault of his/her own
- Not have remarried before age 57

**Children** must meet the same requirements as needed to be eligible for an allowance as described about (under 18, 18-23 full-time students, or disabled before 18).

**Financial Eligibility**

Service-connected compensation is not a needs-based program. Thus, the VA imposes no financial eligibility criteria, except as noted below.

**Compensation benefits for an incompetent veteran with no dependents who is hospitalized will be suspended if his/her estate exceeds $25,000** (excluding the value of his/her home). The suspension will remain in effect until the estate has been reduced to $10,000. If the veteran regains competency for at least 90 days, the amount withheld can be paid in a lump sum.

**Parents** of a deceased veteran are entitled to death benefits if their annual income does not exceed $5,718 for two parents and $3,988 for one parent.

**Program Appeals**

The appeal procedures are the same as for Nonservice-connected Pensions. See Appeals section Part 1 – Page 69.
**Legal Authority**


**Sources and Related Resources**

U.S. Department of Veterans Affairs
Regional Office
251 N. Main Street
Winston-Salem, NC 27155
1-800-827-1000

North Carolina Division of Veteran Affairs
227 East Edenton Street
Raleigh, NC 27601
(919) 733-3851

(District offices of the N.C. Division of Veterans Affairs are listed in Appendix L.)

National Veterans Legal Services Project, Inc. (A non-profit law firm that serves as a national support center in the area of veterans’ law. Its services are available to veterans' service organizations, state and county veterans offices, community-based veterans’ organizations, volunteer attorneys, private bar attorneys, Legal Services programs, and other veterans' advocates.)
2001 S Street, NW
Suite 610
Washington, DC 20009
(202) 265-8305

*The Veterans Advocate* (A monthly newsletter, available free of charge to most veterans' advocacy groups and service organizations, and for a small subscription fee to others. Available from the National Veterans Legal Services Project, Inc. at the above address.)

*Veterans Benefits Manual* (A comprehensive manual for advocates available from the National Veterans Legal Services Project, Inc. at the above address. Prices vary depending on the nature of the entity purchasing the book.)
Federal Benefits for Veterans and Dependents (80-page pamphlet published by the U.S. Department of Veterans Affairs, available free from the Regional Office in Winston-Salem and at most district offices of the Division of Veterans Affairs.)
Workers’ Compensation

PROGRAM SPECIFICS

Quick Lookup

What Is It?
An insurance program that provides weekly cash compensation and medical coverage.

Who Is It For?
Workers who have been injured or killed on the job or who have an occupational disease and their dependents.

Where Are Applications Taken?
Notice is initially given to employers. Claims to resolve disputes are filed with the North Carolina Industrial Commission.

Introduction
Workers’ Compensation is a no-fault insurance program that provides both cash compensation and medical coverage to workers who suffer injuries, contract occupational diseases or die as a result of their employment. Most employers are required to carry workers’ Compensation insurance which covers employees regardless of fault. The program is administered by the North Carolina Industrial commission, which is a division of the N.C. Department of Economic and Community Development. There is no federal involvement in the North Carolina Workers’ Compensation program, but federal employees who work in North Carolina are covered by a separate federal Workers’ Compensation program.

Applications
The employee is required to give written notice to his employer immediately after an injury occurs. The notice should include the:

- Name and address of the employee
- Time and place of the accident
- Nature of the accident
• Resulting injury or death

• Signature of the worker or, in the case of death, of a dependent of the worker or someone else on the worker’s behalf

If immediate notice is prevented for some reason, it must be given within 30 days of the injury or no compensation will be paid. (There are limited exceptions to this notice rule; exceptions must be approved by the Industrial Commission.)

As of an **occupational disease**, notice must be given to the employer as soon as possible, but at least within 30 days, after the worker has been notified by a doctor that he/she has the disease and that it is occupationallly-related. (There are exceptions for asbestosis, silicosis, or lead poisoning.)

**Filing a Claim**

In order to protect his/her right to compensation, a worker needs to be sure that a **claim** has been filed with the Industrial Commission. If the employer’s insurance company is in agreement with the worker about the extent of coverage, the insurance company will have filed the claim. If the insurance company or the employer has not filed a claim, the worker can do it on a particular form printed by the Commission (Form 18). A form can be requested by phone by calling the Claims Department at the Industrial Commission at (919) 733-5020.

**Claims must be filed within two years** after the accident occurred, or in the case of an occupational disease, within two years of death or disability. (There is an exception for radiation injury.) **If this time limit is missed, the worker’s right to coverage is barred.**

**Program Benefits**

**Cash Compensation**

Workers who are unable to work as a result of an occupational disease or an on-the-job injury are entitled to a **weekly check** in the amount of **two-thirds of their average weekly wages**. There are minimum and maximum amounts, which are adjusted annually, not to exceed $816.00 (2009 maximum) per week.

The **first check is due on the 14th day** following the injury. No compensation is due for the first seven days of lost time unless the disability exceeds 21 days. Compensation will continue until the worker has been
released by a physician to return to work, or until maximum medical improvement has been attained. If the accident or disease causes permanent total disability, benefits may be paid for life.

An adjusted benefit is payable to workers who are able to return to lighter duty or part-time work.

In cases of permanent total or permanent partial loss of use of particular body parts or organs, weekly compensation may be paid even if the worker is able to resume work and earn wages. Workers suffering injuries that cause permanent scars or disfigurement or that cause permanent injury to bodily organs are entitled to compensation beyond the weekly benefit amount, up to a maximum of $20,000.

**Death Benefits**

If the accident or disease causes the death of the worker, death benefits are payable to the worker’s dependents or next of kin. Benefits are paid at the rate of two-thirds of the worker’s average weekly wages, for 400 weeks. The period of time can be extended if a widow or widower is unable to support him/her or if a dependent child is still a minor. Up to $2,000 is also payable for funeral expenses.

**Medical Coverage**

The injured or disease worker is entitled to whatever medical care is necessary to cure or relieve the condition. This can include physician and nursing services, surgery, hospitalization, prescription drugs, medical supplies, travel, and rehabilitation.

Generally, the medical care is provided at the direction of the employer, In emergency situations, or upon request to and approval by the Industrial Commission, the employee may obtain treatment by medical providers of his/her choice and it will be covered.

Coverage for medical care is 100 %; medical providers may not charge employees for the care given nor may they accept fees in excess of what is approved by the Industrial Commission.

**Program Eligibility**

**Personal Eligibility**

In order to be eligible for workers’ compensation, the worker must:
• Work for an employer who employs three or more employees and not be excluded from coverage (See exclusions below)

• Have suffered an injury which
  ▪ Was caused by an accident, and
  ▪ Arose out of employment, and
  ▪ Was sustained in the course of employment, or

• Be disabled or have died as a result of an occupational disease which is covered by the law

Minors or aliens employed illegally are covered by the law.

Exclusions

Certain workers are not covered by the Workers’ Compensation law and their employers are not required to insure them. These include:

• Casual employees
• Farm laborers when fewer than ten full-time non seasonal farm laborers are regularly employed by the same employer
• Domestic servants
• Certain railroad workers (who are covered by other laws)
• Prisoners being worked by the state, unless the prisoner died or suffered an injury which continued past his/her release
• Sellers of agricultural products for the producer
• Independent contractors

In addition, a worker who is covered by the law may not be entitled to coverage for his/her injuries or death if it is determined that the injury or death was caused because:

• The worker was intoxicated, unless the intoxicant was provided by the employer, or
• The worker was under the influence of illegal drugs, or
• The worker willfully intended to injure or kill himself or another

Covered Injuries
Not all on-the-job injuries are compensable under the workers’ Compensation program. Following is a brief description of some on the most significant requirements.

Advocate Tip: The law of Workers’ Compensation is very complex. As soon as a worker discovers that his/her claim for compensation has been denied, he/she should seek the services of an attorney experienced in this area. As a rule, Workers’ Compensation cases are handled on a contingency basis by lawyers, meaning that there will be no upfront fee and there will be no fee at all unless the worker ultimately recovers benefits. If the case is successful, the attorney fee will be a percentage of the recovery; in all cases the amount of the fee must be approved by the Industrial commission.

Accident

In order for an injury to be covered, it must have been caused by an accident. An accident is an unusual and unexpected occurrence, which results produced by a fortuitous cause. Injuries that are the result of the employee performing his/her regular duties in the usual and customary manner are generally not compensable.

Two major exceptions to the requirement that there must be an accident involve back injuries and hernias. These injuries may be covered in the absence of an accident, and if they were sustained by the employee performing his/her regular duties in the usual and customary way. There must have been a specific traumatic incident that resulted in the injury, however, rather than a gradual onset of the injury or disability.

In the Course of Employment

An accident must occur in the course of employment to be covered. This means it occurs during the time the employee is engaged in work activities (which includes a reasonable period before and after work and break periods), at a place where the employee is authorized to be, and while he/she is engaged in an activity that is authorized by the employer. Accidents that occur while the employee is traveling to and from work generally are not covered.

Arising Out of Employment
The accident also must have been **cause by** or must **have sprung from the employment** to be covered. The risk of injury must be inherent in the work, and not a risk that is experienced by the population as a whole. Nevertheless, the employment need not be the whole cause of the accident.

**Covered Occupational Disease**

The law lists several dozen specific diseases that are covered by the Workers’ Compensation program, and includes a “catch-all” definition which reads as follows:

Any disease… which is proven to be due to cause and conditions which are characteristic of and peculiar to a particular trade, occupation or employment, but excluding all ordinary disease of life to which the general public is equally exposed outside of the employment.

As with accidental injuries, the **employment need not be the sole cause of the disease** for it to be covered. Special rules apply to hearing loss, asbestosis, silicosis, and byssinosis. A worker should immediately consult an attorney of the Industrial Commission for advice upon suspecting he/she has one of these conditions.

**Financial Eligibility**

Workers’ Compensation is not a needs-based program. Therefore, there are no income or resource guidelines which must be met. Benefits are payable regardless of other sourced of income or assets. Nevertheless, certain other benefits, such as Social Security Disability benefits, may be reduced because of the receipt of Workers’ Compensation.

**Program Appeals**

**Memorandum of Agreement**

If the worker and the employer (usually through the employer’s insurance company) agree to coverage that will be provided, a memorandum of agreement should be filed with the Industrial Commission. No appeal is necessary.

**Deputy Commissioner Hearing**
If the parties cannot agree, however, **either party has the right to appeal to the Industrial Commission for a hearing** on the issues of disagreement. There is no time limit within which a hearing must be requested, so long as a claim has been filed with the Industrial commission within the two-year time limit discussed above.

The hearing will be conducted by a hearing officer, known as a “Deputy Commissioner,” who is employed by the Industrial Commission for this purpose. Hearings usually are held in the county in which the injury occurred. Scheduling may take several months.

The hearing is a trial-like proceeding at which both parties may present their cases. *The insurance company will virtually always be represented by an attorney; it would be unwise for a worker to attend the hearing unrepresented.* Attorneys generally accept Workers' Compensation cases on a contingency fee basis. This means that the injured worker need not pay the attorney unless a favorable decision is reached. Generally, the attorney fee is a percentage of the amount awarded. The amount of the fee must be approved by the Industrial Commission.

At the hearing, sworn testimony will be taken, and documents or other evidence will be received. It is the Deputy Commissioner’s duty to determine the facts, apply the law and make an award if one is merited. A decision will be made within 180 days of the close of the hearing record, unless for good cause the time is extended.

**Review by the Full Commission**

If either party is dissatisfied with the decision of the Deputy Commissioner, he/she may request a **review by the full Commission** within 15 calendar days of the receipt of the decision. The three-member Industrial Commission will review the case. Usually, the Commission allows oral argument on legal points only, although it is authorized to hear additional evidence. The Commission can affirm the decision of the Deputy Commissioner or amend it as the Commission sees fit. The Commission has the authority to make its own determinations regarding the weight and credibility of the evidence heard by the Deputy Commissioner.

**Judicial Review**

Within 30 days of receipt of the Commission’s final decision, either party may appeal to the North Carolina Court of Appeals. The facts as determined by
the Commission are conclusive; only questions of law will be addressed by
the Court.

**LEGAL AUTHORITY**


State Regulations: Rules and Regulations of the N.C. Industrial
Commission (available by sending $5 to the Industrial
Commission at the address below)

**SOURCES AND RELATED RESOURCES**

North Carolina Industrial Commission
Dobbs Building
430 N. Salisbury Street
Raleigh, NC 27603
(919) 733-5020

Jernigan, *North Carolina Workers’ Compensation Law and Practice with Forms*,
Part 2: Food and Nutrition Programs

Food and Nutrition Services ..................................................1
Senior Nutrition Program .......................................................8
Women, Infants, and Children Program .................................14
Food Banks/Pantries ..............................................................17
Food and Nutrition Services
(Formally Food Stamps)

Program Specifics

Quick-Lookup

What is it?

A Federal Food Assistance plan designed to help low income families maintain health and nutrition.

Who is it for?

Eligible low income households

Where are applications taken?

Applications for Food and Nutrition Services are taken at local county Departments of Social Services in the county in which the household resides.

Introduction

Food and Nutrition Services (FNS) is a federal food assistance program that helps low-income families. In North Carolina monthly allotments of FNS benefits are issued via Electronic Benefit Transfer cards (EBT cards). The purpose of Food and Nutrition Services is to end hunger and improve nutrition and health. It helps eligible low-income households buy the food they need for a nutritionally adequate diet.

Food and Nutrition Services is an entitlement program, so all eligible individuals and households can receive assistance. Benefits may be used to purchase most foods at participating stores. They may not be used to purchase tobacco, pet food, paper products, soap products, or alcoholic beverages.

Eligible households must have the opportunity to access benefits no later than thirty days from the date of application. Individuals with special circumstances must have an opportunity to use their benefits within seven days from the date of application.

Applications
Some counties have Food and Nutrition Services outreach offices as well. Persons who live in households consisting only of SSI (Supplemental Security Income) applicants or recipients may apply for Food and Nutrition Services at the Social Security Administration Office. An application for the Food and Nutrition Services can be downloaded via online at:

http://info.dhhs.state.nc.us/olm/forms/dss/dss-8207.pdf

**Program Benefits**

Monthly charge allotments on EBT cards are received upon acceptance of the application. The Electronic Benefit Transfer cards can only be used to purchase food products and certain necessities tobacco, pet food, paper products, soap products, or alcoholic beverages cannot be purchased with the EBT card.

The amount of benefit relies on the household size and is weighted by Gross Income.

<table>
<thead>
<tr>
<th>FNSU Size</th>
<th>Gross Income</th>
<th>Maximum Benefit Allotment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$1,127</td>
<td>$200</td>
</tr>
<tr>
<td>2</td>
<td>$1,517</td>
<td>$367</td>
</tr>
<tr>
<td>3</td>
<td>$1,907</td>
<td>$526</td>
</tr>
<tr>
<td>4</td>
<td>$2,297</td>
<td>$668</td>
</tr>
<tr>
<td>5</td>
<td>$2,687</td>
<td>$793</td>
</tr>
<tr>
<td>6</td>
<td>$3,077</td>
<td>$952</td>
</tr>
<tr>
<td>7</td>
<td>$3,467</td>
<td>$1052</td>
</tr>
<tr>
<td>8</td>
<td>$3,857</td>
<td>$1202</td>
</tr>
<tr>
<td>Each Additional Member</td>
<td>($390)</td>
<td>($150)</td>
</tr>
</tbody>
</table>

**Program Eligibility**

**Personal Eligibility**

**Household Composition**

Individuals residing together, but purchasing and preparing their meals separately, may participate in FNS as a separate household. Some
individuals must participate in FNS as one household even though they purchase and prepare their meals separately.

Individuals who must participate in FNS as one household are:

- Individuals living together who purchase/prepare their food together or will do so upon receipt of food assistance
- Spouses living together or individuals representing themselves as husband and wife to the community
- Individuals under 22 living with a parent
- Individuals under 18 under the parental control of an adult living in the home; or
- Two unmarried adults living in the same home who are parents of a mutual child

**Citizenship/Immigration Status**

Each member of the FNS household must be a U. S. Citizen or an immigrant admitted to the United States under a specific immigration status. Citizens and eligible immigrants must also meet all other FNS eligibility requirements to receive assistance.

**Work Requirements**

Some individuals are required to participate in Food and Nutrition Services work programs, such as Employment and Training and Workfare. These individuals must meet special work requirements. Able-bodied adults between 18 and 49 who do not have any dependent children can get benefits only for 3 months in a 36-month period if they do not work or participate in a Workfare or Employment and Training program other than job search. Other members of the household may continue to get benefits even if this person is not eligible. In some locations, this requirement does not apply.

This limited eligibility requirement does not apply if the adult:

- Works 20 hours a week (or 80 hours a month), or is engaging in a variety of allowable work-related activities for the same amount of time (such as Employment and Training, WIA, etc.), or
- Is pregnant or disabled, or
- Lives in a home where a child under the age of 18 resides.
In addition, adults in certain economically distressed counties are exempt from this requirement.

**Advocate Tip:** Many women and children in Food and Nutrition Services households are also eligible for food assistance through the Women, Infant and Children (WIC) program, administered by the NC Division of Public Health.

### Financial Eligibility

#### Income


A household may be eligible for Food and Nutrition Services if the household’s total income falls below the gross income limits for the corresponding household size. Please be aware that the eligibility workers at the local county Department of Social Services have many other factors to consider in determining eligibility.

"Household" size refers to the number in the household who may be eligible for FNS. Individuals who receive SSI, WFFA, or the household with an aged or disabled individual may have different eligibility requirements.

#### Resources

Households may have $2,000 in countable resources, such as bank accounts and money in certain retirement accounts. Households may have $3,000 if at least one person is age 60 or older or disabled. Certain resources are not counted, such as homes, buildings, and land. The resources of people who receive Supplemental Security Income (SSI) or Work First payments or services are not countable.

### Eligibility Documentation Requirements

The following chart describes the Food and Nutrition Services Eligibility Documentation Required.
**PLEASE NOTE:** In reference to the "What's Needed" column on the chart, if unable to establish eligibility for assistance, additional information may be required.

<table>
<thead>
<tr>
<th>Eligibility Requirement</th>
<th>What's Needed</th>
<th>How Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identity</td>
<td>Contact with someone knowledgeable of your situation, ID</td>
<td>At application or if questionable</td>
</tr>
<tr>
<td>Address/ Living With/Living Arrangement</td>
<td>Lease, rental agreement, contact with someone knowledgeable of your situation</td>
<td>At application, review, change in situation, if moving</td>
</tr>
<tr>
<td>Age</td>
<td>Birth certificate/date of birth</td>
<td>Client's statement acceptable</td>
</tr>
<tr>
<td>Kinship</td>
<td>Client statement, contact with someone knowledgeable of your situation</td>
<td>At application, review, change in situation</td>
</tr>
<tr>
<td>Citizenship/ Alien Status</td>
<td>Verification of citizenship/alien status via Immigration and Naturalization Service</td>
<td>At application, or whenever appropriate</td>
</tr>
<tr>
<td>Social Security Number</td>
<td>Valid social security card or number</td>
<td>At application or until received</td>
</tr>
<tr>
<td>Student Status</td>
<td>Bank records, student's financial records</td>
<td>At application, as needed</td>
</tr>
<tr>
<td>Emancipation</td>
<td>Marriage certificate, court records, Military ID</td>
<td>As needed</td>
</tr>
<tr>
<td>Work Capacity</td>
<td>Medical statement from doctor</td>
<td>As needed</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Statement from doctor</td>
<td>At application, as needed</td>
</tr>
<tr>
<td>Health Insurance</td>
<td>Seeing policy or card</td>
<td>As needed</td>
</tr>
<tr>
<td>Income:</td>
<td>Wage stubs, tax forms contacting employer, Documents from provider, award letter</td>
<td>At application, review, change in situation</td>
</tr>
</tbody>
</table>

Wages/Self-Employment Public Benefits/ Private Retirement Benefits/ Trust, etc.
### Assets/Resources

<table>
<thead>
<tr>
<th>Ownership and tax records - bank and court documents</th>
<th>At application, review, change in situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gas and Electric Bills</td>
<td>Copy of bills</td>
</tr>
<tr>
<td></td>
<td>At application, review, and change in situation</td>
</tr>
</tbody>
</table>

### Online Screening Tool

The USDA has provided a screening for use to determine if a house is potentially eligible. The USDA screening tool can be found at [http://www.snap-step1.usda.gov/fns/index_en.jsp](http://www.snap-step1.usda.gov/fns/index_en.jsp)

### Program Appeals

The household is entitled to:

- Receive an application when they ask for it.
- Turn in their application the same day they receive it.
- Receive their Food and Nutrition Services (or be notified that they are not eligible for the program) within 30 days after they turn in their application.
- Receive Food and Nutrition Services within 7 days if they are eligible for emergency benefits.
- Have a fair hearing if they disagree with any action taken on their case.

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

### Sources and Related Resources

To learn more about Food and Nutrition Services please visit the United States Department of Agriculture's web site: [http://www.fns.usda.gov.fsp](http://www.fns.usda.gov.fsp)

If you have questions or comments please feel free to contact us via email [http://www.ncdhhs.gov/dss/contact/email_form.aspx](http://www.ncdhhs.gov/dss/contact/email_form.aspx)
Senior Nutrition Program
[Referred to as Elderly Nutrition Program by the Administration on Aging (AoA)]

Program Specifics

Quick Lookup

What Is It?

A program to provide meals and supportive services to adults age 60 and over.

**Congregate Nutrition:** A service where a meal (typically lunch), offering one-third of the Recommended Dietary Allowance or RDA (sometimes referred to as Recommended Daily Allowance), is provided in a group setting such as a senior center.

**Home-Delivered Meals:** A service that provides a meal (typically lunch) to a home-bound older adult, offering one-third of the Recommended Dietary Allowance or RDA (sometimes referred to as Recommended Daily Allowance).

Who Is It For?

**Congregate Nutrition:** Anyone age 60 or older and their spouse regardless of age when the older adult is a nutrition client. There is no financial eligibility test.

**Home-Delivered Meals:** Persons age 60 or older who are physically or mentally unable to obtain food or prepare meals, who have no responsible person who is able and willing to perform this service, and who are unable to participate in a congregate nutrition program because of physical or mental impairment. There is no financial eligibility test.

Where Are Applications Taken?

Area Agencies on Aging or local Nutrition Providers (Departments on Aging or Councils on Aging are common nutrition providers).

**Advocate Tip:** If you do not know who the local Nutrition Provider is in your area, the Area Agency on Aging will have the contact information. The state has 18 Area Agencies on Aging,
which are listed with their addresses and telephone numbers in Appendix A

Introduction

Persons age 60 or over and their spouses are eligible to receive meals provided through the Senior Nutrition Program. The Division of Aging and Adult Services, within the North Carolina Department of Health and Human Services, distributes federal money to Area Agencies on Aging, which then contract with other organizations to provide meals at senior centers and other locations (congregate), and to provide home-delivered meals.

At the federal level, the program is administered by the U.S. Department of Health and Human Services, and authorized under Titles III and VI of the Older Americans Act. Title III is administered by the state Division of Aging (NC Division of Aging and Adult Services in North Carolina) and Title VI by Indian tribal organizations.

Applications

Individuals may participate in the Senior Nutrition Program by calling the local Area Agency on Aging or local Nutrition Provider (Departments of Aging or Councils on Aging are common providers). The state has 18 Area Agencies on Aging, which are listed with their addresses and telephone numbers in Appendix A.

Advocate Tip: The Senior Nutrition Program is a dollar-limited program, not an entitlement program, and providers can serve eligible people only as funding permits.

Congregate Nutrition:

Meals can normally be received at a congregate site the day following application. However, if funding is not available, the individual will be placed on a waiting list.

Priority is given to:

- People in adult protective services.
- People at risk of needing adult protective services
- People with health impairments who need nutritional support or people whose living arrangements do not provide adequate meal preparation facilities.
Home-Delivered Meals:

Before a meal can be delivered, providers must conduct an in-home assessment within 7 working days from the date of the referral. Eligibility must be determined (and notification sent) within 10 working days of the assessment. Once determined to be eligible, the person will receive a meal or be placed on a waiting list. A written reassessment must be conducted every 6 months unless the client is on temporary meal status.

Priority is given to:

- People in adult protective services.
- People at risk of needing adult protective services
- People without a caregiver or other responsible party assisting with care.
- People who have ADL impairments (self-care limitations) and IADL impairments (household management limitations)

**Advocate Tip:** Additional factors determine when a client is removed from the waiting list and made active; therefore it is difficult to say how long a person typically remains on the waiting list. Factors affecting client status (active or waiting) may include: 1) route capacity (only 14 people can be on a delivery route at any given time; 2) delivery route structure (due to temperature regulations, the routes must be completed within one hour from the starting point to the last delivery location; 3) funding.

**Program Benefits**

**Meals are provided either at congregate nutrition sites or at the older adult’s home.** Participants are usually asked to make a contribution for the congregate or home delivered meal, but it is not required (food stamps may be used to purchase meals).

Nutrition providers typically offer more than a meal to their participants. They play a critical role in reducing social isolation, promoting health, and preventing physical and mental decline. In most communities, nutrition providers provide screening, assessment, counseling, education, programming, service coordination, and referrals to other agencies.
Congregate Nutrition:

Most programs serve one meal per day, five days per week at midday. The meal must contain one-third of the Recommended Dietary Allowance or RDA (sometimes referred to as Recommended Daily Allowance) of nutrients. Providers are encouraged to offer reduced sodium, low fat, low sugar meals because they are healthy, but some nutritional needs demand strict adherence to diets that cannot be met as part of the broader program.

In some instances, transportation to and from the meal sites is also provided. Participants are usually asked to make a contribution for the transportation, but it is not required.

Many programs have an advisory council made up of project participants that makes decisions regarding menus and other parts of the program. (See chapter on Services for the Adults over 60.)

Home-Delivered Meals: (also referred to as Meals on Wheels):

Volunteers deliver meals Monday through Friday at midday to the homebound older adult’s home and often spend some time with the recipient(s), helping to decrease their feelings of isolation. The volunteers (or staff when volunteers are unavailable) also check on the welfare of the recipient and are encouraged to report any health or other problems they may note during their visits.

Program Eligibility

Congregate Nutrition:

- People age 60 or over and their spouses regardless of age when the older adult is a nutrition client.
- Local providers have the option, based on the Area Agency on Aging’s written procedures, to offer congregate meals to volunteers who work during meal hours.
- Local providers have the option to offer congregate meals to people under age 60 with disabilities who reside with and accompany eligible people to meal sites.
- Local providers have the option to offer congregate meals to people under age 60 with disabilities who reside in housing facilities occupied primarily by older adults at which a congregate nutrition site is located.
Home-Delivered Meals:

- People age 60 or over who are physically or mentally unable to obtain food or prepare meals, who have no responsible person who is able and willing to perform this service, and who are unable to participate in a congregate nutrition program because of physical or mental impairment.

- The spouse of an older person, if one or the other is homebound by reason of illness or incapacitating disability is also eligible.

- The family caregiver of an eligible homebound older adult.

- Local providers have the option to offer home delivered meals to volunteers who work during meal hours.

- Local providers have the option to offer home delivered meals to people under age 60 with disabilities who reside at home with an eligible older adult.

There are no financial eligibility criteria for senior nutrition services; however, services are targeted to older adults who are economically or socially needy, live in rural areas, have severe disabilities or limited English-speaking ability, and older adults with Alzheimer’s or related disorders and their caregivers.

**Advocate Tip:** Nutrition providers have some local flexibility to interpret what homebound means for the home delivered meals program. A person does not have to be bedridden to be generally confined to his or her home, but leaving home for non-medical reasons should be for short periods of time or infrequently.

**Legal Authority**


Federal Regulations: 45 C.F.R. Chapter XIII, Subchapter C, Part 1321

North Carolina Division of Aging and Adult Services has the following on their website under Legal Base:

**Older Americans Act of 1965 as amended**

(as codified in Title 42 of the United States Code, Chapter 35, sec. 3001 et seq.)

[Official compilation not available as of 7-1-03—see AoA website for unofficial compilation: http://www.aoa.gov/]

[Senior Nutrition Program] Part 2 - Page 11
Title 45, Code of Federal Regulations, Part 1321 (Grants to State and Community Programs on Aging)
http://www.access.gpo.gov/nara/cfr

Sources and Related Resources

N.C. Department of Health and Human Services
Division of Aging and Adult Services
Physical Address: Taylor Hall, 693 Palmer Drive, Raleigh, NC  27699-2101
Mailing Address: 2101 Mail Service Center, Raleigh, NC 27699-2101
Phone: (919) 733-3983
Fax: (919) 733-0443
Website: http://www.ncdhhs.gov/aging/

The Division of Aging and Adult Services has a Directory with information about these programs on a county-by-county basis, along with other Home and Community Care Block Grant services. This directory is available on-line at http://www.ncdhhs.gov/aging/meals.htm

North Carolina Legal Services Resource Center (See Appendix H)
The Special Supplemental Program for Women, Infants, and Children (WIC)

PROGRAM SPECIFICS

Quick Lookup

What Is It?

The Special Supplemental Nutrition Program is a program for Women, Infants, and Children up to 5 years old. It serves as a resource for clients to receive nutrition education, breastfeeding support and services, healthy foods, and a referral resource for health care or other programs. Healthy foods include fruits and vegetables, whole wheat bread/whole grains, milk, eggs, whole grain cereals, juice, tofu, infant formula and other foods to eligible recipients.

Who Is It For?

The Program is for pregnant and postpartum women, infants, and children under age five who are nutritionally at risk and have a family income not exceeding 185% of the federal poverty guidelines. A family is defined as a group of people, related or unrelated, who live together and function as one economic unit. The income of everyone in the family is counted to determine eligibility. The agency should consider the income of the family in the past twelve months and the family’s current rate of income to determine which more accurately reflects the family’s status. An applicant/participant who receives Food and Nutrition Services, Work First, or Medicaid is automatically income-eligible for WIC and no additional income screening is necessary. Even in locations where verification of income is required, those who receive these benefits need not show any additional proof to establish financial eligibility for WIC.

Introduction

The WIC program is a federally-funded program that began in North Carolina in 1974. It provides food supplements and nutrition education for eligible recipients who are at nutritional risk. Because this is not considered an entitlement program, not all who meet the eligibility criteria will receive benefits.

Applications

Applications are taken at the local WIC program sites by appointment, which are usually county health departments or community health centers. Information about the WIC provider in a specific area can be obtained from
the North Carolina Family Resource Line at 1-800-FOR-BABY (1-800-367-2229) from 8 a.m. to 5 p.m. Monday through Friday. The application will require the applicant to provide information on residence, income and other eligibility factors.

**Program Benefits**

- Nutritious foods and nutrition supplements
- Nutrition education and assessment
- Breastfeeding support and education
- Referrals for Healthcare

**Nutrition Education**

Each local program must make available free nutrition education as well as specific counseling tailored to the individual participant’s need. WIC participants who decline the nutrition education benefits of the program may not be denied the food supplements as a result. Nutrition education should be simple and take into account the cultural and personal preferences of the participants. Pregnant women must be given information on breastfeeding and other aspects of infant feeding. Families of children less than 5 years old should receive age appropriate information.

**Program Appeals**

WIC applicant and participants have the right to a fair hearing to contest any local program decision regarding initial eligibility or subsequent termination of benefits. Local program must give participants at least 15 days’ notice if they plan to terminate benefits.

**Sources and Related Resources**

The North Carolina Department of Health and Human Services  
Division of Public Health  
Women’s and Children’s Health Section  
Nutrition Services Branch  
1914 Mail Service Center  
Raleigh, NC 27699-1914  
(919) 707-5800

North Carolina Family Health Resource line 1-800-FOR-BABY (1-800-367-2229) (Can provide information about the nearest WIC provider as well as other information regarding pregnancy and babies.) or [http://www.nutritionnc.com/wic/](http://www.nutritionnc.com/wic/).
North Carolina Legal Services Resource Center
224 S. Dawson Street
P.O. Box 27343
Raleigh, NC 27611
(919) 856-2121

Pitt County Public Health Center
201 Government Circle
Greenville N.C 27834
(252) 902-2393
http://www.pittcountync.gov/depts/health/
Food Banks/Pantries:

Program Specifics

The Food Bank of Central & Eastern North Carolina (www.foodbankcenc.org) receives food donations from donors and distributes them to partner agencies (such as rescue missions, food pantries, soup kitchens, and after school programs) in our 34-county service area.

People who need food need to contact the rescue missions, food pantries, soup kitchens or after school program to receive food. The Food Bank is collect food for those organizations that will give it away to consumers. You can contact the food bank that provides services to your county to get information about who their partner agencies are in their area for referral purposes. You can also go online to find the partner agency through a locator tool: http://content.foodbankcenc.org/about/zip.asp. Just enter a zip code or county into the tool and they will display the list of programs providing food.

Mission

The mission of the Food Bank of Central & Eastern North Carolina is to harness and supply resources so that no one goes hungry in central and eastern North Carolina.

Strategies to achieve this mission include:

- Efficiently distributing high quality foods and non-food essentials to nonprofit agencies that serve the hungry - strengthen the agencies directly responsible for distributing food and non-food items.
- Extend Food Bank services to underserved communities within our service area
- Advocate ways to eliminate hunger
- Grow our financial resources in order to achieve our mission

Branch Warehouses and Contacts:

The Food Bank of Central & Eastern NC at Durham:
708 Gilbert Street, Durham, NC 27701
Phone: 919-956-2513
Fax: 919-956-7083
Business Hours: Monday - Friday, 8:30 a.m. to 5 p.m.
The Durham Branch of the Food Bank of Central & Eastern North Carolina serves 6 counties in central North Carolina. They are Chatham, Durham, Granville, Orange, Person and Vance County.

**Raleigh - Administrative Office and Warehouse**

3808 Tarheel Drive, Raleigh, NC 27609  
Phone: 919-875-0707  
Fax: 919-875-0801  
Business Hours: Monday - Friday, 8:30am to 5pm  
Receiving: Monday -Friday, 8:30am to 5:30pm; Saturday 8am-12pm  
Warehouse Contact: Julius Colbert, Warehouse Manager

The Food Bank of Central & Eastern NC at Greenville:  
497 West Ninth Street, Greenville, NC 27834  
Phone: 252-752-4996  
Fax: 252-752-1821  
Business Hours: Monday - Friday, 7:30am to 4 pm.

The Greenville Branch of the Food Bank of Central & Eastern North Carolina serves 8 counties in eastern North Carolina. They are Carteret, Craven, Greene, Jones, Lenoir, Onslow, Pamlico and Pitt County. Three counties served are shared with the Raleigh Branch; these counties are Duplin, Edgecombe and Wilson County.

The Food Bank of Central & Eastern NC at Sandhills:  
195 Sandy Avenue, Southern Pines, NC 28387  
Phone: 910-692-5959  
Fax: 910-692-5910  
Business Hours: Monday - Friday, 8am to 4:30pm.

The Sandhills Branch of the Food Bank of Central & Eastern North Carolina serves 3 counties in south central North Carolina. They are Moore, Richmond and Scotland counties. One county served is shared with the Raleigh Branch, Lee County.

The Food Bank of Central & Eastern NC at Wilmington:  
1314 Marstellar Street, Wilmington, NC 28401  
Phone: 910-251-1465  
Fax: 910-251-3591  
Business Hours: Monday - Friday, 8:30 a.m. to 5 p.m.

The Wilmington Branch of the Food Bank of Central & Eastern North Carolina service 4 counties in southeastern North Carolina. They are Brunswick, Columbus, New Hanover and Pender County.
Part 3: Health Programs

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Hill-Burton

Program Specifics

Quick Lookup

What Is It?

A federal program through which hospitals and other health care facilities provide free and reduced-fee care and engage in certain other practices that increase access to health care.

Who Is It For?

Free and reduced-fee services are available to persons whose incomes are below the federal poverty guidelines who receive medical care at participating health care facilities. The other benefits are available to anyone who lives or works in the service area of a participating health care facility.

Where Are Applications Taken?

At participating health care facilities.

Introduction

The Hill-Burton program was begun in 1947 to assist health care facilities to build, enlarge, or modernize their facilities. Federal funds were made available to hospitals, nursing homes, clinics, and other facilities. Instead of paying back the money, the facilities agreed to provide certain health care benefits to patients. Almost all the hospitals and a large number of other health care facilities in North Carolina participated in the program.

The Hill-Burton program is administered on the federal level by the U.S. Department of Health and Human Services (HHS). The state government is not involved in the administration of Hill-Burton.

Applications

The following application process applies to the uncompensated care component of Hill-Burton. The community service portion has no specific application process, as it is a matter of policy within the facilities.
The patient, or someone assisting the patient, must apply for free or reduced-fee service with the facility. **Applications may be filed at any time** before or after the service is given, even after the facility has turned the account over to a collection agency or filed suit in court to collect the amount owed. **Eligibility is based on income at the time of the application, not at the time the service was rendered.**

The facility may require **reasonable verification of income** as part of the application process. In addition, it may require that the patient **apply for any possible benefits under government programs or other third party insurers.**

**Time Frames**

Facilities other than nursing homes have **two working days** to make a determination of eligibility **if the patient applied before** receiving outpatient services or before being discharged from inpatient care. If the **application was made after** receipt of services or discharge, the facility has **until the end of the first full billing cycle** to make a determination.

**Nursing homes have ten working days to make a determination** if the application is made prior to admission, but no more than **two working days** following admission. Nursing homes also have until the end of the next billing cycle to make a decision if the patient has been discharged.

If the facility has insufficient information to make a decision within the required time limits, it may make a conditional eligibility decision. A conditional decision will state the conditions under which the applicant will be found eligible.

**Note of Determination**

Decisions on eligibility must be **in writing** and a copy given to the applicant. If eligibility is denied, the reasons for the denial must be included in the written notice. If the application is approved, it should notify the patient whether he/she will receive free service or reduced-fee service.

**Advocate Tip**: The most common reasons for patient to be denied are that the patient had family income over the limit or that the facility has exhausted its free care requirement for the period of time in which the application was made. In either case, the patient can apply again if the circumstances change. If the bill has not been paid, and the family income later decreases, another
application can be filed. In this instance, the income eligibility decision should be made based on the income at the time of the second application. Likewise, if the family income is within the limits but the uncompensated care obligation was satisfied at the time of the second application, a new application can be made when a saw “allotment” of uncompensated care is available.

Program Benefits

Health care facilities participating in Hill-Burton have two obligations. One is known as the “uncompensated care” obligation; the other is the “community services” obligation.

Uncompensated Care

Health care facilities are required to provide a certain amount of free or reduced-fee care each year for 20 years after completion of the construction project using Hill-Burton funds. Each year, the value of the care provided must be at least three percent of the facility’s operating costs for the most recent fiscal year or ten percent of all federal funds received, adjusted for inflation, whichever is less. There are provisions to allow “excess services” in any year to be credited against future years, permitting the facility to complete its 20 years’ obligation in fewer than 20 years.

Most health care facilities in North Carolina have already completed their obligation to provide uncompensated service. HHS must do an audit to certify completion. An advocate can call the Atlanta Regional Office of HHS at (404) 331-2109 to check on whether an individual health care facility has completed its obligation.

Uncompensated Services Plan

The participating facilities have some flexibility in designing their own plans for the distribution of free and reduced-fee care. Each Hill-Burton facility must adopt an “uncompensated services plan” listing the following:

- The types of service available for free care coverage.
- How the services will be allocated through the year (for example, whether one-twelfth will be allocated each month, or one-quarter in each three-month period, etc.)
- What income levels will be used to determine eligibility (The facility has the option to provide uncompensated services to those with
incomes under the federal poverty guidelines or to those with incomes under twice the federal poverty guidelines.)

The plan and any subsequent modifications must be published in a newspaper of general circulation in the facility’s area and are not effective until 60 days after publication.

**Notice of the Availability of Uncompensated Services**

Each Hill-Burton facility must post notice of the availability of uncompensated services in appropriate areas, such as the admissions areas, the business office, and the emergency room. In addition, the facility must provide individual written notices to each person who seeks services in the facility. The facility must make reasonable efforts to communicate the contents of the written notice to individuals who it has reason to believe cannot read or cannot read English.

**Community Services**

Under the community services obligation, a Hill-Burton facility must make its services available to anyone who lives within the facility’s service area and has some means of payment. It must make emergency services available to anyone who lives or works within its service area, regardless of that person’s ability to pay.

There is no time limit on the community services obligation, as long as the facility is operated by a non-profit or public entity. If the facility is sold to a for-profit entity, special buyout rules apply.

**Non-discrimination policy**

A Hill-Burton facility may not discriminate on any grounds unrelated to an individual’s need for the service or the availability of the needed service at the facility. The facility may not exclude Medicare or Medicaid recipients or establish practices that make it difficult for recipients of those programs to be admitted to the facility. It may not exclude anyone on the grounds of race, color, national origin, religion, or creed.

A Hill-Burton facility may determine, however, that the prospective patient does not need the medical service requested, needs a service not offered at the facility, or has no ability to pay for the services or make any arrangements to pay for the services. In these cases, the facility may refuse to admit a patient (except for needed emergency services).
Prohibited Exclusionary Policies

- Certain practices are specifically prohibited for Hill-Burton facilities. They include:
- Policies that exclude patients who do not have a physician with staff privileges
- Requirements for advance deposits, if no alternative arrangements are offered to persons who could pay in smaller amounts on the bill

Program Eligibility

The facility may determine the financial guidelines for eligibility for free or reduced-fee care, within certain limits. It must include those persons with an individual or family income at or below the federal poverty guidelines. It may include persons with an individual or family income at or below the federal poverty guidelines. The facility may decide who will receive free care and who will receive reduced-fee care.

The 2008 federal poverty guidelines are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Annual Incomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$10,400</td>
</tr>
<tr>
<td>2</td>
<td>$14,000</td>
</tr>
<tr>
<td>3</td>
<td>$17,600</td>
</tr>
<tr>
<td>4</td>
<td>$21,200</td>
</tr>
<tr>
<td>5</td>
<td>$24,800</td>
</tr>
<tr>
<td>6</td>
<td>$28,400</td>
</tr>
<tr>
<td>7</td>
<td>$32,000</td>
</tr>
<tr>
<td>8</td>
<td>$35,600</td>
</tr>
</tbody>
</table>

Evaluation of Income

Gross income is counted to determine eligibility. Income may be determined either by using actual figures for the twelve months preceding the application for service or by taking the income for the preceding three months and multiplying this figure by four. If either of these methods results in low enough annual income, the person should be found eligible.
Program Appeals

Appeals are made by filing a written complaint with the U.S. Department of Health and Human Services (HHS). Any person may file a complaint alleging that the facility has failed to comply with any requirement of either the uncompensated services or community services obligation. If HHS finds a violation, it may order appropriate corrective action.

Filing Requirements

A complaint that a facility has failed to meet its uncompensated service requirement should be mailed to:

Division of Facilities Compliance and Recovery
Parklawn Building
5600 Fishers Lane
Room 16C-17
Rockville, Maryland 20857

A complaint that a facility is out of compliance with its community service obligation should be mailed to:

Division of Facilities Compliance and Recovery
Parklawn Building
5600 Fishers Lane
Room 16C-17
Rockville, Maryland 20857

The complaint must include the following information:

- The name and address of the person making the complaint
- The name and location of the facility
- A statement of the actions that violate the requirements of the Hill-Burton program

Procedure

HHS may investigate and first attempt mediation with the facility if it determines there is merit to the complaint. If mediation is not successful,
HHS may issue a decision that requires the facility to submit an “affirmative action plan” to bring itself in compliance with its obligations and to make up for past noncompliance. Alternatively, HHS may request the Attorney General to file legal action against the facility to seek compliance.

If HHS determines it will not be able to act on a complaint within six months, it may “dismiss” the complaint and allow the complaining party to file a lawsuit to force compliance. If the complaining party does not wish to wait to see if HHS will dismiss the case, it can request a “right to sue” letter. If HHS has not acted on the complaint at all within the six months after it was submitted, the complainant may go forward in court without a “right to sue” letter.

Lawsuits to enforce the Hill-Burton obligations must be filed in federal district court.

**Legal Authority**


Federal Regulations: 42 C.F.R. 124.500 et seq.

**Sources and Related Resources**

U.S. Department of Health and Human Services  
(see addresses in Appeals section)

North Carolina Legal Services Resource Center  
224 S. Dawson Street  
P.O. Box 27343  
Raleigh, NC 27611

Medicaid

Program Specifics

Quick Lookup

What Is it?

A joint state-federal program that pays for a wide range of health care needs.

Who Is It For?

Persons who are over 65, or disabled, or blind; children; caretaker relatives of children; and pregnant women. Recipients must meet a variety of income and resource tests.

Where Are Applications Taken?

At county Departments of Social Services. Some hospitals, rural health clinics, and county health departments also take applications. Applications may also be downloaded from the internet and mailed in to DSS. Decisions on applications should be made within 45 or 90 days, depending on type of application.

Introduction

Medicaid is a joint federal-state program that provides coverage of medical expenses for eligible recipients. It is a complex and constantly changing program in which the federal government establishes broad eligibility guidelines and gives the state wide latitude to determine the amount of coverage provided and the groups of persons covered.

At the federal level, Medicaid is administered by the Health Care Financing Administration within the U.S. Department of Health and Human Services. At the state level, Medicaid is supervised by the Division of Health and Human Services. At the state level, Medicaid is supervised by the Division of Medical Assistance within the N.C. Department of Human Resources and administered locally by the county Departments of Social Services.

In North Carolina, there are numerous categories of potential Medicaid recipients. The categories often have different eligibility rules and different levels of medical coverage. A potential recipient must fit in one of the categories to receive coverage. Being poor and sick is not enough.
Medical services may be obtained from any medical provider who accepts Medicaid. Only certain hospitals and nursing homes that received “Hill-Burton” loans from the government and public health departments are required to accept Medicaid. It is optional for the other medical providers.

Applications

Applications for Medicaid are taken at county Department of Social Services (DSS). (See Appendix D for a list of the county Department of Social Services.) An applicant must be permitted to apply the day he/she appears at the office. An applicant may apply through a representative, who can be a relative, friend, or advocate. Interview is also required.

Some hospitals, rural health clinics, and public health departments have staff who can take initial Medicaid applications. Follow-up must be done at the county DSS.

Assistance Unit/Budget Unit

Applications are taken for individuals who need medical coverage. Applicants can choose which family members will be in the “assistance unit,” which consists of the persons who will receive coverage. Nevertheless, for determining eligibility, the income and resources of anyone living in the same household who is financially responsible for a covered person will be included. In Aged, Blind and Disabled cases, this generally means spouse for spouse. The persons whose income and resources are included are considered the “budget unit.”

Time Frames

Decisions on applications should be made within 45 days, unless the applicant is applying on the basis of disability, in which case the decision should be made within 90 days. The decision will be in writing and will be mailed to the applicant or his/her representative. If the decision is a denial, the reason for the denial will be stated in the decision, together with the applicant’s appeal rights.

Eligibility is generally approved for six-month or 12 month periods. Prior to the end of 6/12 months, the recipient will receive a notice from the county DSS worker advising him/her that he/she must come to the office/or complete a mail in recertification.” This process is slightly less complicated and lengthy than the original application, but it requires re verification of
certain eligibility factors. If the recipient fails to get recertified, benefits will stop.

Changes affecting eligibility that occur during the six-month period must be reported to DSS by the recipient. A termination will occur whenever an individual no longer meets all eligibility criteria. A ten-day advance notice must be sent to the recipient before termination can occur.

Applications can be made for retroactive medical needs as well as future needs. Coverage can be authorized for services received in the three months prior to the month of application.

Advocate Tip: For an individual who anticipates significant medical care, such as surgery, it may be advantageous to apply after the care has been rendered, as long as it is within the three-month retroactive period. Because of the method used to calculate the deductible (explained at greater length in the Income section below), significantly more coverage may be obtained by applying after the fact. The individual may wish to consult with an experienced advocate (such as a Legal Services lawyer or paralegal) before deciding when to apply. There are certain situations in which the individual may not want to apply in the fashion.

Verification

Much of the information needed for a Medicaid application must be verified by documents or otherwise. As a general rule, the following documents should be brought when applying for Medicaid. (Note, however, that an applicant should not delay in applying if these items are not readily available. They can be produced later in application process.)

- **Proof of income**, such as wage stubs, award from government agencies, etc.
- **Proof of assets**, such as bank books, financial statements, deeds, property tax statements, insurance policies, etc.
- **Social security cards** for all applicants
- **Immigration papers** for all non-citizens
- **Proof of disability** for all those applying on that basis, such as medical reports from physicians
Birth certificates, or other proof of age

The categories of recipients are discussed separately below. They include:

- Aged, Blind and Disabled
- Infants and Children
- Pregnant Women
- Medicare Recipients

**Medicaid for the Aged, Blind, and Disabled**

**Program Benefits**

Listed below are the services generally provided, either at no cost or for a nominal copayment, to an eligible aged, blind, or disabled Medicaid recipient.

- **Hospital care**, both inpatient and outpatient, with a $3.00 copayment for outpatient visits
- **Physicians care**, with a $3.00 copayment in most cases and usually limited to 24 ambulatory visits per year
- **Prescription drugs**, with a $3.00 copayment per prescription and usually limited to eight prescriptions per month. 3 additional prescriptions may be prescribed at the discretion of the pharmacist. There are no co-pays for recipients under the age of 21, for recipients who are in Intermediate Care or Skilled nursing facilities, recipients who are in a Mental Retardation facility, Assisted living facility and group homes.
- **Laboratory work**
- **X-rays**
- **Nursing home care**
- **Home health services**, such as nursing visits and physical therapy, but not private duty nursing except with special approval
- **Personal care services**, such as meal preparation, personal hygiene, and medical monitoring, up to 80 hours in a month
- **Adult health screening**, once per year
- **Family planning services**, not including abortion unless the life of the mother is endangered or she may commit suicide if the pregnancy goes full term
- **Hearing aid services**, only for those under age 21
- **Clinic services**, such as at health department clinics, rural health clinics, and migrant health clinics
- **Chiropractic care** for certain spinal disorders, with a $2.00 copayment per visit
- **Dental care**, with a $3.00 copayment per visit
- **Mental hospital care**, for persons under age 21 or over age 64
- **Eyeglasses** and related services, limited to one pair every two years for persons over age 24 and one pair every year for persons age 24 and younger, with a $3.00 copayment for each visit to an optometrist
- **Specialty hospital care**
- **Medical transportation**, including necessary ambulance transportation and transportation to and from the recipient’s home to the medical provider
- **Mental health care**, including care at mental health centers, and visits to psychiatrists and psychologists
- **Speech or physical therapy**, or other needed therapy
- **Part B Medicare premium**
- **Durable medical equipment**, such as wheelchairs, with prior approval
- **Hospice care**
- **Case Management** for the mentally ill
- **Pregnancy-related services**, including case management, prenatal care, delivery, and postnatal care, without a copayment
- **Nurse-midwife services**

**Community Alternative Program for Disabled Adults**

Additional benefits are available to a small group of disabled adults participating in the Community Alternatives Program for Disabled Adults (CAP/DA). Operated in only 50 counties, this program pays for otherwise
uncovered services that enable a disabled adult to reside in the community rather than in a nursing home. The cost of the home care services must be equal to or less than the comparable cost of institutional care. The additional covered services available to this group are:

- An annual screening/assessment
- Case management
- Adult day health care
- Homemaker services
- Home mobility aids (ramps, grab bars)
- Respite care
- Chore services
- Telephone alert
- Home-delivered meals
- Medical supplies

In participating counties, the program is administered by a lead agency designated by the county commissioners. For information about whether a particular and the identity of the lead agency, call The Division of Medical Assistance at (919) 733-3945.

**Program Eligibility**

**Personal Eligibility**

To obtain Medicaid for the Aged, Blind and Disabled, an individual must:

- Be **age 65 or over**, or
- Be **disabled**, according to the standards for SSI (see Supplemental Security Income chapter, p. 70 for further details), or
- Be **blind** (corrected visual acuity of 20/200 in better eye or worse or tunnel vision), and
- Be in **financial need** (see Income section for further details)
- **Not have resources over $2000 if single or $3000 if married** (see Resource section for further details)
- **Not have transferred property** in violation of the rules prior to obtaining long-term care (see Resource section for further details)
- Be a **U.S. citizen or an eligible alien** (Aliens eligible for full Medicaid coverage are those lawfully admitted for permanent residence or residing in the U.S. under color of law. Other legal aliens are eligible for limited coverage. Illegal aliens and non-immigrant aliens are eligible for emergency care.)

- Be a **resident of North Carolina**

- Have a **Social Security number** or have applied for one

- Assign to the state **all rights to payment for health care** from any third parties

- **Not be in a public institution**, except for certain individuals in public mental hospitals

- **Not be receiving Medicaid** through any other source

**Financial Eligibility**

**Financial Eligibility** for Medicaid for the Aged, Blind and Disabled is determined by examining both **income and assets**. If the applicant’s income and assets (also called resources or reserve) are under specified limits, and the applicant meets all other eligibility requirements, the applicant is eligible for medical coverage upon approval of his/her application. If the applicant is over the limits, however, he/she may be eligible for coverage on a delayed basis. The applicant must incur medical bills equal to the amount he/she is over the limits before Medicaid coverage will begin. This is called “meeting a deductible” or “meeting a spend-down”

**Income**

Income is money received, whether from earnings, investments, government benefit programs, or other sources. The **income of the persons applying for Medicaid is counted, as well as the income of anyone who has financial responsibility for those persons and who is living in the same household** (the budget unit). When comparing an applicant’s income to the limits in the table, the number in the budget unit is used.

**Excluded Income**

Not all income is counted in determining eligibility. The following are the most significant types of income that **are not counted**:

- **Supplemental Security Income (SSI)**
- Earnings of students under age 21 or non-students under age 21 participating in JTPA
- U.S. Department of Education loans
- Most other loans, except when no repayment is scheduled or when a portion of the loan is designed for everyday expenses
- The first $50 in child support each month
- Reimbursements
- Payments received as a participant in certain job training or rehabilitation program
- Special one-time crisis payments
- HUD housing assistance, relocation payments, block grant funds, etc.
- The value of Food Stamps, school lunches, WIC coupons, surplus commodities, donated food, etc.
- Income tax refunds

**Income Deduction**

- Initially, the gross income of the budget unit is calculated. From that, certain **deductions are subtracted**. They are:
  - The first $65 of earned income plus ½ half the remaining earned income, (these amounts are higher for the blind)
  - Work-related expenses
  - Child care or adult day care expenses
  - Alimony or child support paid to someone outside the household
  - The needs of other minor children in the household not in the Medicaid unit (certain maximums apply)
  - $20

**Income Limits**

Following are the monthly income limits (after deductions) for the **Aged, Blind and Disabled**, as of April 2009. These are also known as **“medically needy”** income limits.
<table>
<thead>
<tr>
<th>Budget Unit</th>
<th>Monthly Income Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$903.00</td>
</tr>
<tr>
<td>2</td>
<td>$1,215.00</td>
</tr>
</tbody>
</table>

If an applicant's monthly income is below this amount, he/she is income-eligible for Medicaid with no deductible. If his or her income exceeds this amount, he/she can be eligible after meeting a deductible based on the income scale of $242.00 for an individual and $317.00 for a couple.

**Calculating the Deductible**

If an individual is determined to have a family income over the limit, he/she is assigned a **deductible**, also known as a **spend-down**. Usually this is calculated on a six-month basis, and represents the amount by which the person's income exceeds the income limit. For example, if an elderly woman with Social Security income of $1000 (after deductions) applied for Medicaid, she would have a Medicaid deductible of $6,000. Her income exceeds the income limit by $97.00 per month. Therefore, she is over the income scale of $903.00 and her income has to be compared to the income scale of $242.00 per month. If her net is $1000.00, you multiply that by six months to compute her $6,000.00 deductible.

To meet the deductible, the person must show that he/she has **incurred, but not necessarily paid, medical expenses** in the amount of the deductible within the six months. Non-prescription drugs and other over-the-counter medical supplies count toward the deductible, as well as other medical bills. Receipts should be kept. There are also provisions by which old medical bills can be carried forward and applied to the deductible. Once the deductible is met, Medicaid will pay for all covered services for the rest of that period. The individual will remain liable for the expenses used to meet the deductible.

In certain circumstances a shorter deductible period is calculated, such as when applying for retroactive coverage.

**Long-term Care**

**Income eligibility for persons in long-term care** (i.e., nursing homes) is completely different from the above rules, which apply to persons in...
private living arrangements. As a general matter, a person in long-term care is eligible if his/hers countable monthly income is less than the monthly cost of the nursing home. A recipient may keep $30 a month as a personal needs allowance and enough to pay any medical needs not covered by Medicaid (like over-the-counter drugs). The rest must be used to pay as much of the nursing home bill as possible. Medicaid will pay the remainder.

Special rules apply to recipients who have a spouse at home to protect the income of that spouse. The spouse in the nursing home can give some of his/her income to the spouse at home to supplement the spouse’s income, up to a certain limit. From July 1, 1993 through June 30, 1994, the limit was $1,179 per month, plus an allowance for shelter expenses that exceed $354 per month and an allowance on July 1 and exceptions may be authorized, up to a limit ($1,769 through January 1, 1994).

Resources

Aged, blind and disabled Medicaid recipients must also meet a resource test. Resources are assets that a person owns and can make available for his/her support. They are sometimes called a person’s reserve.

The limits are:

<table>
<thead>
<tr>
<th>Budget Unit</th>
<th>Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$2,000</td>
</tr>
<tr>
<td>2</td>
<td>$3,000</td>
</tr>
</tbody>
</table>

Resources Eligibility

Since the inception of the Medicaid program North Carolina, the rule has been that if the applicant is over the resource limit at all, she/he is not eligible for Medicaid.

Some courts have ruled that the state should assign applicants a resource “spend down” in much the same way they are assigned a deductible. This means a person would be eligible for Medicaid coverage for those bills exceeding the amount by which his/her resources were over the limit. For example, a person with resource $1,000 over the limit would be eligible
for coverage of all but $1,000 of hers/his medical bill. At the time of this writing, the issue had not been finally resolved by the North Carolina Supreme Court. (Persons interested in knowing the most up-to-date information should call the Public Benefits Specialist at the Legal Services Resource Center listed at the end of this chapter.)

Evaluating Resources

A Medicaid applicant’s or recipient’s resources are evaluated at the first moment of the first day of the month. If the person is eligible at that moment, he/she is eligible for the entire month. If he/she is over the limit on the first day, but falls below the limit at some later point during the month, eligibility can be established at that later point.

Real property is evaluated according to its property tax value. Motor vehicles are usually evaluated according to the books published by the National Automobile Dealers’ Association (NADA). Any value assigned to property by the DSS can be rebutted with evidence from a knowledgeable source.

Special rules apply to jointly-held assets. Usually, if the application has access to the whole asset, it will all be counted. Otherwise, he/she will be assigned his/her pro rata share. Important exceptions apply, however, as noted below.

Excluded Resources

Not all of the budget unit’s resources are counted toward the limit. The following are the major resources that do not count:

- Principal place of residence, including the house and lot/acre on which it sits, plus up to $12,000 in value of contiguous property
- Partial interests in real property, such as life estates, reminder interest that cannot be sold, and interests held with others as tenants-in-common
- Personal effects and household goods
- One burial space per family member
- One essential motor vehicle
- Income-producing personal property, such as farm or business equipment
- Cash value of life insurance if face value is $10,000 or less
Irrevocable pre-need burial contracts, or up to $1,500 in revocable burial contract or trust

Savings of a student if designated for education

Retirement accounts, unless they can be withdrawn as a lump sum

Relocation assistance

Unless listed above, all assets will count toward the limit. This will include bank accounts, investments, the value of real property, cars, boats, life insurance, trust funds, etc.

Exceptions to Resource Rules

If an applicant can prove that something which ordinarily is counted is unavailable, such that the applicant cannot gain access to it, it should not be counted. This process may entail filing an appeal after the applicant’s first being denied eligibility.

Usually, the assets of the applicant’s spouse count toward the limit, because the spouse is always in the budget unit. If the Medicaid recipient is in a nursing home, however, certain exceptions are made to protect some of the couple’s joint assets for the spouse at home. As of July 1, 2009, if the total resources were $21,912.00 or less, all of the assets could be protected. If the resources are more than $21,912.00 but not more than $43,824.00; protect $21,912.00. If the resources are more than $43,824.00 but not more than $219,120.00; protect one half. If the resources are more than $219,120.00; protect $109,000.00. These amounts are increased annually.

Transferring Resources

To discourage potential Medicaid recipients from giving away their property in order to become eligible for assistance, penalties apply to certain persons who have transferred their resources prior to applying for Medicaid.

The penalties apply only to persons who apply for Medicaid to pay for nursing home care, and only for transfers made in the 36 months prior to the application (or entrance into the nursing home, whichever is later). This “look-back” period is 60 months in some cases involving trust. The look-back period will eventually increase to 60 months instead of 36 months as indicated above.
The penalty is a period of ineligibility. The length of the period is determined by dividing the value of the transferred property by the average monthly cost of nursing home care. The transfer policy has changed recently so please call DSS if there are questions.

Exceptions to Transfer Penalties

Penalties will not be assessed if it is shown that:

- Medicaid applicant received fair market value in return for the property transferred: or
- The Medicaid applicant transferred the property solely for a reason unrelated to Medicaid eligibility; or
- The property transferred would not have made the applicant ineligible for Medicaid if retained. (Note, however, that this exception does not apply to the transfer of the applicant’s principal place of residence.); or
- The applicant transferred the property to his/her spouse or for the benefits of his/her spouse; or
- The property was transferred to a trust for the applicant’s disabled child or for a disabled individual under age 65; or
- The applicant transferred his/her principal place of residence to his/her:
  - minor child
  - Adult disabled child
  - child who lived in the residence for at least two years prior to the applicant’s entrance into a nursing home, providing care which delayed the need for nursing home care during that two years
  - sibling, who was a co-owner of the home and had resided there at least one year prior to the applicant’s entrance into the nursing home

The penalty will end if it is shown that:

- The property has been transferred back to the Medicaid recipient (although he/she will presumably then be ineligible for having resources in excess of the limit).
- An amount equal to the value of the transferred property has subsequently been paid on behalf of the applicant.
Medicaid for Infants and Children

Program Benefits

Medicaid for Infants and Children (MIC) provides medical coverage for children under age 19 depending on the size of the family and the age of the child(ren).

Program Eligibility

Personal Eligibility

There are no personal eligibility requirements; all financially eligible families can be covered.

Financial Eligibility

The income limits are determined by the family size and the age of the child(ren) for whom you are applying.

There is no limit on resources.

Your monthly countable income cannot be more than the amounts listed below.

| Monthly Income Limits: Medicaid for Infants and Children (Effective April 2009) |
|---------------------------------|------------------|------------------|
| Family Size | Age 0 - 5 | Age 6 - 18 |
| 1 | $1,805 | $903 |
| 2 | $2,429 | $1,215 |
| 3 | $3,052 | $1,526 |
| 4 | $3,675 | $1,838 |
| 5 | $4,299 | $2,150 |

If your family income is greater than the amounts listed above, your child(ren) age 6-18 may be eligible for NC Health Choice for Children or Medicaid with a Medicaid deductible.
**Medicaid for Pregnant Women**

**Program Benefits**

Medicaid for Pregnant Women **only** covers services related to pregnancy:

- Prenatal care, delivery and 60 days postpartum care.
- Services to treat medical conditions which may complicate the pregnancy *(some services require prior approval)*
- Childbirth and parenting classes
- Family planning services
- Maternity Care Coordination services

**Program Eligibility**

**Personal Eligibility**

A pregnant woman may apply for this program before or after she delivers. A woman who has experienced a recent pregnancy loss may also be eligible.

**Financial Eligibility**

The monthly family income cannot exceed 185% of the federal poverty level. There is no limit on resources. If a pregnant woman is covered by Medicaid on the date she delivers, her newborn child may be eligible for Medicaid up to age 1 without a separate application.

Your monthly countable income cannot be more than the amounts listed below.

| Monthly Family Income Limits: Medicaid for Pregnant Women  
(Effective April 2009) |  |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Size</strong></td>
<td><strong>Monthly Income Limit</strong></td>
</tr>
<tr>
<td>2</td>
<td>$2,247</td>
</tr>
<tr>
<td>3</td>
<td>$2,823</td>
</tr>
<tr>
<td>4</td>
<td>$3,400</td>
</tr>
</tbody>
</table>

(The unborn child is always counted in the family size)
**Medicaid for Medicare Recipients**

**Program Benefits**

Medicaid serves Medicare recipients in two ways:

- Medicare-Aid for people who have Medicare and also have limited income and resources.
- Medicare-Aid for working individuals with a disability

Medicaid does **not** pay for prescription drugs for people on Medicare. See [Medicare Part D: Prescription Drugs](#) (Part 3 - Page 43) and the NCRx.

**Medicare-Aid**

Medicare-Aid is a free Medicaid program for people who have Medicare and also have limited income and resources. The program can help pay your Medicare premiums, co-payments and deductibles. It is also known as Medicare Savings Program. There are three different levels of Medicare-Aid. All are based on an individual’s countable income.

**Comprehensive Medicare-Aid (MQB-Q)** covers:

1. Medicare Part B premium
2. Medicare Part A premiums (when applicable)
3. Medicare hospital deductible
4. Medicare annual deductible
5. 20% Medicare co-payment
6. If you go into a nursing home, Medicare-Aid only covers the first 20 days. For more information, see [Medicaid for long term care](#).

**Limited Medicare-Aid (MQB-B)** covers the Medicare Part B premium

**Limited Medicare-Aid Capped Enrollment (MQB-E)** also covers the Medicare Part B premium. Funds for this program may be limited.

<table>
<thead>
<tr>
<th>Program</th>
<th>Number in Family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>MQB-Q</td>
<td>$903</td>
</tr>
<tr>
<td>MQB-B</td>
<td>$1,083</td>
</tr>
<tr>
<td>MQB-E</td>
<td>$1,219</td>
</tr>
</tbody>
</table>
Medicare-Aid for Working Individuals with a Disability

This program helps working individuals who no longer qualify for free Medicare Part A benefits retain their coverage.

If an individual has lost their entitlement to free Medicare Part A benefits because they returned to work and now have earned income, Medicaid has a Medicare-Aid program that may pay their Medicare Part A premium.

To be eligible for Medicare-Aid for Working Individuals with a Disability an individual must be under 65, disabled, and entitled to enroll in Medicare Part A. Contact the local Department of Social Services (DSS) for more information.

Program Appeals

Any decision regarding Medicaid – whether it be an approval, denial, termination, modification, or some other action or inaction by the county DSS – may be appealed. An appeal must be requested, either orally or in writing, within 60 days of the written notice of decision, or within 90 days if good cause is shown for the delay. If the request is made within 10 days of a notice of termination or suspension, benefits can continue until first decision is made. (If the person loses the appeal, the continued benefits are overpayments and must be repaid.)

Local Hearing

The first level of appeal is a local hearing, in all cases except when the issue is whether an applicant is disabled. The local hearing should be scheduled within five calendar days after it is requested, although the person appealing has the request that it be postponed to not later than 15 days from the date of request. It will be held at the Department of Social Services, unless the person appealing is bedridden.

The person appealing has the right to be represented. The representative does not need to be an attorney, but may be. Either the person appealing or his/her representative has the right to see the Medicaid report prior to the hearing. (The county worker will require a representative to have a lease of information signed by the party.)

The local hearing will be conducted, and the decision made, by an employee of the county Department of Social Services who is not familiar with the particular facts of the case. The hearing is informal. The worker involved in
the decision will have prepared a summary of the case, and will read it. Copies of the document relied on by the county will be attached to the summary and a copy provided to all parties. The person appealing or his/her representative can ask questions of the worker to establish or clarify certain facts. The person appealing will have the opportunity to produce evidence (both documents and witness) and testify, and may need to answer questions posed by either the hearing office or the DSS worker. Court rules of evidence do not apply. Closing statements will be allowed.

The local hearing officer will make a decision within five calendar days of the hearing and mail it to the person who appealed.

Advocate Tip: The local hearing is frequently unproductive, especially if a legal interpretation is involved. It is best used to establish facts and clarify misunderstandings. Nevertheless, the local hearing may not be waived. It is a prerequisite to a state level hearing.

State Level Hearing

If the local hearing decision is not satisfactory, a state level hearing may be requested. It must be requested, either orally or in writing, within 15 calendar days of the date of the local hearing decision.

The state level hearing is conducted by a hearing officer from the Hearings and Appeals Section of the Division of Social Services, N.C. Department of Human Resources. The hearing will be held, however, at the county Department of Social Services. It will be scheduled by the hearing officer, and usually will be held within three to six weeks after the request. The hearing officer will be familiar with the program, by not with the fact in the particular case.

The state level hearing is similar in format to the local hearing. Again, the person appealing may be represented, may have access to county files ahead of time, may submit evidence, etc. The hearing will be taped, and any witnesses will be required to testify under oath. The county will begin by reading the appeal summary and reviewing the attached documents. The person appealing or his/her representative may ask questions of the county worker or hearing officer may ask questions of any witness. Closing statements will be allowed. The hearing officer may, upon request, leave the case open to receive additional documentary evidence if a good reason is presented as to why it could not be made available at the hearing.
Advocate Tip: The state level hearing is, for all practical purposes, the last opportunity a person has to introduce evidence. Generally, no additional testimony will be taken nor will any documents (other than written legal arguments) be accepted. Consequently, it is very important to establish all necessary facts at this level. If the case is appealed further, a transcript of this hearing together with the documents submitted will be the official record of the case.

The state hearing officer will issue a written decision and mail it to all parties. The decision is initially tentative. Either party has ten days to request that it be reviewed by the Chief Hearing Officer. If neither party request that it be review, the hearing officer’s decision becomes the final agency decision.

If either party requests it, the Chief Hearing Officer will accept additional written or oral arguments supporting or attacking the decision. The Chief Hearing Officer will then issue a final decision in writing and mail it to all parties. The final decision should be issued within 90 days of the initial request for an appeal.

Judicial Review

The final agency decision can be appealed to Superior Court by filing a Petition for the Judicial Review within 30 days of the receipt of the final decision. As a practical matter, this can rarely be accomplished successfully without the services of an attorney. Free legal help may be available from the local Legal Services program. (See chapter on Legal Services.) The procedures for Judicial Review are controlled by N.C. Gen. Stat. 108A-79(k) and The Administrative Procedures Act at N.C. Gen. Stat. 150B Part 4.

Legal Authority

State Statutes

N.C. Gen. Stat. 150B Part 4

Sources and Related Resources

See Appendix D for list of local DSS offices
Medicare

PROJECT SPECIFICS

Quick Lookup

What Is It?

A federal health insurance program (administered by the Centers for Medicare and Medicaid Services (CMS)) that pays some of the costs (typically 80% of approved costs) of medical care.

Who Is It For?

Individuals who are age 65 and over, those under the age of 65 with certain disabilities or ALS (amyotrophic lateral sclerosis, or Lou Gehrig’s disease), and a person of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).

Where Are Applications Taken?

At District Social Security Administration Offices. (List available in Appendix K)

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Program Benefits: Part 3 - Page: 36
Program Eligibility: Part 3 - Page: 43

Introduction

Medicare is a federal program of health insurance begun in 1966 for individuals 65 or over and eligible individuals with disabilities. It is administered by the Centers for Medicare and Medicaid Services (CMS). Eligibility is not based on need; there are no income or asset limits.

Medicare is not full health care coverage. There are limitations on coverage, and certain deductibles and coinsurance amounts must be paid by the patient. (A deductible is an amount that the beneficiary must pay out of pocket before Medicare will begin; a coinsurance is an amount that must be paid along with the amount covered by Medicare.) For eligible individuals, Medicaid will cover most of the charges not covered by Medicare. (See
Many insurance companies also offer “Medigap” policies that are designed to cover the costs not covered by Medicare.

**Advocate Tip:** “Medigap” insurance policies, ostensibly designed to cover medical care not covered by Medicare, can be expensive and sometimes duplicative of coverage already owned by the consumer. The State Department of Insurance operates The Seniors’ Health Insurance Information Program (SHIIP) to provide counseling and guidance to senior citizens about Medigap and other Medicare products and benefits. The program operates a toll-free telephone line to answer questions: 1-800-443-9354 (919) 807-6900 in Raleigh). Local coordinators and volunteers are also available in every county to provide free counseling and assistance. A listing of coordinators can be obtained by calling SHIIP at the number listed above or by visiting their website: [www.ncshiip.com](http://www.ncshiip.com)

Medicare is financed by a portion of payroll taxes paid by employers and your employees. A portion is also financed through monthly premiums deducted from Social Security checks.

There are four Parts to Medicare (Part A, Part B, Part C and Part D).

- **Part A (Hospital Insurance)** helps cover inpatient hospital care, as well as skilled nursing facility, hospice, and home health care.

- **Part B (Medical Insurance)** helps cover doctors’ services, outpatient care and some preventive services.

- **Part C (Medicare Advantage)** provides beneficiaries with an option of getting their Medicare benefits through private insurance companies as an alternative to traditional Medicare. These plans (HMO’s, PPO’s, PFFSs, and SNPs) include Parts A and B and sometimes prescription drugs.

- **Part D (Prescription Drug Coverage)** helps cover the costs of prescription drugs.

**Applications**

Applications are taken at district offices of the Social Security Administration. (A listing of the offices in North Carolina is located in Appendix K.) A potential
applicant may wish to call 1-800-772-1213 prior to visiting the office to obtain additional information and make an appointment.

Part A

Certain individuals will **automatically receive** Medicare benefits and will not have to apply for them. These situations are outlined below:

- Persons who chose to take an early Social Security benefit before age 65 will be automatically enrolled into Medicare Part A and Part B (unless they refuse it) starting the first day of the month in which they turn 65. The Medicare card will arrive in the mail 3 months before the individual’s 65\textsuperscript{th} birthday.

- Individuals with disabilities under the age of 65 will automatically get Part A after receiving Social Security disability payments or certain disability payments from RRB (Railroad Retirement Beneficiaries) for 24 months. The Medicare card will arrive in the mail on the 25\textsuperscript{th} month of disability.

- Persons with ALS (Lou Gehrig’s Disease) automatically get Part A the month their disability benefits begin.

These individuals should receive a notification form in the mail from Social Security advising them of their automatic enrollment into Part A. If a person meets the criteria stated above and does not receive their Medicare card in the time frame outlined, he or she should contact the Social Security office.

**Advocate Tip:** The form will also state that they will be enrolled in Medicare Part B unless they refuse it. Generally speaking, it is not a good idea for individuals to deny Part B. Individuals considering denial of Part D are encouraged to speak with a SHIIP counselor so they understand all of their options before making a decision. A SHIIP counselor can be reached by calling the NC Seniors’ Health Insurance Information Program at 1-800-443-9354.

Persons who are **not automatically enrolled must file** an application with Social Security during one of the enrollment periods outlined below in order to receive benefits.

**Part A Penalty for Late Enrollment**
Normally, there is no penalty for enrolling late in Part A because it is premium-free. However, individuals who are paying a Part A premium may be penalized 10% for late enrollment. The penalty period lasts the same amount of time as the late period. For example, if a person enrolls in Part A three years late, the penalty would last for three years.

**Part B**

Persons enrolled in Part A are automatically enrolled in Part B, but may opt out of the coverage or delay Part B until a later date.

Medicare beneficiaries or spouses who are actively working for an employer who is providing group health insurance may be eligible to delay Part B when they first become eligible for Medicare.

Note:

- If the beneficiary is older than 65 and actively working, the employer must have 20 or more employees.
- If the beneficiary is younger than 65 (disability) the employer must have 100 or more employees.

Once the employer group health plan ends or is no longer primary (usually when a person or their spouse actually retires or stops working), the person has a special enrollment period of eight months in which they can sign up for Part B without a penalty. This eight month period begins the month following when the employer group health plan ends or stops being primary.

**Part B Penalty for Late Enrollment**

A penalty of 10% will be added to the Part B premium for each year a person was late enrolling in Medicare. This penalty increases as the Part B premiums increase and continue as long as the person has Part B (normally for life).

**Part C**

Generally, you can join a Medicare Advantage plan if you have Medicare Parts A and B; you live in the plan’s service area; and you don’t have End Stage Renal Disease (ESRD). Enrollment in these plans may be cancelled if a beneficiary moves outside of the enrollment area. To find out about a plan’s service area call the plan, or call Medicare at 1-800-MEDICARE (1-
Individuals choosing to enroll in a Medicare Advantage plan must continue to pay their Medicare Part B premiums. Depending on the plan they choose, they may or may not have an additional monthly premium. Individuals who enroll in a Medicare Advantage plan will no longer use their red, white and blue card; they will use the plan’s card.

**Advocate Tip:** Some agents who sell Medicare Advantage plans have misrepresented the product and enrolled beneficiaries who did not understand the product. Agents are no longer allowed to initiate contact with beneficiaries, such as going door to door.

Individuals considering changing their Medicare coverage are strongly encouraged to speak with a SHIIP counselor at 1-800-443-9354 before making any decisions.

Most beneficiaries can join a Medicare Advantage Plan only at certain times during the year and they are as follows:

- When the beneficiary first becomes eligible for Medicare (3 months before they turn age 65, the month they turn 65, and 3 months after the month they turn age 65). A total of 7 months. The month of enrollment determines the month coverage begins.

- If the beneficiary gets Medicare due to a disability, they can join during the 3 months before to 3 months after their 25th month of disability.

- During the Annual Enrollment Period (between November 15–December 31 each year). Their coverage will begin on January 1 of the following year.

Individuals enrolled in a Medicare Advantage plan who wish to return to original Medicare (red, white and blue card) may only do so during certain times of the year, unless they qualify for a special exception period. Call the Seniors’ Health Insurance Information Program (SHIIP) at 1-800-443-9354 for more information.

**Part D**

Enrollment in Part D is voluntary; coverage is not automatic. However, if you qualify for Medicaid or “extra help” and you do not choose a plan on your own, you will be randomly assigned to a plan. This plan may or may
not cover your medications so it is best to compare and choose a plan that best fits your needs. Individuals who receive Medicare and Medicaid do not lose their Medicaid coverage for health care. Their prescriptions are simply covered under a Medicare Part D plan vs. Medicaid.

**Advocate Tip:** Some medications that are not covered under a Part D plan, will continue to be covered under Medicaid. Call Medicare at 1-800-633-4227 or SHIIP at 1-800-443-9354 for more information.

Any individual with Original Medicare (Part A or Part B) can sign up for a Medicare Prescription Drug Plan (Part D) regardless of income or assets. Individuals may sign up when they are new to Medicare during the same initial enrollment period they have for Medicare (see below).

If a beneficiary does not enroll when they are new to Medicare, they must enroll during the Annual Election Period (November 15-December 31) unless they qualify for a Special Enrollment Period. In addition, most people who do not enroll when they are first eligible, and later choose to enroll will have a penalty unless they qualify for a special enrollment period.

**Advocate Tip:** Individuals who have other prescription drug coverage of their own should check with their benefits administrator before making any changes. Examples of other coverage include: current or former employer (yours or your spouse’s), VA, military coverage such as TRICARE, etc.

- **Initial Enrollment Period:** A person can enroll in a Prescription Drug Plan (PDP) three months before their 65th birthday; during their birthday month; and three months following their 65th birthday. If the individual signs up during their initial enrollment period, they will not have a penalty.

- **Annual Election Period:** November 15 thru December 31 of every year (effective January 1 of the following year). Individuals can enroll in a plan, change their plan, or drop their plan during this period. Beneficiaries enrolled in a Medicare Advantage plan, with prescription drug coverage, can enroll in a Part D plan and return to original Medicare.

**Advocate Tip:** Plan premiums, formularies and co-payments change annually. It is important for beneficiaries to
review their coverage and compare plans during the annual election period.

- **Open Enrollment Period:** January 1 thru March 31 of every year (effective the month following the change). Allows beneficiaries:
  - Who have a Medicare Advantage plan with a prescription drug benefit (MA-PD) to switch to another MA-PD or return to Original Medicare and enroll in a prescription drug plan.

- **Special Enrollment Period:** Allows Medicare beneficiaries to enroll or unenroll from a Part D plan outside of the Annual Election Period (AEP) and the Open Enrollment Period (OEP). In most cases, individuals who qualify for a SEP will not have a penalty.

**Medicare Enrollment Schedule**

**Automatic Enrollment**

If you are already receiving Social Security benefits, Railroad Retirement benefits, or Federal Retiree benefits your enrollment in Medicare is automatic. Check with Social Security to verify your Automatic Enrollment as well as your current address. Your Medicare card should arrive in the mail shortly before your 65th birthday. Check the card when you receive it to verify that you are entitled to both Medicare Parts A and B.

**Initial Enrollment**

If you are not eligible for Automatic Enrollment, contact the Social Security Administration at 800-772-1213 or www.socialsecurity.gov, or visit the nearest office to enroll in Medicare Part A and to enroll in Medicare Part B. You have a seven-month window in which to enroll in Medicare without incurring a penalty.

<table>
<thead>
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<th>Initial Enrollment Period (seven months)</th>
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</thead>
<tbody>
<tr>
<td>Three months before 65th birthday</td>
</tr>
<tr>
<td>Birthday month</td>
</tr>
<tr>
<td>First month after 65th birthday</td>
</tr>
<tr>
<td>Two to three months after 65th birthday</td>
</tr>
</tbody>
</table>

| Enroll here and your Medicare is effective the first day of your birth |
| Enroll here and your Medicare effective date will be delayed |
| Enroll here and your Medicare effective date will be delayed until |
| Enroll here and your Medicare effective date will be delayed |
During this Initial Enrollment Period, you will also have the option to enroll in a Medicare Prescription Drug Plan (PDP) available under Medicare Part D. Enrollment in a Medicare PDP is strictly voluntary. These plans are offered by insurance companies and private companies approved by Medicare, and Medicare helps pay for the coverage. Information about what PDPs are available in North Carolina is available from SHIIP (800-443-9354 or www.ncshiip.com). If you fail to enroll in a Medicare PDP during your Initial Enrollment Period and you do not have equal or better coverage through an EGHP, you will incur a 1 percent penalty for each month that you are late enrolling, and you will only be allowed to enroll during the Nov. 15 through Dec. 31 Annual Coordinated Election Period. A beneficiary can also join a Medicare Advantage Plan available under Medicare Part C during this enrollment.

**General Enrollment**

If you do not enroll in Medicare Parts A and B during your seven-month window of eligibility you cannot enroll until the General Enrollment Period, which is Jan. 1 through March 31 each year (unless you are entitled to Special Enrollment, see next page). Your Medicare eligibility will not begin until the following July 1. Your monthly Medicare Part B premium will increase to include a permanent 10 percent penalty for each year of delayed enrollment (unless you are eligible for Special Enrollment).
Special Enrollment

If you or your spouse are actively working at age 65, are covered by an employer’s group health plan (EGHP) and the company has 20 or more employees, you may be able to delay Medicare Part B coverage without penalty. You will still be eligible for Part A without paying a premium (as long as you or your spouse has 40 credits of work).

• Talk to your employer’s benefits officer and ask for information about company health insurance options for people who continue working past their 65th birthday. Ask specifically how many hours you must work to keep your health insurance plan and whether the EGHP will be “primary” or “secondary” coverage to Medicare. Carefully study the company’s current benefit booklet to determine cost and benefits of the plan.

• If your EGHP is primary to Medicare, you do not have to enroll in Medicare Part B at this time. You will need to enroll in Medicare Part B within eight months of the EGHP’s termination of coverage or when it stops being primary. If your EGHP will be secondary to Medicare despite active employment, you must enroll in Medicare Part B during the seven-month Initial Enrollment Period to avoid future penalties. If you voluntarily disenroll from your EGHP before terminating your employment, you could lose any EGHP benefits when you retire.

• Contact the Social Security Administration at 800-772-1213 or go to www.socialsecurity.gov or the nearest Social Security Administration to confirm that you have enrolled in Medicare Part A (Hospital Insurance).

• Give written notice to your company of your intention to continue working after age 65. When you decide to stop working, notify the Social Security Administration immediately. It is also advisable to notify the Social Security Administration that you or your spouse, if covered under your EGHP, will continue to work beyond age 65.

SHIIP: Senior’s Health Insurance Information Program

Seniors’ Health Insurance Information Program (SHIIP) is a consumer information division of the North Carolina Department of Insurance that assists people with Medicare, Medicare Part D, Medicare supplements, Medicare Advantage, and long-term care insurance questions. We also help citizens recognize and prevent Medicare billing errors and possible fraud and abuse through our NCSMP Program.
SHIIP provides education and assistance to North Carolinians in three ways:

- by operating a toll-free consumer information phone line Monday through Friday from 8 a.m. until 5 p.m.
- by training volunteers, including senior citizens, to counsel Medicare beneficiaries within their community about Medicare, Medicare Part D, Medicare supplements, Medicare Advantage and long-term care insurance, and
- by creating educational materials for consumers’ use including the *Medicare Supplement Comparison Guide* and featuring a Medicare Supplement Comparison Database on our Web site (www.ncshiip.com).

**Program Benefits**

Medicare is not full health care coverage. One estimate is that Medicare pays about 40% of an enrollee’s total health care costs. In both Parts A and B there are limitations on coverage, and certain deductibles and coinsurance amounts must be paid by the patient. (A deductible is an amount that must be incurred before Medicare will begin; a coinsurance is an amount that must be paid along with the amount covered by Medicare.) For eligible individuals, Medicaid will cover most of the charges not covered by Medicare. (See Medicaid chapter for more information.) Many insurance companies offer “Medigap” policies that are designed to cover the costs not covered by Medicare.

**Advocate Tip:** “Medigap” insurance policies, ostensibly designed to cover medical care not covered by Medicare, can be expensive and sometimes duplicative of coverage already owned by the consumer. The State Department of Insurance operates The Seniors’ Health Insurance Information Program (SHIIP) to offer advice and guidance to senior citizens about “Medigap” and other health insurance policies. It can also provide training on this issue. The program operates a toll-free telephone line to answer questions: 1-800-443-9354.

**Part A**

Covered services under Part A include hospital care, nursing home care, home health care, and hospice care. All care must be determined to be medically necessary to be eligible for Medicare coverage.
Hospital Care

Medicare will pay for:

- Bed in a semi-private room
- Special care units such as intensive care units or coronary care units
- Operating and recovery room costs
- Services regularly provided by a hospital such as meals, medical supplies, routine nursing services, etc.
- Laboratory tests and x-rays
- Drugs furnished by the hospital
- Physical and occupational therapy
- Blood transfusions, after the first three pints
- Social Services

<table>
<thead>
<tr>
<th>Hospitalized</th>
<th>Covered</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-60 Days</td>
<td>Most costs after Medicare deductible</td>
<td>$1,068 deductible</td>
</tr>
<tr>
<td>61-90 Days</td>
<td>All eligible expenses after you pay per day co-pay</td>
<td>$267 per day</td>
</tr>
<tr>
<td>91-150 Days</td>
<td>All eligible expenses after you pay per day co-pay</td>
<td>$534 per day</td>
</tr>
</tbody>
</table>

Medicare pays nothing after 150 days.

During each spell of illness, the patient is responsible for a **deductible of $1068**. (This is the 2009 figure; deductibles usually increase each January.)

**A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital for 60 consecutive days.

For the first 60 days there is no copayment. After that time, the patient is responsible for a **coinsurance payment of $267 per day** (2009 figure).

Each Medicare recipient is entitled to coverage for **60 additional days of hospital care, known as “lifetime reserve days.”** These are available
only once. The coinsurance payment during these lifetime reserve days is **$534 per day** (2009).

Payment for care in a psychiatric hospital is limited to 190 days per lifetime.

**Skilled Nursing Home Care**

Medicare will pay for the following in a Medicare-certified skilled nursing facility (SNF) or a rehabilitation facility if the beneficiary’s medical condition requires daily skilled nursing care or rehabilitative services:

- Bed in semi-private room
- Services regularly supplied by a nursing home, such as routine nursing services, meals (including special diets), medical supplies, etc.
- Medications furnished by the nursing home during the stay
- Physical, occupational, and speech therapy
- Use of medical equipment and supplies furnished by the facility

*Limitations and coinsurance:* Medicare will cover up to 100 days of skilled care in a nursing home per spell of illness if:

- The skilled nursing facility is a Medicare-certified facility, *and*
- The patient occupies a Medicare-certified bed in the facility, *and*
- The patient’s physician certified and prescribed skilled level of nursing care based on the patient’s need to receive skilled level of nursing care, *and*
- The patient was hospitalized for at least three days for the same illness, *and*
- The entry into the nursing home was within 30 days (in most cases) of the discharge from the hospital, *and*
- The condition that requires skilled nursing home care is the same condition that required the hospitalization. *and*
- The individual must be capable of showing improvement.

There is **no deductible** for nursing home care.
Medicare will pay for all charges during the first 20 days in the nursing home if the above conditions are met. The patient is responsible for a **coinsurance payment of $133.50 per day** (as 2009) on the 21st through the 100th day of nursing home care. Beyond 100 days, Medicare pays nothing.

**Home Health Care**

Medicare will pay for 4-10 hours a week of skilled care as follows:

- Part-time and/or intermittent skilled nursing care
- Physical, speech, and occupational therapy
- Home health aides for intermittent care (bathing or changing of dressings)
- Medical social services
- Medical supplies and appliances (coverage is limited to 80% of the approved amount for durable medical equipment. The patient is responsible for the 20%)  

*Limitations:* Medicare will pay for an unlimited number of home health visits as long as the following criteria are met:

- The patient is homebound (confined to their home and cannot easily get to their provider’s office)
- A physician prescribes the services and certifies that part-time or intermittent nursing services or physical, speech, or occupational therapy is needed
- The home health agency is certified by Medicare
- The patient must be capable of showing improvement

There are no deductibles or coinsurance payments if you are enrolled in Original Medicare. If you have Medicare coverage under Part C (HMO, PPO, PFFS) you may have copayments.

**Hospice Care**

Medicare Part A will pay for most hospice services at 100%:

- Regular home care visits by nurses to monitor the patient’s condition.
• Physician services (at 100% only if the physician is associated with the hospice agency)
• Outpatient medications for symptom control and pain relief (patient may owe a small copayment on this service)
• Physical, occupational and speech therapy
• Home health aide and homemaker services
• Medical social services
• Short-term inpatient respite care (patient may owe a small copayment on this service)
• Respite care for caregiver
• Chaplain services, if desired
• Medical supplies
• Medical appliances and equipment
• Dietary and other counseling services
• Bereavement counseling for both patient and family/friends

There are two 90 day benefit periods followed by an unlimited number of 60-day periods. The benefit periods may be used consecutively or at different intervals and the doctor must certify the patient as terminally ill at the beginning of each benefit period.

The patient must be terminally ill and choose hospice care. By choosing this care, other Medicare benefits are given up, although the choice is revocable.

There is a $5.00 or five percent, whichever is less, copayment for medications for Hospice patients and a five percent copayment for respite care. There are no deductibles.

**Part B**

Medicare Part B pays for doctor care (both inpatient and outpatient) and certain other outpatient health care. There is a $135 deductible per year and a monthly premium of $96.40 (effective 2009). Medicare pays 80% of the reasonable charge for the service. "Reasonable charge" is defined as the lowest of the actual, customary, or prevailing charge. It is determined by the Medicare Part B carrier.
Physicians who “accept assignment” agree to accept the “reasonable charge” as payment in full. Certain fees are capped nationally. Physicians who “do not accept assignment” can charge up to an additional 15% of the Medicare-approved amount.

**Advocate Tip:** Patients should ask every doctor upon each visit whether they accept assignment because the status can change at any time. Also, some doctors who normally do not accept assignment will agree to assist on a case by case basis. It is in the patient’s best interest to ask.

**Covered Services**

Medicare Part B covers the following (see website for updates):

- Doctors’ services, including consultation, diagnosis, and ambulatory surgery
- Home health care
- Physical therapy
- Supplies and drugs that cannot be self-administered and are incidental to doctor care
- Outpatient hospital services, including therapeutic and emergency services
- Diagnostic x-ray, laboratory, and other diagnostic tests
- Surgical dressings and devices for fractures and dislocations
- Durable medical equipment, such as oxygen equipment, wheelchairs, etc. for home use (rental or purchase)
- Prosthetic devices, including pacemakers, braces, artificial limbs, etc.
- Ambulance service to and from a hospital when necessary and reasonable
- Pneumococcal pneumonia and hepatitis B vaccines, and influenza
- One pap smear every three years
- Annual mammograms for women over 65

**Exclusions**
The following services are not covered by Medicare:

- Services and supplies not “reasonable and necessary” for the diagnosis or treatment of an illness or injury
- Eyeglasses and eye examinations, except after cataract surgery
- Hearing aids and hearing examination
- Dental care, except surgical or emergency care
- Routine physical checkups
- Routine foot care and orthopedic shoes, except for diabetics
- Cosmetic surgery
- Immunizations, except for pneumococcal and hepatitis B
- Custodial care

**Waiver of Liability**

When Medicare denies a claim for services, because it was determined not to have been reasonable and necessary, for example, the patient can sometimes avoid liability for payment by using a waiver procedure. This procedure can be used for any service under Part A and for any service provided by a provider who accepts assignment in Part B.

Liability will be waived if it can be shown that the patient could not have been expected to know the service would not be covered. Generally, it is presumed that a patient could not have known a service would not be covered unless the patient received advance written notice of no coverage. When liability is waived, Medicare pays for the service even though the claim was denied.

**Part C (Medicare Advantage)**

Medicare Part C includes several differing Medicare Advantage plans are another health insurance option for Medicare beneficiaries. Part C is entirely optional. Medicare Advantage plans (HMOs, PPOs, PFFS plans and/or MSAs) are available in our state and provide all Medicare Part A and Part B benefits and possibly some extra benefits. Members may be required to utilize a network or group of preferred providers. Check with your doctors and hospital to see if they accept the insurance plan you are considering joining. All four plan options may not be available in the county in which you reside.
Part D (Prescription Drug Plan)

The Medicare Prescription Drug Plan benefit (Part D) is provided by private companies that sell plans approved by Medicare. These plans are called Medicare Prescription Drug Plans or PDP's.

The premiums, formularies, co-payments, and deductibles vary by plan. Therefore it is very important for beneficiaries to compare plans based on the criteria that best fit their situation such as: does the plan cover their medications; can they use the pharmacy of their choice; is the premium affordable; is there a deductible. A SHIIP counselor can help a beneficiary compare plans and understand their options. Call the Seniors’ Health Insurance Information Program at 1-800-443-9354 to find a counselor in your area.

There is help with prescription drug costs for those individuals with limited incomes. This is called the Low Income Subsidy or “Extra Help”. People on Medicaid automatically receive the extra help and do not have to apply for it. North Carolina also has a State Pharmaceutical Assistance Program (SPAP) called NCRx. This program pays a portion of the monthly premium (up to $29) if the individual qualifies and is enrolled in a participating Part D plan.

Program Eligibility

Personal Eligibility

Part A

Eligibility Without a Premium

The following persons are eligible for Medicare Part A without the payment of any premium:

- Recipients of Social Security or Railroad Retirement benefits (and spouses) who are age 65 and older, have worked 40 or more quarters of Medicare-covered employment, and paid Medicare taxes while working.

Eligibility with a Premium

Anyone who meets the following criteria may enroll voluntarily in Medicare Part A upon the payment of a monthly premium:
• Age 65 or older, and
• Enrolled in Medicare Part B, and
• An American citizen or lawfully admitted alien, or
• A disabled person who loses eligibility for Social Security disability benefits due to earnings, but who still suffers from the impairment that was the basis of the disability determination

For qualifying individuals with less than 30 eligible quarters, the Part A premium is set annually by Medicare. ($443 per month for 2009). For individuals with 30-39 eligible quarters, the Part A premium is set annually by Medicare. ($244 per month for 2009)

Eligibility for Automatic Enrollment

See Part A under Applications Section. Part 3 - Page 29

Part B

Anyone entitled to participate in Part A may choose to participate in Part B upon the payment of a monthly premium. Most individuals pay a standard premium ($96.40 for 2009) but the passage of the Medicare Modernization Act of 2003, which became effective in 2007, states the beneficiary’s Part B premium will be based on their annual income and the threshold amounts change annually. Individuals with modified adjusted gross incomes less than $85,000 (2009 figure) will pay the standard rate. Individuals with modified adjusted gross incomes above $85,000 will pay a higher premium based on a sliding scale. Married couples with a combined annual income of $170,000 or less will pay the standard rate, whereas those with an annual income of higher than $170,000 will pay the increased premium.

Medicaid will pay this premium for certain eligible low-income individuals. (See Medicaid Chapter for more information).

Persons may choose to participate in Part B without participating in Part A. Voluntary enrollees in Part A must participate in Part B as well.

Part C

Generally, you can join a Medicare Advantage plan if you have Medicare Parts A and B; you live in the plan’s service area; and you don’t have End
Stage Renal Disease (ESRD). To find what plans are available in beneficiary’s area contact SHIIP at 1-800-443-9354.

**Part D**

If a beneficiary does not enroll in Part D when they are new to Medicare, they must enroll during the Annual Election Period (November 15-December 31) unless they qualify for a Special Enrollment Period. Special Enrollment allows Medicare beneficiaries to enroll or disenroll from a Part D plan outside of the Annual Election Period (AEP) and the Open Enrollment Period (OEP). In most cases, individuals who qualify for a SEP will not have a penalty. There are several situations which qualify for a SEP including, but not limited to:

- Individuals with Medicare and Medicaid (dual eligibles). Duals can change Part D plans at any time during the year. If they lose their Medicaid coverage, they will have a 2 month SEP during which they may change plans.

- Individuals who qualify for extra help or a state pharmaceutical assistance program (SPAP) can enroll in a Part D plan upon qualifying for the “extra help” or SPAP.

- Individuals who move outside of a plan’s coverage area have a 2 month SEP during which they may change plans.

- Individuals who move into, reside in, or move out of a qualified nursing facility (Long term care facility, nursing home). Once the beneficiary has lived in a facility for 30 days, they can change plans as often as once a month. If the beneficiary moves out of the facility, they have a 2 month SEP to change plans if they wish.

- Individuals who lose creditable coverage through no fault of their own OR their creditable coverage is no longer considered to be creditable have an SEP that begins the month they are informed their coverage will end (or no longer creditable). The SEP will last for 60 days after they lose coverage or 60 days after they receive notice, whichever is later.

**Financial Eligibility**

Medicare is not a needs-based program. Therefore, there is no analysis of income or assets to determine eligibility.
Program Appeals

A variety of appeal procedures exist to challenge decisions in the Medicare program. The procedure involved depends on the type of decision being challenged. As of January 1, 2006, the appeal levels for Medicare Part A and Part B are the same.

Eligibility

Decisions about whether an individual is eligible for participation in Medicare—either Part A or Part B—are appealed in the same manner as decisions about eligibility for Social Security benefits. Refer to Appeals, Social Security chapter, Part 1 – Page 26 for more details.

Part A Hospital Services necessary

Decisions about preadmission certification, hospital procedures, length of hospital stay, and hospital care are made by groups called Peer Review Organizations (PROs). PROs are groups of doctors who monitor decisions made by other doctors.

Reconsideration

Within 60 days of the receipt of an unfavorable decision, the patient may request reconsideration by the fiscal intermediary (Blue Cross Blue Shield). The patient should request a detailed explanation of decision before proceeding through this process. Additional evidence may be submitted (like a doctor’s statement), but no face-to-face hearing is held.

Hearing and Further Appeals

If an unfavorable decision is received, the patient may request a hearing with the Social Security Administration within 60 days. The notice of the request must be submitted to the fiscal intermediary. The procedures are the same as for Social Security hearings. Refer to Appeals, Social Security chapter, Part 1 – Page 26 for more details. The amount in controversy must be at least $120 (as of 2008) have to a hearing.

Further appeals (Appeals Council and federal district court) are the same as in the Social Security system. At least $1,000 must be in controversy to appeal to court.
Part B Appeals

Upon notification of a denial of payment for any Part B service, or failure to receive a response to a request for payments within 60 days, the patient may request reconsideration by the carrier (Equicor). (The provider can also request reconsideration by the carrier.) The request must be submitted within six months of the carrier determination either to the carrier or to Social Security.

The reconsideration is a paper review (no face-to-face hearing) but new evidence may be submitted.

Hearing

For services rendered prior to 1/1/87, or involving under $500, the only further appeal step is a hearing officer appointed by the carrier. This hearing must be requested within six months of an unfavorable reconsideration decision.

For services rendered after 12/31/86, and involving at least $500, the further appeal procedures are the same as for Social Security decisions (hearing by an ALJ, Appeals Council review, and judicial review in federal district court.) The hearing must be requested within six months of the reconsideration decision. Refer to Appeals, social Security chapter, Part 1 – Page 26 for further details.

LEGAL AUTHORITY


Federal Regulations: 42 C.F.R. 400-424, 460-498
20 C.F.R. 405 et seq.

Federal Policy: HCFA Medicare Manuals

SOURCES AND RELATED RESOURCES

Medicare
1-800-MEDICARE (1-800-633-4227)
TTY 1-877-486-2048
www.medicare.gov

Social Security Administration
1-800-772-1213
www.socialsecurity.gov

NC Seniors’ Health Insurance Information Program (SHIIP)
11 South Boylan Ave.
Raleigh, NC  27603
1-800-443-9354
www.ncshiip.com

Medicare and You Handbook 2009
Centers for Medicare and Medicaid Services
http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf

**Compare healthcare providers and plans on the web:**
Hospitals:  www.medicare.gov/hospital
Nursing Homes:  www.medicare.gov/NHCompare
Dialysis Facilities:  www.medicare.gov/dialysis
Home Health Agencies:  www.medicare.gov/homehealth
Health Plans:  http://www.medicare.gov/choices/advantage.asp

**Access your Medicare information online**
Track Medicare claims, get copies of your Medicare Summary Notices and find out which Medicare-covered preventive services you can get.
www.mymedicare.gov
State Health Programs

This information was copied from the NC Department of Public Health website and can be found at: http://www.ncpublichealth.com. Please go to the website for the most current information. Here is some of the information copied from the website on types of programs they have available. Each of these topics is expandable with additional information. We urge you to go to the website for more explicit information.

Chronic Disease and Injury - Updated 09/02/09

- CDI Section Home Page - Updated 09/02/09
- N.C. Chronic Disease & Injury Section Integration Blueprint, 2007-2012 (PDF, 2.25 MB)

- Asthma Program
- Cancer Prevention and Control
  - Breast and Cervical Cancer Control Program (BCCCP) - Added 08/28/09
    - NC WISEWOMAN
- Diabetes Prevention and Control
- Forensic Tests for Alcohol
- Healthy Carolinians
- Heart Disease and Stroke Prevention
- Injury and Violence Prevention
- Physical Activity and Nutrition
- Tobacco Prevention and Control

Epidemiology

- Epidemiology Section Home Page

- General Communicable Disease Control
  - Epidemiologic Investigation & Surveillance
  - Tuberculosis Control
- HIV/STD Prevention and Care
- Occupational and Environmental Epidemiology
  - Rabies Control
- Office of the Chief Medical Examiner
• Public Health Preparedness and Response

Human Resources

- Human Resources Home Page: This is the public site for the Division of Public Health (DPH) Human Resources, a division of the Department of Health and Human Services, and the primary source of HR information for more than 2,000 DPH employees throughout North Carolina.

- Benefits
- Classification and Compensation
- Employment
- Employee Relations
- Resources / Forms
- Safety and Health
- Staff Development and Training

Office of Minority Health and Health Disparities

- OMHHD Home Page

- Works throughout Public Health to bridge the health status gap between racial/ethnic minorities and the general population, and advocates for policies and programs that improve access to public health services for underserved populations.

Oral Health

- Oral Health Home Page

- The Oral Health Section (OHS) is the only statewide dental program, either public or private, that provides prevention and education services on dental health specifically for children. The majority of the OHS programs are tailored to the general public and health care providers.

State Center for Health Statistics

- SCHS Health Home Page

- Birth Defects Monitoring Program
- Central Cancer Registry
• Health and Spatial Analysis
• Statistical Services

State Laboratory of Public Health
  o State Lab Home Page
  • Cancer Cytology
  • Environmental Sciences
  • Laboratory Improvement
  • Microbiology
  • Newborn Screening
  • Clinical Chemistry
  • Virology/Serology

Vital Records
  o Vital Records Home Page
  • Birth certificates and other vital records, including marriage, death and divorce certificates.

Women's and Children's Health
  o WCH Home Page
  • Children & Youth
  • Early Intervention/"Together We Grow"
  • Immunization
  • Nutrition Services
  • Women's Health

No one is denied services based solely on ability to pay; however, most services are charged to the client using a sliding fee scale based on documented income. Some services are mandated to be provided at no cost to the client (denoted by *).
Maternal and Child Health Services

- Prenatal Care - Regular and High Risk
- Maternity Care Coordination
- Prenatal and Child Birth Classes
- Family Planning
- WIC for Women, Infants and Children - Nutrition Program
- Immunizations*
- Child Health Screening
- Child Service Coordination (Social Case Management)

Other services available in some local health departments:

- Primary Care for Children

Health Choice: state insurance supported intensive primary care for children (not available General Population Services)

- Flu and Pneumonia Vaccination for High-Risk Populations
- Blood Pressure and Blood Sugar Screening
- Adult Immunizations - Tetanus
- Health promotion and disease prevention activities

Other services available in some local health departments:

- Primary Care for adults
- Home Health – Medicare-certified skilled intermittent care: In-Home Registered Nursing, Home Health Aide, Physical Therapy, Occupational Therapy, etc.

- through all local health departments, but available in all counties)

Adult Health Services

- Flu and Pneumonia Vaccination for High-Risk Populations
- Blood Pressure and Blood Sugar Screening
- Adult Immunizations - Tetanus
- Health promotion and disease prevention activities
Other services available in some local health departments:

- Primary Care for adults
- Home Health – Medicare-certified skilled intermittent care: In-Home Registered Nursing, Home Health Aide, Physical Therapy, Occupational Therapy, etc.

**Environmental Health Services**

- Restaurant Inspections (grading)
- On-site Sewage Program (septic tank permits)
- Testing of Wells (water samples)
- General Solid Waste Concerns
- Vector Control (controlling insects and animals that carry disease)

Please call your county Health Department for more information. Please visit [www.ncalhd.org/county.htm](http://www.ncalhd.org/county.htm) for a list of local health departments by county and region.
Veterans Medical Benefits

Program Specifics

Quick Lookup

What is it?

A program providing medical benefits, including hospital care, nursing home care, and outpatient care.

Who Is It For?

Veterans who were discharged with other than a dishonorable discharge, on a space an available basis.

Where Are Applications Taken?

At VA medical facilities. In North Carolina, there are VA hospitals in Asheville, Durham, Fayetteville, and Salisbury.

Introductions

A wide range of medical benefits is available from facilities operated by the U.S. Department of Veterans Affairs (VA) for veterans who were discharged other than dishonorable conditions. For some veterans, the care is provided free of charge, without regard to income and resources. Other veterans must contribute to the cost of medical care. Because of limited space, not all veterans can receive care when they need it. Many of the criteria establishing priority of treatment are based on receipt of Veterans Service-Connected Compensation or Nonservice-Connected Pensions. Both of these programs are covered in separate chapters in this Guide and should be referred to for a fuller discussion of eligibility requirements.

Applications

Veterans should apply to receive medical care at the nearest VA medical facility. The facilities in North Carolina are listed at the conclusion of this chapter.

An applicant for medical care will be required to provide proof of military service and that he/she meets the eligibility criteria for care. (See Personal and Financial Eligibility sections following.)
There are no time limits on the eligibility of determination process.

**Program Benefits**

**Veterans**

Eligible veterans may be able to receive hospital care, nursing home care, and outpatient services. Generally, these services are provided in VA facilities but may sometimes be provided in private facilities at VA expense. There are NC State Veteran nursing home facilities in Fayetteville and Salisbury. Outpatient clinics are located in Winston-Salem, Charlotte, Durham, Greenville, Jacksonville, Morehead City, Raleigh, and Wilmington. The addresses and phone numbers of these facilities are listed at the conclusion of this chapter.

Also offered at VA-funded Vet Centers is readjustment counseling for Combat veterans. The emphasis is on providing mental health services to veterans with post-traumatic stress disorder.

Vietnam-era veterans can also get a physical examination if they are concerned about the health effects of Agent Orange. This service is also offered to World War II veterans who may have been exposed to radiation in Japan or in atmospheric tests of atomic weapons.

Other services and supplies provided by the VA to veterans who meet specified criteria include (but are not limited to) Prosthetic appliances (e.g., artificial limbs), aids for the blind, outpatient dental services, alcohol and drug treatment, domiciliary care for veterans who do not need nursing home care, and travel reimbursement.

**Dependents and Survivors**

The VA offers a medical insurance program known as the Civilian Health and Medical Program of the VA (CHAMPVA) to the spouses and children of veterans who are permanently and totally disabled from service-connected causes and to widow(er)s and children of veterans who have died as a result of a service-connected disability or who, at the time of death, had a permanent and total service-connected disability for more than 10 years. Those eligible for TriCare are excluded from CHAMPVA coverage.

Under CHAMPVA, the VA will pay a percentage of the cost of approved hospital inpatient services; a percentage of outpatient care and prescription
cost will be covered after the beneficiary meets an annual deductible. Care is provided at non-VA facilities.

To apply for CHAMPVA insurance, contact the CHAMPVA Registration Center, P.O. Box 65023 Denver, Colorado, 80206-9023 or call 1-800-733-8387; or contact the local North Carolina Division of Veteran Affairs office; or the local County Veteran Service Officer.

**Program Eligibility**

**Personal Eligibility**

Only veterans who were discharged under *other than dishonorable conditions* are eligible for VA medical care. (See Personal Eligibility section in Veterans Nonservice-Connected Pension chapter, Part 6 – Page 40 for a fuller explanation of discharge requirement.)

After that threshold is met, a veteran will be entitled to care, on a space available basis, according to his/her assigned Priority Group.

**Enrollment Priority Groups**

**Enrollment Priority 1**
- Veterans with service-connected disabilities rated 50% or more disabling

**Enrollment Priority 2**
- Veterans with service-connected disabilities rated 30% or 40% disabling

**Enrollment Priority 3**
- Veterans who are former POWs
- Veterans awarded the Purple Heart
- Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
- Veterans with service-connected disabilities rated 10% or 20% disabling
- Veterans awarded special eligibility classification under Title 38, U.S.C, Section 1151, “benefits for individuals disabled by treatment or vocational rehabilitation”

**Enrollment Priority 4**
- Veterans who are receiving aid and attendance or housebound benefits
- Veterans who have been determined by VA to be catastrophically disabled

**Enrollment Priority 5**
- Nonservice-connected veterans and non-compensable service-connected veterans rated 0% disabled whose annual income
and net worth are below the established VA Means Test thresholds
• Veterans receiving VA pension benefits
• Veterans eligible for Medicaid benefits

Enrollment Priority 6
• World War I veterans
• Mexican Border War veterans
• Veterans solely seeking care for disasters associated with:
  o Exposure to herbicides while serving in Vietnam; or
  o Exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or
  o For disorders associated with service in the Gulf War; or
  o For any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998
• Compensable 0% service-connected veterans

Enrollment Priority 7
Veterans who agree to pay specified copayments with income and/or net worth above the VA Means Test threshold and income below the HUD geographical index
• Sub-priority a: Non-compensable 0% service-connected veterans
• Sub-priority c: Nonservice-connected veterans

Enrollment Priority 8
Veterans who agree to pay specified copayments with income and/or net worth above the VA Means Test threshold and the HUD geographical index
• Sub-priority a: Non-compensable 0% service-connected veterans
• Sub-priority c: Nonservice-connected veterans

Additional Information:
The term service-connected means, with respect to a condition or disability, the VA has determined that the condition or disability was incurred in or aggravated by military service. Some veterans may have to agree to pay copayments to be placed in certain priority groups.
## Financial Eligibility

### 2009 Copay Requirements

<table>
<thead>
<tr>
<th>Priority Group 1 (SC 50% or more)</th>
<th><strong>INPATIENT</strong> ($10/day +$1024 for first 90 days and $512 after 90 days – based on 365-day period)</th>
<th><strong>OUTPATIENT CARE</strong> ($15 Primary Care; $50 Specialty Care; $0 for x-rays, lab, immunizations, etc.)</th>
<th><strong>OUTPATIENT MEDICATION</strong> ($8 per 30-day supply) PG 2-6 Calendar Year cap: $960</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>No</td>
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</table>

**Priority Groups 2, 3 (SC 10%-40%)**
No medication copay for SC condition, ex-POW, in receipt of VA A&A, HB pension or income below applicable pension threshold

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<th>No</th>
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**Priority Group 4**
Copay rules apply if placed from lower PG based on VHA catastrophic disability determination

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<th></th>
<th>No</th>
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**Priority Group 5**
No medications or extended care services copay if in receipt of VA pension or income below applicable pension threshold

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<th>No</th>
<th>No</th>
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**Priority Group 6 (Combat Veteran, SHAD, SC 0% compensable, ionization radiation)**
Copay rules apply if unrelated to PG6 placement

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**Priority Group 7**
Inpatient copay is reduced 80% of full rate

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<th>Yes</th>
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</table>

**Priority Group 8**
Unless income is below applicable pension threshold for medication and extended care services copays

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<tr>
<th></th>
<th>Yes</th>
<th>Yes</th>
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Program Appeals

Decisions that a veteran does not meet the eligibility criteria to receive care at a VA facility are appealable in the same way other benefits are appealable. (See Appeals section in Nonservice-Connected Pension chapter Part 1 – Page 62). Before initiating this process, however, the veteran should ask that the decision be reviewed by senior staff at the facility.

Decisions that a veteran does not need medical care are not appealable.

Medical Malpractice

A veteran who suffers injury or the survivors of a veteran who died as a result of VA health care can seek relief through the Federal Tort Claims Act. This is a specialized area of the law, and a veteran or his/her survivors should consult with an experienced attorney. The first step in the process is an administrative claim, which must be filed within two years of the individual’s awareness of the injury and that it was likely the result of the VA’s action.

In addition to pursuing a tort claim, a veteran and/or his/her survivors may apply for disability compensation or death and indemnity compensation. Another avenue of possible relief is either to apply for an increase in service connected disability benefits or to claim compensation for a condition secondary to a service-connected condition. In some cases, these benefits will be reduced if the veteran and/or survivors prevail in a tort claim and are awarded money damages.

Legal Authority

Federal Statute: 38 U.S.C §§601-664
Federal Regulations: 38 C.F.R. §§ 17.30-17.953

Sources and Related Resources

U.S. Department of the Veteran Affairs Regional Office
251 N. Main Street
Winston-Salem, NC 27155
1-800-827-1000

North Carolina Division of Veterans Affairs
227 East Edenton Street
Raleigh, NC 27601
National Veterans Legal Services Project, INC. (A non-profit law firm that serves as a national support center in the area of veteran’s law. Its services are available to veteran service organizations, state and county veterans offices, community-based veteran’s organizations, and volunteer attorneys, private bar attorneys, Legal Services programs, and other veteran’s advocates.)

Medical Facilities in North Carolina

Asheville Medical Center
1100 Tunnel Road
(828) 298-7911
(800) 932-6408
Fax: (828) 299-2502
Charlotte Outpatient Clinic
Presbyterian Plaza
8401 Medical Ctr. Dr. #350
Charlotte, NC 28262
(704) 547-0020

Durham VA Medical Center
508 Fulton Street
Durham, NC 27705
(919) 286-0411
(888) 878-6890
Fax: (919) 286-6825
Durham Outpatient Clinic
1824 Hillandale Road
Durham, NC, 27705
(919) 383-6107
Part 4: Housing Programs

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Federally Subsidized Housing.............................................10
Rental Assistance (Section 8 Existing Housing)......................17
State Housing Programs.......................................................25
Tenant Protection.................................................................30
Federal Public Housing

Program Specifics

Quick Lookup

What Is It?

Government-owned housing units made available to low-income individuals and families at no cost or for nominal rental rates.

Who Is It For?

Public housing is limited to low-income families and individuals. An HA determines your eligibility based on: 1) annual gross income; 2) whether you qualify as elderly, a person with a disability, or as a family; and 3) U.S. citizenship or eligible immigration status.

Where Are Applications Taken?

Applicants if interested in applying for public housing should contact the local public housing authority.

Introduction

The federal public housing program was established by the Housing Act of 1937 in order to provide decent, safe, and sanitary housing for low-income families. The program allows local public housing authorities (PHAs) own and operate rental housing with financial support from the federal government.

At the national level, the program is administered by the U.S. Department of Housing and Urban Development (HUD). HUD’s role is primarily that of funding the projects, overseeing local PHAs in their operation of federal public housing, ensuring compliance with federal statutes and regulations, and monitoring contracts between the PHAs and HUD. There is no state involvement in the administration of public housing, although the existence of PHAs is authorized by state law. Locally, programs are administered by local public housing authorities, which may be associated with a region, county, or municipality and answer to local Boards of Commissioners. The federal law gives these local authorities considerable discretion in operating the projects, so there are many differences among the PHAs in the state.
Applications

Applications for public housing are taken at the local PHA. In most locations there are long waiting lists, and the PHA is authorized to stop taking applications when, in its discretion, the waiting list is too long. Because public housing is not considered an “entitlement,” there is no requirement that all persons who meet the eligibility criteria be provided housing.

Despite the existence of a waiting list, admission into public housing is not necessarily on a first-come, first-served basis. In addition to the date of the application, certain preference and selection criteria are used to determine who will be offered the next available unit.

Selection Criteria

HUD authorizes PHA to develop locally-based admission preference based on local housing needs. These criteria may include:

- Avoid concentrations of the most economically and socially deprived families in any one project,
- Attain a broad range of income levels,
- Keep out applicants whose habits and practices may have detrimental effect on other tenants,
- Give preference to certain groups, such as veterans.

The preference criteria may not be racially discriminatory and may not require that vacancies be held open for higher-income tenants when lower-income applicants are waiting.

Notification

Applicants determined to be ineligible are entitled to receive a written notification of the reason for the denial. In addition, they are entitled to an informal review with someone other than the person who made the initial eligibility decision.

Program Benefits

Families admitted into public housing have the right to continued occupancy in a “decent, safe, and sanitary” housing unit for a rent of 30% of the family income.

Right to Continued Occupancy
Unlike private rental housing, in which a landlord can evict a tenant at the end of a lease term, tenants in public housing may not be evicted except for repeated or serious violations of the lease or for other good cause. The lease must be renewed annually. Good cause would include situations in which the family became financially ineligible for public housing or failed to meet some other basic eligibility, although even in these situations numerous protections apply that may allow continued occupancy.

If PHA determines there is cause for eviction, it must give the family written notice of a proposed lease termination. The individual lease will determine how far in advance the notice must be given; it must be at least 14 days in the event of nonpayment of rent and 30 days in most other situations. The notice must state the reason for the proposed termination and notify the tenant of the right to a grievance. (See Grievance Procedures section Part 4 - Page 7)

**Right to Adjusted Rent**

A family in public housing should not pay more than 30% of its annual adjusted income for shelter cost. This includes the cost of rent and basic utilities. A family’s income is examined at least annually and a rental amount set for the year. If the family’s income goes down, it has the right to report the decrease and have its rent adjusted accordingly.

**Utility Allowances**

Most PHAs establish a schedule of normal usage of electricity and other utilities, known as utility allowance. In some cases, the PHA pays for the utilities, in which case the utility allowance is included with the rent the tenant must pay. In other cases, the tenants pay utilities directly to the utility companies. In those cases, the utility allowance is subtracted from the tenant’s obligation to the PHA. If the family uses more than the established amount, it must pay for the overage.

**Lease Protections**

Tenants in public housing have the right to a written lease. The federal law requires that every lease contain certain tenant protections. At a minimum the lease must:

- State the amount of the rent, and the utilities provided
- Set out the procedures by which there will be redeterminations of rent
State the circumstances under which tenants will be charged for repairs, utilities, late fees, or other costs

Provide that the PHA will be responsible for all maintenance required to keep the units in decent, safe, and sanitary condition

Provide that the tenant has the right to reasonable accommodation of guests and visitors

Set out the specific obligations of the tenants (such as keeping the premises clean, refraining from illegal or disruptive conduct, using the facilities in a reasonable manner, etc.)

Set out the specific conditions under which the lease may be terminated and the procedures that will be used

**Program Eligibility**

**Personal Eligibility**

To be eligible for public housing, a tenant must be described by one of the following:

- A **family** (which is not defined in the federal regulations but in most cases is interpreted as a group of individuals related by blood or marriage, and in some cases requires the presence of children)

- A **single, pregnant woman** with no other children

- An individual age 62 or older

- An individual with disabilities

Persons with disabilities may be authorized to have a live-in attendant who is not related to live with him/her if it is essential for applicant’s care.

**Financial Eligibility**

A family or individual must be either “low income” or “very low income” to be eligible for public housing. **Low income is defined as having an annual income of less than 80% of the median income in the area. Very low income is defined as having an annual income of less than 50% of the median income in the area.** HUD publishes the median income levels for each county for use by PHAs.

**There is no minimum income requirement.**

**Counting Income**
The gross income of all members of the household counts toward the determination of annual income except specifically excluded items. Income includes:

- Gross wages, commissions, tips, and other fees,
- Net income from self-employment (i.e., after deduction for operating expenses),
- Interest, dividends, or other return investments,
- Periodic payments received from Social Security, Veterans Administration, public or private annuities, retirement plans, and other payment process,
- Unemployment Insurance, Workers’ Compensation, AFDC, or other regular cash benefits,
- Child support, alimony, or other regular contributions from someone outside the home.

Excluded Income

The following income is not counted in determining annual income:

- Earnings of children under age 18,
- Foster Care payments,
- Irregular income, including gifts, inheritances, lump sum insurance payments, or proceeds from the sale of an asset,
- Medical reimbursements,
- Income of a live-in attendant,
- Scholarships for school expenses (but any portion designated for “living expenses” is included as income),
- Food Stamps or Energy Assistance,

Amounts received under HUD-funded training programs, SSI “PASS” income and other reimbursements received under public assistance programs are excluded income.

Rent Compensation

After a tenant family is admitted into public housing, its rent payment is based on the amount of its income. Generally, a family’s rent payment
(including basic utilities) should be equal to 30% of its adjusted income.

Usually, there is a **once-a-year re-examination of income and other eligibility factors.** An effort is made to predict annual income for the coming twelve months based on current income. A monthly rental is set based on this prediction. Under the terms of most public housing leases, a family must report increases in income during the year and decrease in income. When adjustments are reported, the PHA is obligated to adjust the rent to keep it in line with the 30% rule. Most leases require that if a decrease is implemented and the income goes up again before the next annual examination, that increase must be reported and the rent adjusted upward.

**Adjusted Income**

From the total annual income that was calculated to determine eligibility, certain items are deducted. They are:

- $480 for each dependent household member who is under age 18, a full-time student, elderly, or individual with disabilities (other than the head of the household or any foster children)
- $400 for any family in which the head of household is elderly, handicapped, or disabled
- Unreimbursed medical expenses in excess of three percent of the total annual income in families in which the head of the household is elderly, handicapped, or disabled
- Child care expenses, when necessary for the employment of a parent or other caretaker

**Formula**

Once the adjusted income is determined by subtracting deductions, the following formula is used:

**Annual adjusted income**

\[
12 \times 30\% \text{ of monthly adjusted income} = \text{Total Monthly Payment}
\]

If the PHA pays for the utilities, the total monthly payment is due to the PHA. If the utilities are paid directly by the tenant to the utility company, the utility allowance is subtracted from the total monthly payment and the remainder is due to the PHA. If the result of subtracting the utility
allowance is a negative number, then the PHA must pay the tenant family the amount less than zero, so that the family can pay for the utilities.

**Program Appeals**

**Grievance Procedures**

If a tenant is dissatisfied with any action by the PHA, he/she may file a **grievance**. A grievance may be filed if the PHA proposes a lease termination or eviction raises or fails to decrease the rent, assesses extra charges, and fails to perform maintenance. Grievances may be used to resolve disputes between tenants or to address project-wide complaints.

Grievance procedures may vary from housing authority to housing authority. Each PHA must publish and post its procedure.

**Limitations**

The PHA may refuse to allow a tenant to use the grievance procedure in cases in which the tenant’s conduct is a threat to the health, safety, or peaceful enjoyment of the premises of other tenants of PHA employees, or if there is alleged drug related activity on or near housing authority premises. In non-payment of rent cases, the PHA can require the tenant to deposit the unpaid rent in escrow before using the grievance procedure. The inability of the tenant to do so can result in waiver of the right to use the grievance procedure.

**Procedures**

The following steps are included in grievance procedures:

1) The aggrieved tenant must discuss the grievance informally with the designated manager

2) The manager must provide a written summary of the discussion and any resolution to the tenant.

3) If dissatisfied, the tenant must submit a written request for a hearing within the time specified.

4) A hearing must be selected. At some PHAs, a hearing officer or hearing panel is selected periodically and used for all grievances. At other PHAs, a hearing officer is selected for each hearing. There should be some tenant participation in the selection regardless of which system is used.
5) A hearing shall be conducted at the convenient time and place. The tenant has the right to be represented, the right to see the relevant documents ahead of time, and the right to confront and cross-examine witnesses against him/her. The hearing is informal and court rules of evidence do not apply.

6) The hearing officer must issue a written decision, which is binding on the PHA unless it is rejected by the PHA Board. The board may reject a decision because it violates the law or doesn't concern PHA action that adversely affects the tenant.

Court Action

If the hearing officer upholds the PHA determination to evict the tenant, the PHA must still precede through the Summary Ejectment procedures in Small Claims Court and prove its case. The tenant loses no rights to defend the Summary Ejectment action by having gone through the grievance procedure, and may raise any claims he/she may have against the PHA in the court procedure. (See Tenant Protection chapter for more information about the Summary Ejection procedures.)

A court action for Summary Ejectment by the PHA can usually be successfully defended if the PHA failed to give the tenant the opportunity to file a grievance prior to the court action, or if the grievance procedure failed to meet all of the procedural requirements.

Legal Authority


Federal Regulations: 24 C.F.C. Parts 912, 913, 960, 965-970

Federal Policy: Public Housing Occupancy Handbooks 7465.1 REV and 7465.1 REV.-2 (Available from HUD Administrative Services at the addresses below)


Sources and Related Resources

U.S. Department of Housing and Urban Development
Office of Assisted Housing
415 N. Edgeworth Street
Federally Subsidized Housing

Program Specifics

Quick Lookup

What Is It?

A group of programs through which the federal government subsidizes the construction, rehabilitation, purchase, or operation of housing units so that tenants can rent units below market rates.

Who Is It For?

For most programs, individuals or families with incomes of less than 80% of the median income or the area in which they live.

Where Are Applications Taken?

Either at local public housing authorities or at the housing units themselves; applications are also taken online.

Introduction

Over the last several decades, Congress has enacted numerous programs designed to make available housing units to lower income families and individuals at below market rates. In some cases, the government has subsidized the mortgage interest at the purchase of housing units, thereby allowing the owner to charge lower rents. In other cases, the government contracts with the owner of property to pay the difference between the fair market rent and percentage of each tenant’s income.

Each of the programs has its own set of rules. For some tenants, more than one subsidy is involved, subjecting them to two sets of rules. In most federally subsidized situations, the property is owned and managed by private housing developers who agree to provide certain benefits to tenants in exchange for receiving certain economic benefits from the government. In some situations, the local public housing authority is involved in determining eligibility and rents, and in others it is not. At the federal level, the programs are all administered by the U.S. Department of Housing and Urban Development (HUD).
The various programs are often known by section numbers, which refer to sections of the National Housing Act or other legislation. The most common subsidized housing programs are Section 236; Section 221(d)(3); Section 202; Section 8 New Construction, Substantial Rehabilitation, Moderate Rehabilitation and Set-Aside; and Rent Supplementation.

**Applications**

In most situations, **applications are made directly to the property owner or manager**, who is responsible for selecting tenants. The local public housing authority (PHA) will usually be able to refer interested persons to the subsidized units in the community. In the Section 8 Moderate Rehab program, applications are taken by the PHA and eligible tenants referred to the property managers. The public housing authorities in North Carolina are listed in Appendix J.

Generally, the selection criteria are left to the owner, who must assure HUD only that the criteria are none, disciplinary and meet any applicable fair housing laws. Waiting lists must be maintained.

**Preferences**

In units with a **Section 8 subsidy**, preference is to be given to prospective tenants who:

- Are currently living in substandard housing or are homeless, or
- Are currently paying more than 50% of the median income for the country or metropolitan area
- Have been involuntarily displaced by a disaster or government action
- Assist low income families, elders, and people with disabilities

These preferences do not apply in Section 236, Section 221(d) (3), or Section 202 projects, unless the tenant also has a Section 8 subsidy.

When the rent is either a flat rate or is limited by a minimum, the landlord may consider the family’s ability to pay as a selection criterion.

Applicants who are **denied admission** to a unit must be given a written notice that specifies the reason for denial. They are entitled to an **informal review** by someone within the property management who did not make the initial decision to deny the application.
Program Benefits

The two primary benefits of living in subsidized housing are:

1) Rent at below market rates, and
2) The right to continued occupancy unless the tenancy is terminated for good cause.

Below Market Rent

Several different formulas are used to determine how much rent a tenant will be charged, depending on the program. Below are the most common formulas used:

Flat rate: In Section 221(d) (3) housing, for example, a rental amount is determined for each unit, depending on its size. Every tenant pays the same amount, regardless of income. The rent is generally at least 25% less than rents in comparable private housing.

Maximum/Minimum: In Section 236 housing, a maximum rent and a minimum rent are set for each unit, depending on its size. The tenants pay 30% of their adjusted family income for rent, but never less than the minimum or more than the maximum.

30% of Adjusted Income: In the Section 8 programs, a tenant pays 30% of the adjusted family income for rent. There are no maximums or minimums. If the family income drops during the lease term, the tenant may report the decrease and the rent should be adjusted accordingly.

It is possible for a tenant to live in a subsidized unit, such as a unit in a section 221(d) (3) project, and also have a Section 8 subsidy. In this case, HUD would pay the owner of the property the difference between the established rent and 30% of the tenant’s income.

Utilities

When the tenant is required to pay no more than 30% of the family income in rent, the 30% also includes utilities. Utility allowances are calculated for each size unit and should reflect a reasonable consumption of energy. If the tenant pays the utilities directly to the utility companies, the utility allowance is subtracted from 30% of the family income. The remaining amount is the rent due. If the utility allowance exceeds 30% of the family income, the rent is zero, and the tenant receives a check to help pay for utilities.
Continued Occupancy

Unlike in private rental housing, where the landlord can refuse to renew the lease for any reason, tenants in federally subsidized housing have the right to continued occupancy unless the lease is terminated for good cause.

**Good cause** is defined as:

- **Material noncompliance with the rental agreement**, which includes a serious violation of the lease, repeated minor violations of the lease, nonpayment of rent or other financial obligations, or failure to provide income information when rent is based on income.

- **Material failure to carry out obligations under state landlord-tenant law**, which include keeping the rented premises and plumbing fixtures clean, properly disposing of garbage, and refraining from damaging the dwelling.

- **Other good cause**, which is undefined but indicated that the reason may not be arbitrary, discriminatory, or the like. It may include certain business or personal decisions made by the property owner.

Department of Housing is **not** required to continue housing if:

- Tenants owe the department or any other federally subsidized housing program money;

- Had a clear record of poor house cleaning or poor property maintenance;

- Or were asked to move for repeated neighborhood disturbances and or lease violations.

**Notice of Termination**

Before the lease can be terminated, the tenant must receive **written notice** of the termination that informs the tenant of the specific **date of the termination**, the **reason for the termination**, and that the **tenant may defend** against the termination in court. If the tenant refuses to leave the unit voluntarily after receiving notice of termination, the **landlord must proceed through the court Summary Ejectment procedure to evict the tenant**. Notice of Termination should also give right to appeal and right to request a hearing; or to request a conference or hearing. Contact local legal aid office for further help.
If the termination is for “other good cause”, the notice must be at least 30 days for year-to-year prior to the date of termination. The federal law requires the landlord to follow state law requirements with regard to the notice period for other violations. In North Carolina, however, there is no minimum notice period when the landlord is terminating the lease because of a violation. Only the provisions of the lease determine whether a notice must be given a certain number of days, a judge would have to determine if the notice were sufficient. For a week-to-week lease, the landlord must provide a two-day notice; for a month-to-month lease, a landlord must provide a seven-day notice.

**Program Eligibility**

**Personal Eligibility**

**Most Units**

For Section 236, Section 221(d) (3), and Section 8 New Construction, Substantial Rehab, and Set Aside projects, there are virtually no personal eligibility requirements. Families and single persons are eligible. There are no citizenship or alien requirements.

**Section 202**

Eligibility for Section 202 housing requires that the tenant be age 62 years or older or have a disability.

*Tenants can be a family* in which the head of household (or his/her spouse) is age 62 or older, or has a handicap or disability. Not everyone in the unit must be over 62 or have a disability.

*A person who is handicapped* is one who has an impairment that is expected to last indefinitely, that substantially impedes his/her ability to live independently, and is of such nature that his/her ability to live independently could be improved by more suitable housing.

Typically one bedroom apartments with a kitchen and bath include special features such as non-skid flooring; grab bars and ramp to help older persons remain safer and more independent as they age.

Many sections 202 facilities also provide access to supportive services such as home delivered meals, housekeeping, and transportation to community health providers.
Financial Eligibility

Known as the Section 8 low income limit

For most programs, the prospective **tenant may not have a family income that exceeds 80% of the median income for the area.** HUD publishes these figures

Income is counted the same way it is counted for Public Housing. When the rent is based on 30% of the family income, it is computed as it would be in public housing. See Federal Public Housing, Financial Eligibility section at Part 4 – Page 4 for more information.

Program Appeals

There is no formal grievance hearing for tenants in subsidized housing who disagree with the decision made by the property owners or managers. In most situations, the tenant has the right to at least an informal discussion or review of the decision.

Courts around the country disagree on whether the actions of owners and managers of federally subsidized property are the “state action,” which would require that tenants be afforded certain due process protections. Some tenants have had more success than others in trying to assert rights in court. Tenants who believe their rights are being violated by the property owners or managers should seek legal advice. Most tenants of federally-subsidized housing are eligible for free legal services. See Legal Services chapter.

Evictions

A property owner may not evict a tenant without properly terminating the tenancy. The procedures of the lease must be followed, as well as state law on evictions. A tenant faced with eviction should seek legal help immediately. Grounds for eviction: Nonpayment of rent; Holdover; Breach of Lease; or Expedited Eviction of Drug Traffickers and other Criminals.

Legal Authority

**Section 236 Housing**


Federal Regulations: 24 C.F.R Parts 219, 236, 243, 245, 246, 247
<table>
<thead>
<tr>
<th>Section</th>
<th>Federal Statute</th>
<th>Federal Regulations</th>
</tr>
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<tbody>
<tr>
<td>221(d) (3)</td>
<td>12 U.S.C §1715(d) (3)</td>
<td>24 C.F.R Part 221 Subparts C and D, Parts 219, 243, 245, 246, 247</td>
</tr>
<tr>
<td>202</td>
<td>12 U.S.C §1701q</td>
<td>24 C.F.R Parts 202, 277, 243, 278, 885</td>
</tr>
<tr>
<td>8 New Construction and Substantial Rehabilitation</td>
<td>42 U.S.C §1437f</td>
<td>24 C.F.R. Part 880, 881</td>
</tr>
<tr>
<td>8 moderate Rehabilitation</td>
<td>42 U.S.C § 1437f</td>
<td>24 C.F.R § 882.401 et seq. and 882.50 et seq.</td>
</tr>
<tr>
<td>8 Set-Aside</td>
<td>42 U.S.C. §1437f</td>
<td>24 C.F.R Part 886</td>
</tr>
<tr>
<td>Rent Supplementation</td>
<td>12 U.S.C §1701s</td>
<td>24 C.F.R Part 215, 247</td>
</tr>
</tbody>
</table>

**Sources and Related Resources**

U.S Department of Housing and Urban Development  
Office of Multifamily Loan Management  
415 N. Edgeworth Street  
Greensboro, NC 27401  
(910) 856-2121

North Carolina Legal Services Resource Center  
224 S. Dawson Street  
P.O Box 27343  
Raleigh, NC 27611  
(919) 856-2121
Rental Assistance (Section 8 Existing Housing)

Program Specifics

Quick Lookup

What is it?

Housing Assistance.

A federally-funded program in which families receive a voucher that entitles them to rental assistance in private housing units

Who is it for?

Low income families, seniors, individuals with disabilities or handicap.

Where Are Applications Taken?

At public housing authorities. There is no time limit within which applications must be acted upon. At most housing authorities, there are long waiting lists

Introduction

Rental Assistance, known as the Section 8 Existing Housing Program or the Housing Assistance Program (HAP), allows tenants to live in private housing and receive assistance with their rent and utilities. The U.S. Department of Housing and Urban Development (HUD) contracts with an owner of private housing to pay the difference between the fair market rent and 30% of the tenant’s income. The local public housing authority administers the selection of tenants, who receive certificates of family participation of vouchers and then may rent a dwelling of their choice in community as long as it meets certain standards.

Applications

Applications for the section 8 certificates and vouchers and vouchers are taken at the local public housing authority. (A list of the PHAs in North Carolina is found in the Appendix J.) Each PHA has a limited number of certificates and vouchers. Once they have been distributed, an applicant must wait until a certificate or voucher is returned before receiving one. Because the voucher program is newer, there are relatively few vouchers
available. Most PHAs have considerably more certificates that vouchers to distribute.

Waiting List

PHAs are required to establish a new section 8 waiting list. Add names to an existing Section 8 waiting list to limit outreach to those households that are potentially eligible for the vouchers.

In addition to applying the federal preferences, the PHA may have other selection criteria. These criteria should be publicly available. They may not discriminate of the basis, of race, sex, religion, national origin, the presence of children, or handicap. They may, however, prefer tenants who currently live in the PHA’s jurisdiction, veterans, or other favored groups.

In this program, the **PHA may not exclude applicants because it determines they would not make suitable tenants.** The private landlord makes that determination when he/she accepts or rejects the tenants.

Notification

The PHA must provide **written notification if an applicant is denied a certificate or voucher or a place on the waiting list.** The notice must specify the reason for the denial. The denied applicant is entitled to an informal review (may be conducted by: Chief of Housing; Representative of the county attorney of Exec. OH.) of the decision by a person other than the one who made the original decision. The applicant should be given the opportunity to present oral or written objections to the PHA decision. The PHA must provide a written determination after the informal review.

- Tenant-Based
- Project Based

Program Benefits

Eligible tenants receive a **Certificate of Family Participation** or a **voucher** from the local public housing authority (PHA). A frequently known as a “Section 8 voucher **entitles the tenant to rental assistance in a private housing unit.**

**Upon receipt of a certificate, the tenant must find a unit** that rents for **not more than a maximum rent.** HUD sets maximum rents depending on the
size of the unit needed and the location. For example, a tenant needing a	hree bedroom unit may be able to choose a unit that rents for not more than
$475 a month. **Tenants who receive vouchers are not restricted to units
that rent for a specified amount.** They can choose a unit regardless of its
rental amount.

The unit chosen must meet certain physical standards which qualify it as a
“**decent, safe, and sanitary**” dwelling. The landlord must be willing to enter
a lease with the tenant and a housing assistance contract with the PHA

**The tenant must locate a unit within 60 day of obtaining a certificate of
voucher,** although extensions may be available from the PHA. If the tenant
fails to find a unit the certificate or voucher expires.

**Continuing Entitlement**

If the tenant finds a unit within the time limit, the **voucher continues to
entitle the tenant to rental assistance unless and until the certificate or
voucher is properly terminated for good cause.** This is true even if the
tenant moves to a different unit, as long as the PHA authorizes the move and
the new unit meets the rent limit(s) and physical standards. Even an eviction
by the landlord does not terminate the rental assistance.

A voucher may be used at another unit within the jurisdiction of the PHA that
issued it. A voucher may be used at another unit anywhere in the United
States as long as there is a PHA in the new location with a voucher program.

**Rental Assistance**

**Voucher-based**

**Vouchers give tenants a specific amount of assistance to be applied
toward rent and utilities.** The amount is set so that the tenant will not be
paying more than 30% if the family income for rent and utilities if the
chosen unit rents for not more than a specified amount set by HUD. The
tenant can choose, however, to rent a more expensive unit. If he/she
does, he/she will end up spending more than 30% of the family income on
rent and utilities.

**Utility Allowances**

The PHA sets a **utility allowance** for each size unit, which should reflect
the **cost of a reasonable consumption of utilities.** If the tenant pays for
utilities directly to the service providers, the utility allowance is subtracted from 30% of the family income. The amount remaining is the amount paid in rent to the landlord, and the tenant must pay for the utilities as used. If the utility allowance exceeds 30% of the family income, the tenant’s share of rent is zero and the PHA makes a payment to the tenant family to assist with the payment of utilities. If the family uses more than a reasonable amount of utilities, it will end up paying more than 30% of its income for shelter costs.

**Lease Protections**

The PHA must approve the lease between the landlord and the tenant. It must be for **at least a year**. If the landlord offers an additional term after the first year, the lease must allow the tenant to terminate it without cause any time after the initial year.

Certain provisions will not be approved. Generally, these are ones that require the tenant to give up certain rights, such as the right to a court hearing before eviction, the right to certain notices, or the right to appeal.

The lease must require the landlord to keep the premises in a fit and habitable condition that meets the quality standards set by HUD. The local PHA is required to inspect the unit annually to assure that it remains a decent, safe, and sanitary unit.

**Lease Termination by Landlord**

The landlord may terminate the lease during the lease term or at the end of the term only for:

- **Serious or repeated violation of the lease**
- **Violations of legal obligations** in connections with the occupancy of the dwelling
- **Other good cause** (limited to tenant malfeasance when used during the first year)

**Other good cause** (after the initial year) includes a decision by the landlord to convert the dwelling to personal use, sell or renovate the unit, discontinue participation in the Section 8 program, or the like.

Without a showing of one of the above factors, the landlord must continue leasing the unit to the tenant indefinitely.
**Advocate Tip:** When the landlord fails to keep the premises in a decent, safe, and sanitary condition, the PHA first sends a notice and attempts to get the landlord to make the necessary repairs. If the landlord fails or refuses, however, the PHA will stop paying its share of the rent. At that point, the landlord may attempt to evict the tenant for “non-payment of rent,” even though the tenant family has made all of its payments. The tenant should get legal help immediately if this occurs. It is usually possible to prevent the eviction and establish court orders that will force the landlord to make repairs. If the tenant does not wish to remain in the unit, the PHA must issue another certificate or voucher so the family can find another suitable unit.

**Program Eligibility**

**Personal Eligibility**

To be eligible for Rental Assistance, a tenant must be one of the following:

- A **family** (which is not defined in the federal regulations but in most cases is interpreted as a group of individuals related by blood or marriage, and in some cases requires the presence of children)
- A **single pregnant woman with no other children**
- An individual age 62 or older
- A **handicapped of disabled** individual

Handicapped or disabled individuals may be authorized to have an attendant who is not related live to him/her if it is essential for the individual’s care.

**There are no requirements that tenants be U.S. citizens or legal aliens**

**Disqualifications**

An applicant may be denied a certificate or voucher, or a current certificate or voucher holder may be terminated from the programs, for the following reasons

- The **applicant currently owes money to the PHA** as a result of unpaid charges, which may have arisen while the applicant lived in public housing or another Section 8 unit.
- The **applicant has committed fraud** in connection with a housing program.
• The applicant has violated any obligation he/she has in the program much as allowing inspection, providing income information or provide notice of a vacationing a unit.

Financial Eligibility

A family or individual must be either “low income” or “very low income” to be eligible to participate in the section 8 Existing Housing Program. **Low income is defined as having an annual income of less than 80% of the median income in the area. Very low income is defined as having less than 50% of the median income in areas.** HUD publishes the median income levels for each county for use by the PHA’s.

In order to rent a unit that first became available for Section 8 occupancy after October 1, 1981, the tenant family must be in the very low income category. Units that were available prior to that time may be rented by those in either category.

There is no minimum income requirement.

The rules for counting income and rent computation are the same as those for public housing. (See Public Housing, Financial Eligibility section, Part 4 – Page 4.)

**Program Appeals**

Unlike tenants in public housing, **Section 8 tenants are not entitled to a formal grievance hearing** if they disagree with decisions of the PHA affecting their certificates or vouchers. Nevertheless, an informal hearing must be offered by the PHA if PHA:

- Denies a certificate or voucher
- Terminates the rental assistance
- Sets the tenant’s share of the rent at an amount different from what the tenant thinks is correct
- Makes certain decisions regarding the number of bedrooms allowed

**Hearing Requirements**

The PHA must publish its procedures for informal hearings. For **persons who already hold a Section 8 certificate or voucher**, the procedure must provide at least the following:
- **Written notice** of reasons for the action taken will be provided to the tenant.

- **The decision will be made by some other than the person who made the first decision.**

- **The tenant may be represented** by a lawyer, a paralegal or other representative.

- **The tenant may testify, submit documents, present witnesses and question witnesses** against him/her.

- **A written decision** must be made, based on the facts brought forth at the hearing, and a copy furnished to tenant.

The only requirements for the informal review when an applicant is denied a certificate or voucher are that a person other than the one who originally made the decision shall conduct the review and the applicant shall have the opportunity to present written or oral objections to decision.

If the tenant is wrongfully denied participation in the Section 8 program, he/she may wish to consider legal action against the PHA. The services of an attorney would be required. Free legal services may be available at the local Legal Services office. (See legal Services chapter.)

**Eviction**

Landlords who wish to evict tenants must proceed through the Summary Ejectment procedures required by law. (See Tenant Protection chapter.) A tenant who is faced with eviction should seek legal advice immediately.

**Legal Authority**

- Federal Statue: 42 U.S.C §1437f
- Federal Regulations: 24 C.F.R Parts 812, 813m 842, 882
- Federal Policy: HUD Handbook for the Section 8 Existing Housing program 7420.7 (available from the Administrative Services section of the HUD office listed below)

**Sources Related Resources**
U.S. Department of Housing and Urban Development
Office of Assisted Housing
415 N. Edgeworth Street
Greensboro, NC 27401
9910) 547-4000

North Carolina Legal Services Resource Center
224 S. Dawson Street
P.O. Box 27343
Raleigh, NC 27611
(919) 856-2121
State Housing Programs

Program Specifics

Quick Lookup

What are they?

A group of programs through which housing developers, lenders, and community agencies provide services and benefits to allow low-income persons to live in decent and affordable housing.

Who are they for?

Most of the programs target persons with a family income below 80% of the median income in their local area. Some programs target persons with 50% or less of the area median income.

Where are applications taken?

At various locations, depending on the program. These may include housing sites, lending institutions, or community agencies.

Introduction

Primarily through the North Carolina Housing Finance Agency (NCHFA), the state coordinates a variety of programs designed to expand housing opportunities for low income persons. Renters, homeowners, and first time home buyers can be assisted through the various projects. Many projects are done in cooperation with local housing developers, community agencies, local governments, and lending institutions. Certain federal benefits are also coordinated through the NCHFA to give low-income North Carolinians housing options. Brief summaries of the various programs and projects are included below. A full listing of the housing programs in the state is available in the Housing Resource Manual published by the NCHFA. (See Sources and Related Resources at the conclusion of this chapter for information on obtaining the manual.)

Applications

Application process described program by program.

Program Benefits and Eligibility
Below-Market Home Mortgages

Through the sale of tax-exempt bonds, the NCHFA is able to generate revenue to finance a program that allows first-time home buyers to obtain below-market interest rates on loans for the purchase of a home. The mortgages are available through lending institutions around the state. The mortgages are all 30-year fixed-rate, FHA-insured loans.

To qualify for a NCHFA loan, a borrower must:

- Be a North Carolina resident
- Have an annual income of not more than between $30,000 and $40,000, depending on the household size and location or
- Have net assets of $40,000 or less if under age 61; $50,000 or less if age 62-64; $60,00 or less if age 65 and older; $75,000 if handicapped
- Be a first-time home buyer, or not have owned a home as a principal residence during the past three years (this requirement is waived in economically distressed areas)
- Be a reasonable credit risk.

A home purchased through the program may not exceed a specified purchase price. A new home may not exceed more than $200,000; an existing home may not exceed more than $190,000, depending on the location. (These limits are increased with some frequency.) The buyer must be able to pay a three to five percent down payment and a one percent origination fee. If the home buyer sells the home within 10 years of the purchase, some of the interest subsidy may be recaptured in future tax years.

Interested home buyers should apply at a participating lender after having negotiated a contract on a home. The names of participating lenders are available from the NCHFA Single Family Department.

Mortgage Credit Certificates

Each year, the NCHFA is able to allocate a certain number of Mortgage Credit Certificates to first time home buyers. These certificates allow home buyers to receive a federal income tax credit for either 15% or 25% of their mortgage interest payment, up to a limit of 2,000 a year. The availability of the tax credit allows the home buyer to reduce his, her federal tax withholding, and thereby increase disposable.
Applications for the Mortgage Credit Certificates are taken by participating lending institutions. A list of participating lenders is available from the NCHFA Single Family Development. The credit can be used with any of the variety of loans. If the home buyer sells the home within ten years of its purchase, some of the credit may be recaptured in future tax years.

A recipient of the credit must meet the same eligibility requirements as are described above in the Below-Market Home Mortgage program. The limits on the price of the house are the same as well.

Home Ownership Challenge Fund

A special fund of money available through the NCHFA is directed to local governments, nonprofit agencies, and private developers to allow them to create housing for the poor. The money allows these housing providers to make low-interest mortgages, down payment assistance, monthly housing subsidies, and mortgage tax credits available to the poor to help them purchase housing. The new homeowners are those with incomes of less than 80% of the median income for the area; frequently they are those with incomes of less than 55% of the median area income.

Individuals interested in benefiting from this program must apply with the local groups handling the funds. Names and addresses of the participating groups are available from the NCHFA Single Family Department.

Housing Trust Fund

This fund of money is funneled through local sponsors, such as local governments, non profits and private developers, to build and repair homes and apartments for the poor. Projects completed with Housing Trust Fund money include new houses in rural areas, city revitalization, elderly apartments and homeless shelters. Many homes have been rehabilitated as well.

Most of the households receiving benefits under this program have family incomes of less than half of the median for the area. Different eligibility criteria apply depending on the project. Interested persons can contact the NCHFA Program Development Department to learn about the Trust Fund projects occurring in their geographic area.

Home Improvement Programs
Low income homeowners may be able to improve their homes through either of two additional programs.

**Home Improvement Loan Program**

The NCHFA coordinates a **Home Improvement Loan Program** that makes available **low-interest loans of up to $15,000 to help homeowners repair substandard housing**. Applications are taken through local governments and nonprofit organizations. A list of participating governments and organizations is available from NCHFA. Recipients must have an annual family income of not more than $30,000 in nonmetropolitan counties and $34,500 in metropolitan counties to qualify for a loan. (This program is funded by the sale of bonds, and may not always be available.)

**Community Development Block Grant Funds**

Many local governments have available federal **Community Development Block Grant (CDBG) funds** that can be used for home improvement. The money is coordinated through the North Carolina Department of Commerce, Division of Community Assistance. Programs may be structured differently from community to community.

CDGB funds are available as either grants or loans, and can be used either on owner-occupied housing or rental housing. Generally, the home must be located in an area targeted for rehabilitation and the homeowner or renter must have an income that is less than 80% of the median area income (using figures published by the Department of Housing and Urban Development). Applications are taken by local governments.

**Rental Housing**

Several programs, especially a federal low-income tax credit, allow developers to build rental housing for the poor. In exchange for the tax credits, which subsidize development cost, developers agree to lease their units at reduced rates for at least 15 years. Most units are rented to families with income under 60% of the median area income. The federal government, through the Department of Housing and Urban Development (HUD), determines the rents and sets other criteria.

These programs are similar in structure to federally subsidized housing. (See Federally Subsidized Housing chapter). Individuals interested I finding out
where such rental projects are located in their local region may contact the NCHFA Multifamily Department.

**Program Appeals**

Each program requires notice of disqualification. Notices can then be brought directly into the court system for decisions.

**Legal Authority**


**Sources and Related Resources**

North Carolina Legal Services Resource Center
224 S. Dawson Street
P.O. Box 27343
Raleigh, NC 27601
(919) 856-2564

Housing Resource Manual (A guide to all the organizations participating in housing programs throughout the state, including indexes by service area, programs offered and type of organization) available for $10.00 from NCHFA, Department of Program Development, P.O. Box 28066, Raleigh, NC 27611-8066.
Tenant Protection

Program Specifics

Quick Lookup

What Is It?

A variety of state and federal laws designed to protect tenants in residential rental situations.

Who Is It For?

Anyone who rents his/her place of residence.

Introduction

Residential tenants are protected by five main laws in North Carolina. The laws provided tenants the following rights:

➢ The right to remain in the rented residence unless properly evicted through the court system
➢ The right to live in a fit and habitable dwelling
➢ The right not to be evicted for complaining about needed repairs or asserting tenant rights
➢ The right to have the security deposit returned or accounted for
➢ The right to be free from discrimination on the basis of race, color, religion, sex, national origin, family status, and handicap.

These laws apply to tenants in both public housing and private housing. The tenant does not need to have a written lease to be protected, although a written lease may contain additional protections not found in the law.

To enforce this right, it is usually helpful and sometimes necessary to have a lawyer. Low-income persons are usually eligible for free legal assistance. (See Legal Services chapter.)

Tenants can’t unilaterally withhold rent from a landlord who fails to make required repairs. Landlord and tenant can agree to reduction in rent, however.
Under the law in North Carolina, there is **only one way a landlord can properly evict a tenant. That is by using the court system.** It is *strictly illegal* for the landlord to evict a tenant by changing the locks, removing the tenant’s possessions, turning off the utilities, or using other forcible methods. The steps of the court procedure are outlined below.

**Program Benefits**

**Fit and Habitable Housing**

All landlords are required by law to keep the rented premises in a safe and decent condition. This is true even if the rent is very low, and even if the tenant initially accepted the premises in an unsafe or unfit condition. The law sets out four specific obligations of the landlord, although some overlap with each other. The landlord must:

- **Obey the local housing code.** Not all areas of the state are covered by a code, but most of the cities are. When a city has a code, it also has staff that inspects and enforces the code. If the tenant thinks his/her dwelling does not meet the code, he/she should call the local housing inspector to do and inspection.

- **Make all repairs necessary to put and keep the premises in fit and habitable condition.** Fit and habitable is not specifically defined in the law, but generally it means that the premises should not be dilapidated or unsafe in any way.

- **Keep the common areas, such as stairways, sidewalks, or parking lots, in a safe condition.**

- **Maintain in good and safe working order, and promptly repair all appliances and facilities provided, such as heating, cooling, plumbing, and electrical appliances.**

  **Advocate Tip:** Because the term “fit and habitable” is not specifically defined in the law, it may not be enforced in the same way from judge to judge. Generally, however, unsafe conditions, such as rotten floor boards, loose hand railings, or broken window or door locks will be considered in violation of the law. In addition, a unit that is not weather tight usually will not be considered fit and habitable. More questionable conditions include the need to cleaning or painting or other cosmetic needs. The law authorizes a tenant to bring a claim against the landlord not only to have the
unfit conditions repaired, but to obtain a rebate on the rent paid. The amount of rent rebated will depend on how serious the defects have been and for what period of time.

**Program Eligibility and Appeals**

**Summons and Complaint**

The landlord must begin by filling a Complaint at the county courthouse. It is called a “Complaint in Summary Ejectment.” This is a statement that he/she is bringing **legal action for eviction against the tenant**. The complaint must state the reason for the eviction and what the landlord wants. Usually, the landlord wants immediate possession of the rented premises and any money due from the tenant.

At the same, the landlord must have the Clerk of Court issue a **Summons**. This is a notice that the tenant has been sued. It sets out a **time, place, and date** when the tenant may appear and defend against the eviction. Eviction actions are heard in Small Claims Court, also known as Magistrate’s Court.

**Service**

A **copy of the Complaint and Summons must be served** on the tenant. This is generally done either by **posting** or **personal service**. Posting is when the sheriff leaves the Summons and Complaint on the door of the dwelling. Personal services are when the sheriff hands the Summons and Complaint directly to the tenant or to someone who lives with the tenant who is old enough to reliably deliver the papers to the tenant. Often, a second copy of the papers will be delivered to the tenant.

Must maintain facilities in good and working order. Promptly repair all electrical, plumbing, sanitary, heating, ventilating, air conditioning, and other appliances.

**Court Hearing**

The **landlord must prove in court that he/she has grounds for eviction.** (See following section on Grounds for Eviction.) The tenant has the right to question the landlord and explain to the magistrate his/her side of the story. At the end of the hearing, the magistrate will decide whether the landlord has proven that he/she has the right to evict or not.
If the magistrate rules for the landlord, he/she will enter a judgment for the landlord. The judgment will give the landlord the right to possession of the dwelling, and may give the landlord the right to collect certain money due. It may also give the landlord the right to be reimbursed for court cost.

**Appeal**

The judgment is not final for ten calendar days. During these ten days, the tenant (or the landlord if the tenant won in Small Claims Court) may file an appeal to district court with the Clerk of Court. This must be done in writing (unless it was done orally at the end of the Small Claims Court hearing). An appeal fee must be paid or an order obtained from the Clerk of the Court that the fee is waived because the appealing party does not have the funds to pay the fee.

In order for the tenant to stay in the dwelling until the appeal can be scheduled, the tenant must pay his/her rent into court as it becomes due. A bond promising to do this must be signed.

**Execution**

If no appeal is filed, or if an appeal is filed but no bond to pay the rent is signed and filed, the landlord may return to the courthouse on the eleventh day after the judgment was entered and ask the sheriff to “execute the judgment.” This means that the sheriff must carry out the magistrate’s order.

Within the next few days, the sheriff will leave a notice at the dwelling stating that the landlord has won the right to possession of the unit. It will give the tenant a date and a time when the sheriff will return to carry out the eviction, which will be within the next few days.

If the tenant has not vacated the unit by that time, the sheriff will require all persons inside to leave and will padlock the dwelling. Sometimes, the belongings of the tenant will be left inside the unit; sometimes they will be moved to a storage facility. The tenant has 21 days to claim his/her possessions without having to pay anything for storage or any money due to the landlord. If the tenant does not claim within that period, the landlord can refuse to release them unless fees are paid.

**Advocate Tip:** During the ten-day period after the judgment is entered but before it is final, it is not uncommon for landlords and tenants to “work something out.” If the eviction is for non-payment
of rent, many landlords will agree not to have the judgment executed if the rent is paid. Tenants need to be extremely careful in making these arrangements. The landlord has the legal right to accept the back rent and still go forward with the eviction. The tenant needs to obtain a clear agreement (in writing if at all possible) from the landlord that he/she will not go forward with the eviction upon the payment of the rent due.

Grounds for Eviction

In order for the landlord to be successful in the eviction action, he/she must prove that there is a legal reason for the eviction. The landlord must show that one of the following situations exists:

- **The tenant has failed to pay the rent due.** If there is no written lease or if the written lease does not specify, the landlord must have made a demand – either written or oral – for the rent and waited ten days before beginning the court procedure. If there are written lease provisions about failure to pay rent, the landlord must follow whatever procedures are set out in the lease.

- **The tenant has violated the lease.** In order for the landlord to use this as grounds for eviction, there must be written lease and the lease must say that if the tenant violates the particular provisions, the lease automatically terminates and the landlord has the right to "reenter" the premises.

- **The lease period has ended.** This would be the case if the tenant remained in the unit after the time set out in a written lease. It would also be the case if the tenant were renting the unit week-to-week or month-to-month (pursuant to either an oral or written lease) and the landlord gave the proper notice that the lease would not be renewed. In a week-to-week situation, proper notice is two days, in a month-to-month situation, it is seven days. If the tenant is renting a mobile home lot, a 30-day notice is required regardless of the term.

The lease can only be terminated at the end of the rental term and the notice must always be given the correct number of days before the end of the current term. Thus, if the tenant is renting from the first to the first of each month, notice must be given at least seven days prior to the first of the next month that the lease will not be renewed at the end of the current month. The notice demanding that the tenant leave in the middle of the month (in a month-to-month situation) is not valid.
Except in public housing or federally subsidized housing, a landlord does not need to have a reason for ending the lease. The landlord may choose not to renew at any time for any reason, except that he/she may not violate the laws prohibiting discrimination. (See the following section on Protection from Discrimination.)

**Tenant Obligations**

In order to enforce the landlord’s obligations, the tenant must do certain things. The tenant must:

- **Notify the landlord of needed repairs.** For repairs to the appliances and heating, cooling, plumbing and electrical facilities, the notice must be in writing except in emergencies. The law does not otherwise require the notice to be in writing, but it is wise to make a written request for repairs. A tenant should keep a copy of any written request.

- **Keep the premises clean.** The tenant must properly dispose of garbage, and keep the plumbing system as clean as possible.

- **Refrain from damaging the premises, and keep family members and guest from damaging the premises.** Although the landlord may be responsible for repairing the damage, he/she can charge the tenant for the repairs.

- **Continue to pay rent on time.** The law does not allow a tenant to withhold rent to try to force the landlord to make repairs. If the landlord refuses to make the necessary repairs within a reasonable time after notification, the tenant should consult an attorney about ways to force the landlord to meet his/her obligations.

**Protection from Retaliation**

A landlord is prohibited from evicting a tenant in retaliation for the attempts by the tenant to secure decent, safe, and sanitary housing. If a landlord brings an eviction action against the tenant, it can be defeated if the tenant can show that the landlord’s action is in response to any of the following:

- **A good faith request for repairs**

- **A good faith complaint to a government agency about the landlords violation of the housing code or other failure to maintain the premises**
The issuance by the governmental agency of a complaint to the landlord

A good faith effort to enforce any tenant rights

A good faith attempt to organize or join any organization to protect tenant rights.

The landlord can still prevail if he/she can show that there is legitimate reason to evict, such as the failure of the tenant to pay rent, the breach of a lease condition by the tenant, the need to demolish or substantially remodel the building to meet the housing code, or a good faith desire to use the rented premises for personal use or otherwise take it off the rental market.

Security Deposits

A landlord may require a tenant to pay a security deposit at the beginning of a tenancy. The amount of the security deposit may not exceed two weeks rent if the tenancy is week-to-week, one and a half months rent if the tenancy is month-to-month and two months’ rent if the tenancy is for a long term.

When the landlord collects the deposit, he/she must:

- Deposit the money into a trust account in a bank or savings institution in North Carolina (or outside of N.C. if a bond is provided)
- Notify the tenant within 30 days of receipt of the name and address of the institution holding the deposit (or the name of the company providing the bond)

Return of the Deposit

Within 30 days after the termination of the tenancy, the landlord must refund the deposit to the tenant unless he/she is authorized by law to retain all or part of it.

The landlord is authorized to retain all or part of the deposit in the following situations:

- The tenant owes rent
- The tenant damaged the dwelling unit
- The tenant left before the rental period was up
- The landlord incurred expenses for removal and storage of the tenants property after a court eviction action
The landlord incurred court cost in a court eviction action.

The landlord may only retain the amount of money actually spent or lost as a result of one of the above situations. For example, if the tenant leaves before the lease is up, but the landlord has a waiting list of prospective tenants and is able to fill the unit without losing any rent or incurring any cost, none of the security deposit can be retained. The landlord is not permitted to retain the deposit to pay for routine cleaning or to repair any conditions that resulted from ordinary wear and tear.

The landlord is required to provide a written itemization of the uses of the deposit, together with any balance remaining, within 30 days of the termination of the tenancy. If the landlord is unaware of the tenant’s address, the money must be held for at least six months. The tenant is responsible for letting the landlord know where to return the deposit.

Court Action

If the landlord fails to return the deposit within 30 days, or provide an acceptable itemization of how it was used, the tenant may institute legal proceedings against the landlord. (It is usually helpful to first make a written demand upon the landlord for a return of the deposit, making clear the address where it should be sent. A copy of this letter should be kept and produced in court if it fails to achieve the desired result.)

As long as the amount of the deposit is less than $2,000, the legal action should be taking in Small Claims Court. It is not necessary to have a lawyer representing the tenant in Small Claims Court, but the tenant would be wise to obtain legal advice before proceeding.

Protection from Discrimination

Both state and federal laws protect tenants from discrimination on the basis of race, color, religion, sex, national origin, family status, or handicap. Many cities have municipal ordinances that contain similar protections. These “fair housing” laws prohibit landlords from refusing to rent to potential tenants because they either have or do not have particular characteristics. For example, the protection regarding family status prohibits landlords from refusing to rent to tenants who have children; the protection regarding handicap prohibits a landlord from refusing to rent to a person with AIDS or who is mentally ill. (Note: These laws also protect potential purchases of housing.)
Certain housing built especially for elderly residents is exempt from the law that prevents discrimination on the basis of family status.

**Enforcement**

If a tenant believes he/she has been illegally discriminated against, he/she may take a variety of measures to see enforcement.

The state law and most local laws require that a complaint be filed with an agency set up to enforce the laws. Anyone in the state can file a complaint to be filed with an agency set up to enforce the laws. Anyone in the state can file a complaint with the **North Carolina Human Relations Commission**, 121 W. Jones Street, Raleigh, NC 27603-1334, and (919) 733-7996. *This complaint must be made within one year of the discriminatory incident.* An investigator will talk to the complaining party to determine if the problem actually falls under the protections of the fair housing laws. If it does, and investigation will take place, if the commission determines there was illegal discrimination, it will try to get the parties to settle the matter without going further. An investigation will usually be complete in about 90 days.

If the parties cannot agree on a settlement, the case can precede either to an administrative hearing in the state Office of Administrative Hearings, or to state Superior Court.

Person believing they are discriminated against can also file a complaint with the local Human Relations Council (or other local agency set up for this purpose) and an investigation will take place. Most local ordinances also have a hearing process that can be used if the situation is not resolved during the investigations, and allow the case to be taken on to court.

Another avenue for a person who believes he/she is the victim of discrimination is to file a lawsuit directly in federal district court. There is no requirement that such a lawsuit be preceded by an administrative investigation. Such a lawsuit must be brought within two years of the discriminatory incident.

If discrimination is found, the victim may receive money damages to compensate for out-of-pocket expenses as well as the humiliation and embarrassment involved. In addition, the offending person may be required to take certain actions to compensate for the discrimination, such as make an apartment available, change certain policies, or take another action. Punitive damage and/or civil penalties may also be assessed.
**Legal Authority**


Discrimination:


**Sources and Related Resources**

North Carolina Legal Services Resource Center
224 S. Dawson Street
P.O Box 27343
Raleigh, NC 27611
(919) 856-2121

North Carolina Human Relations Commission (regarding discrimination)
121 West Jones Street
Raleigh, NC 27603-1334
(919) 733-7996
Part 5: Utility Programs

Crisis Intervention Program...........................................1

Low Income Energy Assistance Program.......................9

Weatherization Assistance Program..............................19
Crisis Intervention Program (CIP)

Program Specifics

Quick Lookup

What Is It?

An emergency energy assistance program that provides cash payments of up to $600 per year to persons in a heating or cooling-related crisis

Who Is It For?

Households whose monthly income does not exceed 150% of the federal poverty guidelines

Where Are Applications Taken?

At county Departments of Social Services

Introduction

The Crisis Intervention Program (CIP) is a Federally-funded program that provides assistance to low-income households that are in a heating or cooling related emergency. It is part of the Low Income Energy Assistance Program, administered nationally as a block grant program by the U.S. Department of Health and Human Services, Office of Community Services. At the state level, it is supervised by the Public Assistance Section, Division of Social Services within the North Carolina Department of Human Resources. It is administered locally by the Departments of Social Services.

The goal of the CIP program is to help families stay warm in the winter and cool in the summer. By doing so, this reduces the risk of health and safety problems such as illness, fire or eviction.

Applications

Applications are taken at the county Department of Social Services at any time. There is no limit on the number of times a household may apply. An applicant must be permitted to sign an application the day he/she appears at the department. The Departments of Social Services are listed in Appendix D.

Each country has an allocation of money for the fiscal year, which begins each July 1 and ends each June 30. If the funds are exhausted prior to the
end of the fiscal year, the department can stop taking applications. Applications are taken only for households that reside in the county.

A decision on the application should be made in **48 hours**. If the situation is life-threatening, a decision should be made in 18 hours.

An applicant can make the process move more quickly by bringing verification of as many eligibility factors as possible. This would include:

- Utility cut-off notice or other verification that a crisis exists
- Most recent wage stubs
- Proof of child care costs
- Verification of amount of Social Security, Veterans benefits or other checks
- Verification of any other countable income
- Social Security cards
- Alien registrations

**Program Benefits**

Benefits may vary based upon the amount needed to alleviate the crisis; however, benefits cannot exceed $600 and/or the maximum allowed benefit amount established by the county, per State fiscal year.

The maximum allowed benefit amount can be up to $600 per application, per crisis situation. The maximum benefit amount determined by the County Director will also be the maximum allowed benefit amount per application for that county.

**Program Eligibility**

**Personal Eligibility**

A household that applies must:

- Have at least one U.S. Citizen or a noncitizen who meets certain eligibility criteria
- Meet an income test
- Be in a heating or cooling related emergency.
Household Status

The Crisis Intervention Program (CIP) is available to households.

Everyone who lives at the same residence must be included in the CIP household unless the residence is known to be a boarding house or has a separate apartment.

Citizenship

At least one household member must be a U.S. citizen or eligible alien. Eligible aliens include permanent resident aliens, refugees, those granted asylum. A list of required documentation is listed in Section 320 in the LIEAP Manual.

Energy Crisis

To be eligible, the household must be in a heating or cooling-related crisis. A household is in a crisis if it is experiencing a life-threatening or health-related emergency and sufficient, timely, and appropriate assistance is not otherwise available.

The county Department of Social Services is to apply “prudent judgment” in determining whether a household is eligible. It must consider whether someone’s life or health is at risk if the crisis is not alleviated. This will include consideration of the outside weather conditions and the age and health status of members in the household. Other factors that will be considered are whether the fuel source is exhausted or terminated, whether the household has any of its own resources, and whether there are other community resources available to alleviate the situation.

Also a factor is the department’s analysis of the degree of “fault” on the household’s part in creating the crisis. Staff will consider whether the household could have prevented the crisis or whether the situation was brought on by unforeseen factors or circumstances beyond the household’s control. Even if the department considers the household to be at fault, if a household member’s health or life could be jeopardized, the benefit should still be authorized.

Advocate Tip: Because there is a great amount of discretion vested in the staff of the county Department of Social Services, an advocate can be crucial in assisting a client in
receiving this benefit. If you refer a client to DSS to apply for CIP funds, call and talk to the county worker yourself. You can help the client by articulating the situation the client is in and describing the risks involved if no help is given. By your making the situation as sympathetic as possible, the county worker is more likely to determine that your client is eligible.

Financial Eligibility

A household’s combined monthly countable income must not exceed 150% of the deferral poverty guidelines. Following are the figures effective in April 1, 2009:

<table>
<thead>
<tr>
<th>No. Eligible In Household</th>
<th>Maximum Countable Income</th>
<th>No. Eligible In Household</th>
<th>Maximum Countable Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$1,301</td>
<td>13</td>
<td>$6,701</td>
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<tr>
<td>2</td>
<td>$1,751</td>
<td>14</td>
<td>$7,151</td>
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<tr>
<td>3</td>
<td>$2,201</td>
<td>15</td>
<td>$7,601</td>
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<tr>
<td>4</td>
<td>$2,651</td>
<td>16</td>
<td>$8,051</td>
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<td>$3,101</td>
<td>17</td>
<td>$8,501</td>
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<tr>
<td>6</td>
<td>$3,551</td>
<td>18</td>
<td>$8,951</td>
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<td>7</td>
<td>$4,001</td>
<td>19</td>
<td>$9,401</td>
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<tr>
<td>8</td>
<td>$4,451</td>
<td>20</td>
<td>$9,851</td>
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<tr>
<td>9</td>
<td>$4,901</td>
<td>21</td>
<td>$10,301</td>
</tr>
<tr>
<td>10</td>
<td>$5,351</td>
<td>22</td>
<td>$10,751</td>
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<tr>
<td>11</td>
<td>$5,801</td>
<td>23</td>
<td>$11,201</td>
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<tr>
<td>12</td>
<td>$6,251</td>
<td>24</td>
<td>$11,651</td>
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<tr>
<td>25</td>
<td></td>
<td>12.101</td>
<td></td>
</tr>
</tbody>
</table>

To compute countable income, count:

A. Wages from employment, tips, seasonal employment, baby-sitting, domestic employment, Work Force Investment Act (WIA) or work experience payments. Count gross amount before any deductions.

B. Income from roomers, boarders, or tenants

C. Farm income

D. Small business income, including income from self-employment

E. Income from rental property

F. Foster care payments (only if child is included in the household) and adoption assistance payments.
G. Work First Family Assistance
J. Veteran's benefits (VA). This includes Aid and Attendant Care benefits.
K. Railroad Retirement benefits
L. Unemployment Insurance benefits
M. Trade Readjustment benefits
N. Private disability or unemployment benefits
O. Worker's Compensation
P. Pensions
Q. Contributions
R. Support payments
S. Work release income
T. Interest, dividends from stocks, bonds, other investments, and income from trust funds
U. Military allotments and alimony
V. Brown or Black Lung benefits
W. Monthly payments received from sale of property
X. Educational assistance in the form of scholarships offered by civic groups and institutions, and athletic scholarships.

The following income is **excluded**:

- Earned income of students under age 18
- Income of children (under age 19) participating in Job Partnership Act
- In-kind contributions
- Payments to vendors on behalf of the household
- Irregular earned income
- Personal loans
- The portion of educational loans or grants used for tuition, school supplies, books, fees, travel and child care expenses necessary for school attendance
- Child support kept by the Child Support Enforcement Unit
- The value of Food Stamps, school lunches or surplus commodities
- Earned Income Tax Credit

From a household’s gross income, certain deductions are subtracted. These include:

- The amount of any Medicare premium paid by a household member
- A medical deduction of $85 for each household member age 60 or over, recipients of SSI, VA, Medicaid
- Work-related expenses for those earned income according to the following chart:

<table>
<thead>
<tr>
<th>Gross Earned Income ($)</th>
<th>Deduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 50</td>
<td>$10</td>
</tr>
<tr>
<td>51 – 100</td>
<td>$20</td>
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<tr>
<td>101 – 150</td>
<td>$30</td>
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<tr>
<td>151 – 200</td>
<td>$40</td>
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<tr>
<td>201 – 300</td>
<td>$60</td>
</tr>
<tr>
<td>301 – 400</td>
<td>$80</td>
</tr>
<tr>
<td>401 – up</td>
<td>$20%</td>
</tr>
</tbody>
</table>

- Child care costs, up to 200 for each child under age 2 and $175 for each child age 2 and over.
- Legally obligated child support, which is court ordered, ordered through an administrative process (such as IV-D) or ordered through a legally enforceable agreement. Allow as a deduction the actually paid amount.

*Note:* Special rules for counting income apply if the household contains an ineligible alien. Consult with the Department of Social Services or the LIEAP Manual.

**After adding together all the countable income, subtract the deductions and compare the result to the income chart. If the result does not**
exceed the amount on the chart for the appropriate household size, the household is financially eligible.

Reserve

There is no reserve test for eligibility for CIP funds. This means that the value of assets owned by the household (i.e., savings accounts, the value of land, insurance) will not be a factor in determining eligibility. Nevertheless, the county DSS worker can consider the availability of liquid assets when he/she is determining whether the applicants are in a crisis and in need of CIP funds. (Liquid assets are those that are either cash or readily convertible to cash.

Program Appeals

An applicant can appeal a decision if he/she is denied the right to apply, is denied benefits, believes the payment is incorrect, or believes the decision was not made in a timely manner.

An appeal must be requested, either orally or in writing, within 60 days of the date of the denial or approval, or within 90 days if good cause is shown for the delay.

The hearing process is the same as the hearing process for WFFA, except with regard to certain time frames. The time frames that apply to CIP are:

- After a local hearing is held, the household has only five calendar days to appeal the local hearing officer’s decision and obtain a state level hearing. If this deadline is missed, but the request for a state level hearing is within 90 days of the initial denial or approval, and good cause is shown for missing the deadline, the request will be honored.

- The state level hearing officer must render a decision within 15 days of the date of the hearing.

Legal Authority

Federal Statute: 42 U.S.C. §8223(a)
Federal Regulations: 45 C.F.R. §1061.70
State Regulations: 10 N.C.A.C Chapter 29C
State Policy Energy Manual (Available at county Departments of Social Services)
**Sources and Related Resources**

N.C. Department of Human Resources  
Division of Social Services  
Public Assistance Section  
325 N. Salisbury Street  
Raleigh, NC 27603  
(919) 733-9370

North Carolina Legal Services Resource Center  
224 S. Dawson Street  
P.O Box 27343  
Raleigh, NC 27611  
(919) 856-2121

CARELINE 1-800-662-7030 (N.C Department of Human Resources information and referral service)
Low Income Energy Assistance Program (LIEAP)

Program Specifics

Quick Lookup

What Is It?

A once-a-year cash supplement to low-income households to assist with the payment of heating bills.

Who Is It For?

Those households with countable income below 110% of the federal poverty guidelines, with resources of less than $2,200 and that are subject to rising energy costs.

Where Are Applications Taken?

At county Departments of Social Services.

Introduction

This is a federal program begun in 1981 as a state block grant. The federal government annually allocates a specific amount of money to each participating state, and the state distributes that money to each eligible household. At the federal level, the program is administered by the Department of Health and Human Services. At the state level, it is administered in the Public Assistance Section, Division of Social Services, and the North Carolina Department of Human Resources.

Applications

Applications for LIEAP are taken by county Departments of Social Services during a specified period of time during the month of November. Anyone interested in applying should call the local Department of Social Services to inquire of the time frame designated in November. The Departments of Social Services are listed in Appendix D.

The program is not a first-come, first-served program. All eligible households will get a check. (See Personal Eligibility section below for a definition of a LIEAP household.) The county department must take an application the day the applicant appears at the agency. Any adult in the household may apply.
for the household; just one application per household will be taken. Elderly or homebound individuals can request that they be mailed an application or call the local Department of Social Services.

Certain information requested on the application must be verified. The household must cooperate in providing the verification requested. The following items should be taken to the Department of Social Services by the household member applying:

- Wage stubs for October
- Bank statements or bank books
- Documentation of property owned
- Social Security cards of all household members
- Alien registrations

Decisions about eligibility are mailed to applicants in February. Approval notices accompany the check. Denial notices contain a statement of the reason for the denial and the applicant’s right to appeal.

**Program Benefits**

**One check is sent to each eligible household in February.** The amount of the check is determined by a calculation taking into account a variety of factors including: the household’s income range, the number of persons in the household, the household’s vulnerability to rising energy costs, the type of fuel primarily used (at the time of application), the region of the state in which the household lives, the total number of eligible households and the amount of money available for the program.

**Advocate Tip:** Without knowing all of the above factors, it is impossible to determine if your client received the correct payment. To pursue such a case, first find out from the county Department of Social Services the household’s income, the number of persons in the household, the vulnerability status and the type of fuel used. If your client agrees that the county got those items correct, next call the Public Assistance Section of the Division of Social Services, N.C. Department of Human Resources at (919) 733-7831. Find out the remaining factors and the formula. Apply the formula to determine if your client’s payment is correct.

**Utility Cut-Off Moratorium**
Certain persons who qualify for LIEAP may also benefit from a limited moratorium on the termination of utility services. As a result of an order by the North Carolina Utilities Commission, certain households may not have their utility services discontinued from November 1 through March 31.

An eligible household is one that:
- Has a child under 6 years old
- Contains a member who is age 65 or over or who is handicapped
- Cannot pay the utility bill in part or in full, and
- Meets the eligibility requirements for LIEAP, and
- Has been certified as being eligible for LIEAP, and
- Receives utility services from a regulated electric or natural gas company.

Program Eligibility

Personal Eligibility

LIEAP is available to households. A household is a single individual living alone or a group of individuals who:

- Live together; and
- Share or contribute to household expenses; and
- Customarily purchase their heating fuel in common.

The following people will never be considered separate households: spouses living together, minor children living with parents or caretaker relatives, anyone who doesn’t contribute to the household’s heating bill, anyone who supplements the household’s primary heating source, anyone who rents a room (unless it’s a boarding house or the renter purchases heating fuel separately).

A household must be vulnerable to rising energy costs to be eligible. A household is fully vulnerable if it is responsible for all utilities and receives no federal subsidy. A household is partially vulnerable if it is responsible for only part of the heating costs because it receives a utility allowance through a federally subsidized housing program (such as Section 8, Section 202, Section 236, etc.). Public housing tenants subject to payment of excess charges for utilities are partially vulnerable. Both fully vulnerable and partially
vulnerable households are eligible for LIEAP, although those that are fully vulnerable are entitled to higher benefit.

A household must include at least one **U.S. citizen** or **eligible alien**. Lawful permanent resident aliens, certain refugees, persons granted asylum, and aliens admitted under the following sections of the Immigration and Nationality Act are eligible:

- **Section 210** Special agricultural workers
- **Section 245A** only if aged, blind, disabled, legal Cuban or Haitian entrants, or if admitted more than five years before the application for LIEAP
- **Section 210A** only if aged, blind, disabled, legal Cuban or Haitian entrants, or if admitted more than five years before the application for LIEAP

### Financial Eligibility

A household must meet both **income and reserve guidelines** to qualify for LIEAP.

**Income**

A household’s combined **countable income** for the month of October must be equal to less than 110% of the current federal poverty guidelines.

<table>
<thead>
<tr>
<th>Number Eligible in Household</th>
<th>Maximum Countable Net Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$993</td>
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<tr>
<td>2</td>
<td>$1,337</td>
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<tr>
<td>3</td>
<td>$1,679</td>
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<tr>
<td>4</td>
<td>$2,022</td>
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<td>5</td>
<td>$2,365</td>
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<td>25</td>
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</tbody>
</table>

If there are **more than 25 in a household**
call the Economic Services Section for the maximum monthly income

**Counting Income**

In determining whether a household meets the income guidelines, certain income is counted (**countable income**) and certain income is disregarded. After all the countable income is added up, certain deductions are subtracted. The result is the figure that must be compared to the chart.

Following is a list of the most common types of **countable income**:

— Gross wages from employment
— Self-employment or farm income, minus operating expenses
— Income from roomers, boarders, or tenants
— Contributions
— Foster care payments
— Supplemental Security Income (SSI)
— Veterans or Railroad Retirement benefits
— Unemployment Insurance
— Workers’ Compensation
— Pensions, retirement or disability income, whether public or private
— Trade Readjustment benefits
— Small business income
— Income from rental property
— Adoption Assistance payments
— Work First Family Assistance
— Work Release Income
— Private Release Income
— Private Disability or unemployment benefits.

Following is a list of the most common types of excluded income:

— Earned income of students under age 18 that is under parental control of an adult household member.
— Income of child (under age 19) participating in Workforce Investment Act
— In-kind contributions
— Payments to vendors on behalf of the household
— Irregular earned income (under 30 in a calendar quarter)
— Personal loans
— The value of Food Stamps, school lunches or surplus commodities
— Earned Income Tax Credit
— Disaster or relocation assistance
— Reimbursements
— Utility assistance payments from HUG
— Emergency Assistance Programs
— Nonrecurring lump sum payments

Income Deductions

Once the gross countable income is calculated, certain deductions are subtracted. These include:

— Amount of Medicare premium if paid by a household member
— $85 for each household member who has only unearned income and pays a health insurance premium other than Medicare
— Out-of-pocket child care costs, up to $200 per month for a child under age 2, and $175 per month for a child age 2 and over
— Amount of child support paid by a household member who is legally obligated to make such payment
— Work-related expenses, according to the following chart:

<table>
<thead>
<tr>
<th>Gross Earned Income ($)</th>
<th>Deduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 50</td>
<td>$10</td>
</tr>
<tr>
<td>51 – 100</td>
<td>$20</td>
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<tr>
<td>101 – 150</td>
<td>$30</td>
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<td>151 – 200</td>
<td>$40</td>
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<tr>
<td>201 – 300</td>
<td>$60</td>
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<tr>
<td>301 – 400</td>
<td>$80</td>
</tr>
<tr>
<td>401 – up</td>
<td>20%</td>
</tr>
</tbody>
</table>

— Amount paid by roomer/boarder for room and board, if roomer/boarder’s income was included in household income

Note: Special rules for counting income apply if the household contains an ineligible alien. Consult with the Department of Social Services or the Energy Manual.

Reserve

Reserve means assets which are available to households to meet their needs. Reserve is counted on October 31. A household’s reserve may not exceed $2,200 to be eligible for LIEAP benefits.

Counting Reserve

There is no need to calculate reserve for any household in which all members receive AFDC, Medicaid, SSI, or Food Stamps. They automatically meet the LIEAP reserve requirements.
For households in which no one receives another benefit, or in which only some members receive another benefit, use the following rules:

— Add to that the countable reserve of the other household members. The reserve of the other household members generally includes the following:

- Cash on hand
- Current balance of savings accounts
- Checking account balance, except that portion which represents monthly income
- Stocks, bonds, mutual funds, etc.
- Accessible retirement funds
- Revocable trust funds
- Salable life estates and remainder interests in real property
- Equity in real property not used as a home site

— Don’t count the following items:
- The home
- Household goods and personal belongings
- Income-producing property
- Burial assets
- Heir property
- Insurance
- Any lump sum payments received after September 1
- Relocation assistance payments
- HUD community development block funds
- Savings of students under age 18 saving money to attend college

**Program Appeals**

Any household has the **right to appeal** the decision regarding the LIEAP payment. A household that has been denied may appeal; a household that has been approved may appeal the amount of the check or the timeliness of the decision. There are 3 levels of Appeals which are:

1. Local Hearing
2. State level Hearing
3. Judicial Review

An appeal must be requested, either orally or in writing, within **60 calendar days** from the date of notification of approval or denial. The request may be made within 90 days if good cause is shown for the delay. The request should be directed to the county Department of Social Services.

The hearing process for LIEAP is the same as the hearing process for Work First except with regard to certain time frames. (See Work First Appeals section, Part 1 – Page 9) The time frames that apply to LIEAP are:

- After a local hearing is held, the household has only **five calendar days** to appeal the local hearing officer's decision to obtain a state level hearing. If this deadline is missed, but the request for a state level hearing is within 90 days of the initial denial or approval, and good cause is shown for missing the deadline, the request will be honored.

- The state level hearing officer must render a decision within 15 days of the date of the hearing.

Legal Authority

Federal Regulations: 45 C.F.R. Part 96
State Regulations: 10 N.C.A.C. Chapter 29B
State Policy: Energy Manual (available at county Departments of Social Services)

Sources and Related Resources

N.C department of Human Resources
Division of Social Services
Economic Independence Section
325 N. Salisbury Street
Raleigh, NC 27603
(919) 733-9370

North Carolina Legal Services Resource Center
224 S. Dawson Street
P.O Box 27343
Raleigh, NC 27611
(919) 856-2121

CARELINE 1-800-662-7030 (N.C. Department of Human Resources information and referral service)

DSS Energy Assistance Manual
(Available at county departments of social services and on-line: http://info.dhhs.state.nc.us/olm/manuals/dsslei-40/man/index.htm.)
Weatherization Assistance Program

Program Specifics

Quick Lookup

What Is It?

A program that pays for the installation of energy conversation measures in the homes of eligible North Carolinians.

Who Is It For?

Households with a family income of 200% of the federal poverty guidelines or less.

Where Are Applications Taken?

At community Action Agencies and other non-profit agencies designated to accept applications.

Introduction

This is a federally-funded program designed to increase energy efficiency and thereby lower the energy bills of low-income, elderly, and handicapped individuals. The state receives an annual allocation from the federal government and then makes sub grants to non-profit agencies around the state. The agencies contract for the materials and labor so that the homes of eligible persons can be weatherized.

Applications

Applications are taken at the local Community Action Agency or at a non-profit agency that has contracted with the state to administer the program. A list of the contracting agencies is located in Appendix C.

Preferences

Because there is a limited allocation of money for Weatherization Assistance, not everyone who is eligible will receive assistance. Preferences are given, in order, to:

- The elderly (defined as age 60 or older)
➤ The **handicapped** (generally, a person who has been determined to be disable or handicapped by another agency such as the Social Security Administration or the Veterans Administration)

➤ **Families** with small children (usually under age seven)

Preferences may also be extended to households facing emergencies.

The local agency is required to keep a waiting list of applicants, but may cut off the list when the agency determines it will not be able to serve the applicants within the next year. After the preferences have been given, the applicants should be served in order of the date of the application.

**Determinations**

There is no time limit within when the agency must act on an application. When a decision regarding eligibility is made, the agency must send a **written notice** stating either that the applicant is eligible or ineligible. IF it is determined that the applicant is ineligible, the reasons for the ineligibility must be stated.

**Program Benefits**

The **installation of weatherization materials** in the home of the recipient is the primary benefit of this program. These weatherization materials typically include **caulking, weather-stripping, attic and floor insulation, and water heater insulation**. Other possible items are storm windows or doors, heating system repairs, vapor barriers, and other energy savings devices.

The local Community Action Agency or other non-profit agency that administers the program on the local level determines what items are needed for the particular housing unit. The agency purchases the materials and labor. There is no cost to the property owner (although at some point in the future, there may be a requirement that the owner of rental property make a contribution).

**Program Eligibility**

**Personal Eligibility**

**Dwelling Unit**

Weatherization Assistance is available for **dwelling units in which eligible persons live**. (Eligible persons are those who meet the
citizenship and financial guidelines discussed below.) The unit may be inhabited by a single individual or a group of individuals, who may or may not be related. The dwelling unit may be a single family house, an apartment, a stationary mobile home, a room, or a group of rooms which constitute separate living quarters. The unit may be owned by the occupants or rented by them.

Multi-unit dwellings may be weatherized as long as two-thirds of the occupants (half if there are four or fewer units) are eligible. The property owner must agree to the renovations, and agree not to raise the rent as a result of any increase in the value of the property.

Citizenship

The household must contain a U.S. citizen or an eligible alien. Eligible aliens include lawful permanent residents, refugees, aliens granted asylum, and certain other specialized aliens.

Financial Eligibility

Income

The combined countable annual income of the household members must not exceed 200% of the federal poverty guidelines. Income from the 12 months preceding the application is examined to determine if the financial criteria are met.

Sources and Related Resources

Office of Economic Opportunity: http://www.ncdhhs.gov/oeo/programs.htm

North Carolina Weatherization Assistance Program: http://www.ncdhhs.gov/oeo/WAP/weather.htm

Martin County Community Action Inc.: www.mccai.org
Part 6: Services for the Adults Over 60 and People with Disabilities

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Mental Health Services .......................................................... 4
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Services for the Deaf and Hard of Hearing ............................ 22
Services for the Adults over 60 ............................................. 26
Vocational Rehabilitation ..................................................... 35
Independent Living Rehabilitation Program

Program Specifics

Quick Lookup

What is it?

A program that provides services to persons with severe physical disabilities with the intention of helping them retain their independence.

Who is it for?

Persons with severe physical disabilities

Where are applications taken?

At the Department of Health and Human Services

Introduction

The Independent Living Rehabilitation Program is run by the State Department of Health and Human Services in order to provide services to persons with severe physical disabilities; to provide an alternative to institutionalization when possible; to improve functioning in one family, home and community; or assist in preparing a person for a vocational rehabilitation program. Services may be provided directly, or coordinated through other community resources.

Applications

Applications are completed with a counselor either in the applicant’s home, or at the IL office.

Once an application is completed, an evaluation is completed to determine the needed services. Next a plan of services is written with the applicant. Once the plan of services is complete the applicants file is closed. Applicants can reapply for services at anytime.

Program Benefits

Services include:

• Guidance and Counseling
• Rehabilitation Engineering
• Personal Assistance Services
• Home and Vehicle Modifications
• Housing Placement and Assistance
• Purchase of Medical Equipment and Assistive Devices
• Recreational Therapy.

**Program Eligibility**

**Personal Eligibility**

The person must have a severe physical disability. The disability severely limits the person’s ability to live independently and receipt of services will significantly improve the person’s ability to live independently.

*Advocate Tip: Remember the disability must be severe. Diabetes is not considered a severe disability, but the neuropathy that results from diabetes is considered severe.*

**Financial Eligibility**

At application, the applicant needs to provide information about their income and about their medical diagnosis. A family of one can have an income of $1064 per month. Larger families can have more income. Financial criteria are adjusted every year. If a family has excess income, medical expenses can be used as deductions to the family income. The medical information must document a severe disability.

*Advocate Tip: Items that can be used as deductions are the cost of a lift equipped van; co pays for doctors, cost of medicine, cost of personal care, educational expenses, child care costs, Applicant must meet financial eligibility to have the Program pay for any services. Guidance and counseling, rehabilitation engineering, and recreational therapy can be provided regardless of income.*
Program Appeals

Independent Living is a “sister agency” to Vocational Rehabilitation. Both programs use the same appeals process, and are administratively the same in Raleigh. This process can be found on Part 6 – Page 43. IL is funded with NC State funds, and VR receives State and Federal funds.

Sources and Related Resources

Department of Health and Human Services
Independent Living Rehabilitation Program

http://dvr.dhhs.state.nc.us/DVR/IL/ilhome.htm

Physical Address
101 Fox Haven Drive
Greenville, NC 27858

Mailing Address
P.O. Box 2487
Greenville, NC 27834
Mental Health Services

Program Specifics

Quick Lookup

What is community mental health?

A group of services offered through private providers and statewide institutions that address treatment needs related to mental health, developmental disabilities, and substance abuse.

Who Are They For?

Both children and adults who experience psychiatric symptoms, substance abuse addictions, and developmental disabilities.

How Do I Access Services?

The point of entry for mental health services is through a provider within the community or the local management entity (LME). Your services are managed in the community through a Local Management Entity or LME.

Introduction

North Carolina’s system for providing services to those with mental health needs is carried out through a network of 15 statewide inpatient and residential institutions and community providers. The statewide facilities are operated by the Division of State Operated Healthcare Facilities within the N.C Department of Human Resources. Services within the community are managed by the Local Management Entity (LME). The LME has a relationship with service providers to ensure that quality services are provided to consumers. Every community has a way to access services 24-hours-a-day, seven-days-a-week and 365 days-a-year. This is done through your LME access team. You can ask about obtaining ongoing services or emergency mental health, developmental disabilities, or substance abuse services. The access team is available by phone or by visiting the LME office near you. If you do not know how to contact the LME, call the DHHS CARE-LINE -any time 24-hours-a-day, seven-days-a-week, 365 days-a-year - 1-800-662-7030 (English/Spanish) or TTY 1-877-4522514 for the hearing impaired or by looking in Appendix B in this book.

The services offered at the local level vary from one area to another, and thus not all the programs described in this chapter are available in all
locations. Information on which services are available from an area program can be obtained from the LME’s access team.

The first step in determining eligibility for services is assessment of the presenting problem and establishing medical necessity. LME’s must ensure that people receive services appropriate to their needs and according to established best practice and clinical guidelines - the right service, in the right amount, for the right length of time. LME’s work with provider agencies to assist as many individuals as possible to find those services through a variety of funding sources.

People who are eligible for Medicaid can receive services through the provider community. People who do not have Medicaid or other insurance coverage may be eligible to access care through State funding. State dollars are limited and are only available to specific groups known as target populations. Some services may only be available to people with severe needs and may be limited due to available funding. People who fall outside the State target population groups are usually referred to other local organizations, both public and private, to meet their needs.

The major populations served by the system are:

- Adult Developmental Disability
- Child Developmental Disability
- Adult Mental Health
- Child Mental Health
- Adult Substance Abuse
- Child Substance Abuse

North Carolina has an enhanced benefit package for people with Mental Health, Developmental Disabilities and Substance Abuse needs. For a complete listing of services and the definition of services please visit the website below: [www.dhhs.state.nc.us/mhddsas/servicedefinitions/servicedef1-9-06final.pdf](http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/servicedef1-9-06final.pdf)

Each of the populations and the services designed to address their problems are described more fully below.

**Program Benefits**

**Persons with a Developmental Disability**
A developmental disability is a severe, chronic disability that is attributable to a mental or physical impairment, or both, and is generally manifested before the age of 22. Likely to continue indefinitely, developmental disabilities result in substantial limitations in the individual’s ability to carry out major life functions. Examples of developmental disabilities are mental retardation, autism and traumatic brain injury.

Services

Three categories of services may be available to the developmentally disabled. They are day services, support services, and residential services.

Day Services

Day services include supported employment and supervision. Supported employment provides job training and ongoing supervision in regular work settings.

Support Services

Support Services are targeted case management, and in-home support services.

Targeted Case management services provide a counselor to a client and his/her family who can assist in coordinating and monitoring services available from a variety of agencies.

In-home support services are given to people where they live, whether it is a private home, a rest home, or other setting. These are services that are not needed daily, but on a more occasional basis, and may include assessment, consultation, and treatment.

Residential Services

Alternative family living allows children and adults to live with and receive care from trained professionals in a family-style atmosphere in a residential community.

Adult group homes provide a community setting for the developmentally disabled.

Five mental retardation centers are located around the state providing a specialized residential service for those who are unable or live in a community setting.
Community Alternatives Program

Some individuals with mental retardation or other developmental disabilities that would normally require a higher level of care such as a group home or institution may be able to live in the community by participating in the Community Alternatives Program for the Developmentally Disabled (CAP-MR/DD).

CAP-MR/DD operates under a Medicaid home and community-based services waiver granted by the Health Care Financing Administration (HCFA). HCFA approves the services, the number of individuals that may participate, and other aspects of the program. The participants must be at risk of institutionalization. The Medicaid cost for community care must be cost effective in comparison to the cost of ICF/MR care. The participants must be eligible for Medicaid. (See Medicaid for the Aged, Blind, and Disabled, Part 3 – Page 13.) Through CAP/DD, certain services not otherwise covered by Medicaid are paid for while the participant lives in a community setting. More information is available from the local LME.

Child Mental Health Services

Below are some of the services for child mental health. Please be advised that every service may not be available in every area. Furthermore services are subject to funding and legislative changes. Please contact the local management entity to access services in your area.

**Mobile Crisis** is a crisis service designed to bring mental health professionals into the community 24 hours a day/ 7 days a week/365 days a year. The service is integrated service focused on crisis response, crisis stabilization interventions and crisis prevention.

**Crisis Respite** provides a temporary, supervised residential environment for children in crisis situation. This is a short term crisis or emergency service only. It is not intended to take the place of inpatient care nor is it to be viewed as a residential placement.

**Psychiatric Residential Treatment Facility (PRTF)** provides residential treatment for children or adolescents who have mental illness or substance abuse/dependency, who do not need inpatient care but does require supervision and specialized interventions on a 24-hour basis. It should be noted that adolescents who appropriately require this level of care might have demonstrated unlawful or criminal behaviors. Therefore, this level of care may be court-ordered as an alternative to incarceration.
This court order does not automatically guarantee PRTF admissions. Further, this program will not be used when the primary problems are social or economic (placement) issues alone. Medical necessity criteria must still be met.

**Inpatient treatment** is a short term treatment provided in a community hospital or state psychiatric hospital to children with severe disturbances who cannot be served in the community. Services may include psychological evaluations, testing, diagnosis, medication management, individual, group and family therapy.

**Multi Systemic Therapy and Intensive In-Home** are services offered to reduce the need for out-of-home placement for children. Through parent training, counseling, and support groups, parents can learn to better understand and cope with their child’s disability.

**Day treatment** is targeted to children with moderate to severe problems who have difficulty participating in public school programs or who may need hospitalization without intensive intervention.

**Outpatient treatment** may include screening, evaluation, diagnosis and treatment including therapy and medication management.

**Adult Mental Health Services**

Below are some of the services for adult mental health. Please be advised that every service may not be available in every area. Furthermore services are subject to funding and legislative changes. Please contact the local management entity to access services in your area.

**Mobile Crisis** is a crisis service designed to bring mental health professionals into the community 24 hours a day/ 7 days a week/365 days a year. The service is integrated service focused on crisis response, crisis stabilization interventions and crisis prevention.

**Outpatient treatment** may include screening, evaluation, diagnosis and treatment including therapy and medication management.

**Rehabilitation, supervision, and access to community resources** allow mentally ill individuals to participate in the community. Included in these efforts are psychosocial rehabilitation programs, vocational employment opportunities, self-help group, and supported housing.
Inpatient treatment is a short term treatment provided in a community hospital or state psychiatric hospital to children with severe disturbances who cannot be served in the community. Services may include psychological evaluations, testing, diagnosis, medication management, individual, group and family therapy.

**Child Substance Abuse Services**

Below are some of the services for child substance abuse. Please be advised that every service may not be available in every area. Furthermore services are subject to funding and legislative changes. Please contact the local management entity to access services in your area.

**Mobile Crisis** is a crisis service designed to bring mental health professionals into the community 24 hours a day/ 7 days a week/365 days a year. The service is integrated service focused on crisis response, crisis stabilization interventions and crisis prevention.

**Primary Prevention Services** are provided to children/adolescents who are at risk for substance abuse. The services are designed to prevent the first use of the drugs or alcohol.

**Outreach services** are provided in a variety of community locations. They chiefly give information to children and/or families about the dangers of substance abuse and the availability of treatment services.

**Screening and evaluation** services assess substance abuse problems to determine the need and eligibility for services. An evaluation assesses a child’s social, emotional, physical, behavioral, and intellectual strengths and weaknesses, and becomes the foundation for future services.

**High-risk intervention** attempts to delay the onset or reduce the severity of substance abuse problems among youth who are at high risk of developing problems. Early treatment, psychological counseling, educational activities, and recreational activities may be offered.

**Outpatient treatment** includes individual, group, and family counseling for substance abuse problems. It can be provided in a variety of settings.

**Day treatment** is intensive group treatment for adolescents who need more structured treatment than outpatient services. Among the services offered may be individual, group, and family counseling; recreational therapy; substance abuse education, and life skills education.
Adult Substance Abuse

Both drug and alcohol abusers are eligible for services. Special emphasis placed on providing service to intravenous drug users, especially those who are HIV-positive, and to be pregnant, and postpartum women.

Outpatient treatment may include screening, evaluation, diagnosis and treatment including therapy and medication management. Some area may have methadone treatment facilities.

Residential programs provide 24-hour treatment to substance abuses in non-hospital settings. Room, board, and supervision are important parts of the care, treatment, and rehabilitation provided in residential programs. Treatment services are offered on-site or in other locations.

Halfway houses are residential services that provide structured living environments for individuals who are substance abusers. Halfway house residents must be engaged in outpatient treatment. The goal is to return individuals to independent living within a specified time.

Treatment Alternative to Street Crime (T.A.S.C) is a support service link between the criminal justice system and substance abuse services. T.A.S.C. offers supervised community-based alternatives to incarceration or potential incarceration, primarily to individuals who are substance abusers and who are involved in non-violent crimes. The services include screening, identification, evaluation, referral, treatment, and treatment monitoring.

Program Eligibility

Any resident of North Carolina with mental illness, a developmental disability, or a substance abuse problem is eligible for services. Nevertheless, there are insufficient resources to provide services for everyone who is eligible, and therefore some eligible individuals may be unable to obtain all desired services.

Cost of Services

While no one is denied services due to an inability to pay, fees are charged on a sliding scale for services. Each area program has its own policies regarding charges for various services.

Program Appeals
Each LME and institution maintains written policies and procedures to review and resolve client grievances. Program administrators will make these written policies available on request.

**Legal Authority**


**Sources and Related Resources**

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services  
325 N. Salisbury Street  
Raleigh, NC 27603  
(919) 733-7011

Carolina Legal Assistance, Inc. (free legal services to persons with mental disabilities)  
224 S. Dawson Street  
P.O Box 2446  
Raleigh, NC 27611  
(919) 856-2121

Governor’s Advocacy Council for Persons with Disabilities (State funded council employing advocates who will investigate the complaints of and pursue remedies on behalf of disabled citizens who feel they have been discriminated against in areas such as education, employment, housing, treatment, or transportation)  
1318 Dale Street  
Suite 100  
Raleigh, NC 27605  
(919) 733-9250

Family Support Network of North Carolina (focuses on information for families with children with developmental disabilities, behavioral problems, and chronic illness)  
1-800-TLC-0042
Services for the Blind

Program Specifics

Quick Lookup

What Are They?

Services to assist the visually impaired, including an eye care program, an independent living program, and a rehabilitations program.

Who Are They For?

Persons in North Carolina with visual impairments. Some services are offered only to those with low income.

Where Are Applications Taken?

Each county Department of Social Services has a social worker for the blind who can assist eligible people in gaining access to the system. In addition, the state Division of Services for the Blind has eight district offices where applications can be taken for some programs.

Introduction

The Division of Services for the Blind (DSB) within the N.C. Department of Human Resources coordinates the services available in North Carolina for the blind and visually impaired. The programs offered are designed to prevent blindness and restore sight, if possible, and to help people without sight develop their maximum individual capabilities and become self-sufficient. The three main programs offered by DSB are the Medical Eye Care Program, the Independent Living Program, and the Rehabilitation Program. The programs are funded from both federal and state sources.

The Division of Services for the Blind has two regional offices around the state and eight district offices. In addition, there are 57 social workers for the blind stationed in county Departments of Social Services. These social workers cover all 100 counties. The addresses and phone numbers of the district offices are listed at the conclusion of this chapter. The addresses and phone numbers of the Departments of Social Services are located in Appendix D.
The state also sponsors the Governor Morehead School for the Blind, located in Raleigh, which provides education for blind children. Lions Clubs around the state offer additional services for the blind.

## Medical Eye Care Program

### Program Benefits

Through this program, **people with visual problems who cannot afford proper medical care are provided, free of charge, all necessary care relating to the eye condition.** Services available include examinations, medications, outpatient treatment, surgery or other inpatient hospital treatment, and medical supplies, including glasses or other aids to improve vision.

The Medical Eye Care Program also includes vision screening, glaucoma screening, and education in care for the eyes, and low vision services to anyone who needs these services, regardless of income. Low vision services include evaluation of the eye condition and assistance in identifying technical devices that may improve the individual’s vision.

Individuals should contact the social worker for the blind at their county Department of Social Services to apply for help through this program.

### Program Eligibility

Must demonstrate medical need for service. Prior to receiving free care, however, it must be determined that the individual **does not qualify for Medicaid.** If Medicaid is available, that program will be sued first. See Medicaid chapter in this *Guide* for more information (Part 3 – Page 27).

Guidelines and criteria that must be met can be found on their website at:

http://info.dhhs.state.nc.us/olm/manuals/dsb/mec/man/MEC200.htm#TopOfPage

This also includes all application and screening forms.

### Counting income

To determine if an individual meets the income criteria, all income, either earned (from working) or unearned (from any type of government benefit or investments) of all family members is added up. From that gross figure, the following **deductions** are subtracted:
• Mandatory payroll withholding (taxes, Social Security, retirement, etc.)
• Medical expenses and insurance premiums
• Child care expenses, if incurred to allow a parent to work
• Travel to and from work at $.10/ mile
• Property taxes]certain extraordinary expenses (such as special school tuition)

The result after subtracting the deductions is compared to the chart. There are no restrictions on resources or assets.

**Program Appeals**

An individual who is dissatisfied with the eligibility determination decision made by the Division of Services for the Blind may appeal the decisions to the Office of Administrative Hearings pursuant to the state Administrative Procedures Act.

**Independent Living Program or Services**

**Program Benefits**

The Independent Living Program targets those persons with visual impairments that cannot be improved. The goals are to prevent institutionalization, help individuals achieve maximum self-sufficiency, and prevent the abuse, neglect, and exploitation of the blind.

Among the services provided are:

• Independent living skills training
• Home and vehicle modification
• Peer counseling and advocacy
• Rehabilitation engineering
• Adaptive Aids, prosthetics, and orthotics
• Consumer-managed personal assistance services
• Recreational Therapy
• Communication/ Environmental control systems
• Orientation and mobility instruction
• Training in self-help skills and techniques
• Recreation with adaptation for the blind and visually impaired
• Housing and home improvement services
• Medical transportation
• Chore services for individuals who are not capable of living independently
• Counseling
• Health support services
• Employment and training support services
• Consultation and training for preschool visually-impaired children and their families

Individuals interested in applying for this program can contact the social worker for the blind at the county Department of Social Services.

**Program Eligibility**

Persons accepted into the Independent Living Program must have a visual impairment at the following level of severity:

• Best correct vision of no better than 20/100 or a field of vision no better than 20 degrees, or

• Best corrected vision of 20/100 with a progressive eye condition or a 30-degree field limitation, or

• Best correct central vision of no better than 20/70, or

• Best corrected vision of better than 20/70 with a functional handicap and/or a chronic, progressive eye pathology

**Financial Criteria**

There are no financial eligibility criteria for the program, except for the receipt of chore services. In order to receive chore services, which are in-home services to help with home management, shopping, meals, etc.; individuals must meet an income test. If an individual's income is over the following amounts, he/she is not entitled to chore services. If his/her income is less than the amounts the services are provided free of charge.
### Table: Annual Gross Income by Family Size

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Annual Gross Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$8,451</td>
</tr>
<tr>
<td>2</td>
<td>$11,051</td>
</tr>
<tr>
<td>3</td>
<td>$13,652</td>
</tr>
<tr>
<td>4</td>
<td>$16,252</td>
</tr>
<tr>
<td>5</td>
<td>$18,852</td>
</tr>
<tr>
<td>6</td>
<td>$21,453</td>
</tr>
<tr>
<td>7</td>
<td>$21,940</td>
</tr>
<tr>
<td>8</td>
<td>$22,428</td>
</tr>
</tbody>
</table>

Note: These figures are set by the N.C General Assembly. They have not been increased in many years, and no imminent increases were expected at the time of this writing.

### Program Appeals

And individual who is dissatisfied with the DSB decision regarding his/her eligibility for the program may appeal to the Office of Administrative Hearings pursuant to the N.C Administrative Procedures Act.

### Rehabilitation Program

#### Program Benefits

The Rehabilitation Program for the Blind is a federal/state program operated through the Rehabilitation Services Administration within the U.S. Department of Education. It is part of the overall Vocational Rehabilitation program in North Carolina, but is focused solely on the needs of the blind and visually impaired among the services available are counseling and guidance, work evaluation, vocational training, job placement, and assistance in establishing small businesses. See the vocational Rehabilitation chapter in this Guide for a fuller description of the program.

An individual can contact the nearest DSB district office or the social worker for the blind at the county Department of Social Services to apply for this program.
Program Eligibility

In order to receive rehabilitation services, the following must be true:

- The individual must have a visual disability that causes a handicap to the individual in obtaining employment, and
- There must be a reasonable expectation that, if rehabilitation services are provided, the individual can become gainfully employed.

Services and Financial Criteria

Some rehabilitation services are available free of charge, without regard to income. These include:

- Evaluation, including diagnostic services
- Counseling, guidance, and referral
- Job placement services
- Tuition and supplies for publicly-operated sheltered workshops
- Tuition and fees
- Interpreter services for the deaf
- Reader services, rehabilitation teaching services, and orientation and mobility services for the blind
- Recruitment and training services to provide new employment opportunities in rehabilitation and other public services employment
- DSB Rehabilitation Center Services, including transportation and training supplies contingent on an individual's participation in the Center programs
- Extended evaluation services
- Diagnostic transportation
- On-the-job training
- Equipment and initial stocks and supplies for state-owned vending stands

The following services will be provided based on economic need:

- Physical and mental restoration services (medical services other than diagnostic)
- Maintenance costs
- Transportation, except where necessary in connection with the eligibility determination
- Services to members of the blind person’s family
- Telecommunications and sensory and other technological aids and devices
- Post-employment services to assist with job maintenance
- Occupational licenses
- Tools, equipment, and initial stocks
- Expenditures for medical care for acute conditions arising during the course of vocational rehabilitation, which, if not cared for, well jeopardize the rehabilitation plan
- Books and other training materials
- Other goods and services reasonably expected to benefit the individual in terms of employment outcome

**Economic Needs Test**

Those persons whose income and resources are below the limits are eligible for all services without charge. Those persons whose income and resources exceed the limits are expected to contribute depends on the amount by which their income and resources exceed the guidelines.

The *income limits* and the method of calculating income are the same as in the Division of Vocational Rehabilitation program. See part 6 – Page 41 for details.

In the VR program, the individual is expected to contribute his/her “Excess resources” towards the costs involved in the rehabilitation plan. “Excess resources” are those in addition to the limits below.

<table>
<thead>
<tr>
<th>Cash</th>
<th>Two times the income limit for the appropriate family size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Property:</td>
<td>$5,000</td>
</tr>
<tr>
<td>Personal Property Used in business:</td>
<td>$5,000</td>
</tr>
<tr>
<td>Real Property</td>
<td>$1,000</td>
</tr>
<tr>
<td>--------------</td>
<td>--------</td>
</tr>
<tr>
<td>Excluding the home site:</td>
<td></td>
</tr>
<tr>
<td>Scholarships, Grants:</td>
<td>$0 (meaning that none is exempt, all is expected to be used toward rehabilitation)</td>
</tr>
</tbody>
</table>

A determination will be made of the amount of the individual’s “excess resources” and the cost of the rehabilitation services needed. DSB will pay for those services that cannot be covered by the person’s “excess resources.”

**Program Appeals**

The appeals process for the rehabilitation program for the blind is the same as it is in the Division of vocational Rehabilitation. See Vocational Rehabilitation chapter, part 6 – Page 43 for details.

**Governor Morehead School for the Blind**

**Program Benefits**

The Govern Morehead School is the only school in North Carolina devoted exclusively to educating blind and visually-impaired children. Located in Raleigh, it offers a residential as well as a day program for children from birth to age 21. Children are provided a basic public school curriculum as well as specialized training focused on their needs as visually-impaired persons. A special unit can accommodate children who have multiple handicaps.

In addition to educating blind and visually-impaired children at the Gov. Morehead School, school staff is also available to provide resources and planning assistance to educators in public schools around the state that have programs for blind children.

**Program Eligibility**

As a general rule, a child must have best corrected vision no better than 20/200, have significantly reduced peripheral vision, or have another significant visual impairment.
There are no financial criteria and there in no tuition.

**LEGAL AUTHORITY**

N.C. Gen. Stat. §143B-157  
N.C. Gen. Stat. §143B-176.1-.2  
(establishment of Gov. Morehead School)

State Policy: 10 N.C.A.C. Title 19

**SOURCES AND RELATED RESOURCES**

The Division of Services for the Blind  
309 Ashe Avenue - Fisher Building  
Raleigh, NC 27606-2102  
(919) 733-9822

DSB District Offices:

50 South French Broad Ave.  
Asheville, NC 27215  
(828) 251-6732

101 Executive Park West  
2260 South Church Street  
Burlington, NC 27215

5855 Executive Center Dr, Suite 100  
Charlotte, NC 28212-8843  
(704)563-4168

225 Green Street  
Suite 500  
Fayetteville, NC 28301  
(910) 486-1582

404 St. Andrews Dr.  
Greenville, NC 27834  
(252) 355-9016
307 Ashe Ave- Cole Building  
Raleigh, NC 27606  
(919)733-4234

3240 Burnt Mill, Suite 7  
Wilmington NC, 28403  
(910)251-5743

4265 Brownsboro Road, Suite 100  
Winston-Salem, NC 27106  
(336)896 2227

Vocational Rehabilitation Client Assistance Program  
PO Box 26053  
Raleigh, NC 27611-6053  
(919)733 3364

Governor’s Advocacy Council for Persons with Disabilities  
(Investigates complaints and pursues remedies on behalf of persons with disabilities who feel they have been discriminated against)  
1314 Mall Service Center  
Suite 100  
Raleigh, NC 27605-3243  
1-800-821-6922  
919-733-6250 (in Raleigh)

The Lions Club in many communities provides services and supplies for the blind.
Services for the Deaf and Hard of Hearing

Program Specifics

Quick Lookup

What are they?

North Carolina Division of Services for the Deaf and the Hard of Hearing is a state agency available to all North Carolinians, to address issues affecting Deaf, Hard of Hearing and Deaf-Blind individuals.

Who Are They For?

Persons in North Carolina with visual impairments. Some services are offered only to those with low income.

Where are they available?

Services and applications are available through the Regional Centers for the Deaf and Hard of Hearing listed below.

Introduction

Established in 1977 as the North Carolina Council for the Hearing Impaired, the North Carolina Division of Services for the Deaf and the Hard of Hearing has developed into a statewide network of programs providing a wide variety of services to Deaf, Hard of Hearing and Deaf-Blind people.

Program Benefits

Services/topics include

- Advocacy for the rights and needs of individuals who are Deaf, Hard of Hearing or Deaf-Blind
- Assistance with communication needs
- Sign language interpreting
- Hearing aids
- Assistive technology
- Telecommunication needs
• Captioning services
• Video Relay Services
• Assistance in accessing appropriate community resources
• Legal
• Financial
• Medical
• Mental Health
• Employment
• Social Services
• Housing
• Education
• Independent Living Skills
• Recreation
• Emergency Systems
• Information and support in achieving full participation in daily life
• Consultation and education to community agencies, organizations, employers and service providers in meeting the needs of people with hearing loss
• Opportunities for borrowing books, CDs, DVDs, videos and other materials from our Regional libraries.

Program Eligibility

Equipment Distribution Services
North Carolinians with hearing loss may qualify for a hearing aid with a telecoil ("T-coil) or select from a wide variety of adaptive telephone and other telecommunications devices available to Deaf, Hard of Hearing, Deaf-Blind and Speech-Impaired individuals. These specialized devices enable these individuals to call standard telephone users such as their loved ones, to order a pizza, or to make appointments.

To qualify, an individual must:

• Be a resident of North Carolina
• Have a limited family income or be a recipient of public funds
• Be certified by a qualifying professional to be Deaf, Hard of Hearing, Hard of Hearing/Vision Impaired or Speech Impaired

**Program Appeals**

Appeals are made through the Regional Centers and the Division of Services for the Deaf and the Hard of Hearing.

**Sources and Related Resources**

**Regional Centers**

The Division of Services for the Deaf and the Hard of Hearing provides services through its seven regional centers located throughout North Carolina. These regional centers serve all 100 counties and are open to Deaf, Hard of Hearing and Deaf-Blind individuals and their families, professionals, agencies and individuals seeking information or assistance.

Please contact the center nearest you for assistance.

**Asheville Regional Center**

12 Barbetta Drive  
Asheville, NC 28806  
800-681-8035 TTY  
800-681-7998 V  
828-670-5054 Fax

**Charlotte Regional Center**

5501 Executive Center Dr.  
Suite 101  
Charlotte, NC 28212  
704-568-8505 TTY  
704-568-8558 V  
800-835-5306 TTY  
800-835-5302 V  
704-568-9615 Fax

**Greensboro Regional Center**

122 North Elm Street  
Greensboro, NC 27401  
336-273-9692 V/TTY  
888-467-3413 V/TTY  
336-256-0689 Fax

**Morganton Regional Center**

517 C West Fleming Dr.  
Morganton, NC 28655  
828-432-5336 TTY  
828-432-5335 V  
800-205-9920 TTY  
800-999-8915 V  
828-432-5341 Fax

**Raleigh Regional Center**

2301 Mail Service Center  
Raleigh, NC 27699-2301  
919-874-2212 V
919-874-2214 TTY
800-851-6099 V/TTY
919-855-6872 Fax

Wilmington Regional Center
3340 Jaeckle Drive
800-205-9915 V

Wilson Regional Center
1901 Tarboro St. SW
Suite 300
Wilson, NC 27893
252-243-1951 TTY
252-243-3104 V
800-205-9925 TTY
800-999-6828 V
252-243-7634 Fax

The Randall Bldg.
Suite 104
Wilmington, NC 28403
800-205-9916 TTY
Services for the Adult over 60

Program Specifics

Quick Lookup

What are they?

Services devoted to meeting the health, nutritional, social, and other needs of senior citizens. These services support older and disabled adults and their families through a community-based system of opportunities, services, benefits, and protections.

Who are they for?

Individuals eligible for Home and Community Care Block Grant services include persons 60 years of age and older and their unpaid primary caregivers in need of in-home and community based services. Specific eligibility criteria for each block grant service are outlined in the service standard.

Where are Applications Taken?

At any of a variety of local agencies that contract to provide specific services. The services are coordinated through Area Agencies on Aging, which are listed in Appendix A.

Introduction

The Home and Community Care Block Grant was designed to begin addressing this complexity by consolidating, under a single set of policies, procedures and service requirements, several existing funding sources targeted to older adults. The block grant is also designed to improve the planning, management and coordination of in-home and community based services for older adults by providing counties increased flexibility with regard to the planning and delivery of aging services to meet the unique service needs of older adults in their communities while also ensuring that the requirements of the Older Americans Act are met. Services allowable under the Home and Community Care Block Grant are intended to provide in-home and community based services in support of older adults and their unpaid primary caregivers.
Area Agencies on Aging are offices established through the Older Americans Act that serve to facilitate and support the development of programs to address the needs of older adults in a defined geographic region and support investment in their talents and interests. In North Carolina, AAAs are located within regional Councils of Government. These AAAs have functions in five basic areas: (1) advocacy; (2) planning; (3) program and resource development; (4) information brokerage; and (5) funds administration and quality assurance.

The Division of Aging and Adult Services has designated 17 area agencies on aging in the state to administer the funds on a regional basis. Each area agency contracts with local agencies to provide specific services. Many counties have established departments or councils on aging to be the lead agency within the county to coordinate services for the elderly at the local level.

This chapter briefly describes the services generally available. For more information about the services or where it can be obtained in a local area, the area Agency on Aging should be contracted. (See Appendix A for addresses and phone numbers.)

**Program Benefits**

**Services**

The following services may be provided with Home and Community Care Block Grant funds. All services must be provided in accordance with service standards issued by the Division of Aging and Adult Services.

**Adult Day Care**

Provides an organized program of services during the day in a community group setting for the purpose of supporting the personal independence of older adults and promoting their social, physical, and emotional well-being. Services must include a variety of program activities designed to meet the individual needs and interests of the participants, and referral to and assistance in using community resources. Also included are medical examinations required for individual participants for admission to day care services and thereafter when not otherwise available without cost, and food and food services to provide a nutritional meal and snacks as appropriate. Transportation to and from the service facility may also be provided or arranged when needed and not otherwise available within the
geographical area specified by the Adult Day Care Program. Services must be provided in a home or center certified to meet State Standards for Adult Day Care programs.

**Adult Day Health Care**

Provides an organized program of services during the day in a community group setting for the purpose of supporting older adults' personal independence, and promoting social, physical, and emotional well-being. Services must include health care services and a variety of program activities designed to meet the individual needs and interests of the participants, and referral to and assistance in using appropriate community resources. Also included are food and food services to provide a nutritional meal and snacks as appropriate to the program. Transportation to and from the service facility is provided or arranged for when needed and not otherwise available within the geographical area specified by the Adult Day Health Program.

**Care Management**

Provides professional assistance for older adults with complex care needs and/or their families in accessing, arranging and coordinating the package of services needed to enable the older adult to remain at home.

**Congregate Nutrition**

The provision of a meal in a group setting that provides 1/3 of the Recommended Daily Dietary Allowance.

**Group Respite**

The provision of respite care in a safe setting where caregivers can take care of receivers who do not require personal (hands-on) care to get a break from their caregiving responsibilities. The program operates on a scheduled basis for a period of less than 6 hours a day. This service provides caregivers and care receivers with social opportunities, activities, information about community resources, and/or other services. Group respite services are sometimes called “Caregiver’s Day Out”.

**Health Promotion and Disease Prevention**

 Provision of allowable services which promote the health and wellness of eligible older adults.
Health Screening

General medical testing, screening and referral for the purpose of promoting the early detection and prevention of health problems in older adults.

Home Delivered Meals

The provision of a home delivered meal that provides 1/3 of the Recommended Daily Dietary Allowance to a home-bound older adult.

Skilled Home (Health) Care

Skilled health care prescribed by a physician which is provided in the home of an older adult in need of medical care. Allowable services include: skilled nursing; physical, occupational, and/or speech therapy; medical social services and nutrition care.

Housing and Home Improvement

A service which assists older adults with obtaining or retaining adequate housing and basic furnishings. Types of assistance provided may include: providing information regarding housing/housing with services options available; methods of financing alternative housing/housing with services options; helping to improve landlord-tenant relations; identifying substandard housing; securing correction of housing code violations; assisting with finding and relocating to alternative housing; and providing labor and/or materials for minor renovations and/or repair of dwellings to remedy conditions which create a risk to the personal health and safety of older adults.

Information and Case Assistance

A service which assists older adults, their families and others acting on behalf of older adults, in their efforts to acquire information about programs and services and to assist older persons with obtaining appropriate services to meet their needs.

In-Home Aide

The provision of paraprofessional services which assist functionally impaired older adults and/or their families with essential home management, personal care and/or supervision necessary to enable the older adult to remain at home as long as possible.
Institutional Respite Care

The temporary placement of an older adult who requires constant care and/or supervision out of his/her home to provide their unpaid, primary caregiver relief from caregiving responsibilities.

Legal Services

Older adults are provided legal advice and representation in some cases on issues such as government benefits, wills, consumer issues, and housing problems. Community education is also provided.

Mental Health Counseling

A service which incorporates care consultation, evaluation, and outpatient treatment to older adults who are experiencing mental health problems.

Senior Companion

A part-time stipend volunteer opportunity for low-income persons 60 years of age or older who are interested in community service. Senior Companions provide support, task assistance and/or companionship to adults with exceptional needs (i.e. developmental disabilities, functional impairments, or persons who have other special needs for companionship).

Senior Center Operations

Operation of a multipurpose senior center includes the provision of a broad spectrum of services and activities for older adults. The primary objectives of a multipurpose senior center are: the centralized provision of services which address the special needs of older adults; opportunities for older adults to become more involved in the community; and the prevention of loneliness and premature institutionalization by promoting personal independence and wellness.

Transportation

A service which provides travel to and/or from community resources such as medical appointments and nutrition sites or other designated areas for older adults needing access to services and activities necessary for daily living.

Volunteer Program Development
The development and operation of a systematic program for volunteer participation. The service is intended to involve volunteers of all ages in providing services to older adults while also providing community service opportunities for older adults.

**Long-Term Care Ombudsman Program**

The Ombudsman Program provides advocacy services on behalf of residents in nursing homes and rest homes. Ombudsmen provide training and support to nursing and rest home advisory committees; ensure that patients’ rights are protected; work to resolve grievance and complaints involving patients; educate the public on long-term care issues; and monitor the development and implementation of federal, state, and local laws, regulations, and policies with regard to long-term care.

Ombudsmen receive and investigate complaints made by or on behalf of long term care residents and work for their resolution. The Ombudsman Program is an advocacy program, not a regulatory agency. North Carolina's Long Term Care Ombudsman Program consists of state and regional ombudsmen who help residents of long term care facilities to exercise their rights. In addition to being an advocate for residents, they educate the public and facility staff about rights and help resolve grievances between residents/families and facilities. The regional ombudsmen, who are located within Area Agencies on Aging, also help support the efforts of Adult Care Home and Nursing Home Community Advisory Committees (N.C.G.S. 131E-128 and 131D-3). These local committees, which are composed of volunteers appointed by county commissioners, routinely visit facilities, serve as advocates for residents, help ensure that the intent of the resident's bill of rights is maintained, and work to increase community involvement in long term care facilities.

**Family Caregiver Support Program**

For individuals with a high-risk for nursing home placement, funds can be used to target low and moderate income individuals and their caregivers who may be better served through home and community-based services. Through a variety of consumer-directed options, such consumers may select their own providers and direct how their services will be delivered. The types of available service depend on the county.

The Family Caregiver Support Program serves:
Family caregivers of an older adult (age 60 years or older) or Family caregivers of an older adult who is age 60 or older.

Family caregivers of a person with Alzheimer’s disease or a related dementia may be served regardless of the age of the person with dementia.

Grandparents and other relative caregivers providing care to children (under age 18 years) may receive services at 55 years of age and older;

Grandparent or relative caregivers, providing care for adult children with a disability, who are between 19 and 59 years of age, can now be served under the NFCSP as follows:

Caregivers must be age 55 years and older

Priority is given to caregivers providing care for an adult child with severe disabilities

Services provided to these caregivers are not counted against the 10% ceiling for grandparents and other caregivers providing care to children under the age of 18 years

Older caregivers providing care to their adult children with disabilities can be served in the NFCSP if the adult children are 60 years of age and older.

**Program Eligibility**

**Eligibility for Home and Community Care Block Grant**

**Services**

Individuals eligible for Home and Community Care Block Grant services include persons 60 years of age and older and their unpaid primary caregivers in need of in-home and community based services. Specific eligibility criteria for each block grant service are outlined in the service standard.

**Priority for Receipt of Block Grant Services:**
Once community service providers have determined that individuals meet the eligibility criteria for a given service as specified in the service standard, individuals must be served in the following priority order:

1. Older adults for whom the need for Adult Protective Services has been substantiated by the local department of social services and the service is needed as part of the adult protective service plan.

2. Older adults who are at risk of abuse, neglect, and/or exploitation.

3. Older adults with extensive impairments in activities of daily living (ADL's), or instrumental activities of daily living (IADL's), who are at risk of placement or substitute care. "ADL's" include: eating, dressing, bathing, toileting, bowel and bladder control, transfers, ambulation and communication (ability to express needs to others e.g. speech, written word, signing, gestures, communication devices). "IADL's" include: meal preparation, medication intake, cleaning, money management, phone use, laundering, reading, writing, shopping and going to necessary activities.

4. Older adults with extensive ADL or IADL impairments.

5. Older adults with less extensive (1-2) ADL or IADL impairments.

6. Well Older Adults. Community service providers must establish a process to screen prospective service recipients for the purpose of determining priority for receipt of service(s) in accordance with the above.

**COST OF SERVICES**

All of the services funded by the Older American Act are offered free, but people who are financially able are asked to make a contribution to the cost of the service.

**LEGAL AUTHORITY**

The following is a summary of key state and federal legislation affecting the administration of the Home and Community Care Block Grant.

**North Carolina General Statute 143B-181.1(a) (11)**

This statute specifies that the Division of Aging shall administer a Home and Community Care Block Grant for older adults, effective July 1, 1992.
Older Americans Act of 1965 as Amended: 42 U.S.C. 3001; {Public Law 100-175}
This Act provides for the development and enhancement of comprehensive and coordinated community based systems of services, opportunities, and protection for older adults to assist older adults in leading independent, meaningful, and dignified lives in their own homes and communities as long as possible.

**North Carolina General Statute 143B-181.1(c)**
This statute gives the Division of Aging authority to establish policies and procedures for programs administered by the Division.

**North Carolina General Statute 143B-181.1(a) (10)**
This statute requires the Division of Aging to charge fees for in-home and community based services funded by the Division of Aging unless prohibited by federal law, effective January 1, 1992.

**SOURCES AND RELATED RESOURCES**
N.C Department of Human Resources, NC Division of Aging and Adult Services

CARELINE 1-800-662-7030 (N.C Department of Human Resources Information and Referral service)

National Eldercare Locator (Nationwide Information and Referral Program) 1-800-677-1116

Directory of Agencies Providing In-Home and Community-Based Services for older Adults in North Carolina is online at: [http://www.disability.gov/health/specific_populations/older_adults](http://www.disability.gov/health/specific_populations/older_adults)

The addresses and phone numbers of the Area Agencies on Aging are located in Appendix A.
Vocational Rehabilitation

Program Specifics

Quick Lookup

What Is It?
A program to assist individuals with disabilities in preparing for, obtaining and/or maintaining employment.

Who Is It For?
People who have substantial limitations on their ability to work due to physical, mental, or emotional disabilities and require rehabilitation services in order to enter or remain in the workforce.

Where Are Application Taken?
At Vocational Rehabilitation unit offices. Offices are located throughout the state and cover all counties in North Carolina, and can be located through the public VR website at http://dur.dhhs.state.nc.us/ or Appendix M.

Introduction
A joint state-federal program, Vocational Rehabilitation (VR) is designed to assist persons with physical, mental, or emotional disabilities to participate in the workforce. A wide range of services are available. Some services require a financial needs test, where income levels apply. Clients who do not meet the financial eligibility guidelines will be required to pay for some or all of the services offered. All services are provided with the objective of obtaining employment.

The VR program is administered at the state level by the Division of Vocational Rehabilitation Services within the N.C Department of Health and Human Services, there are 32 “unit” offices around the state where services are provided, listed in Appendix M.

Applications
Applications for VR services are taken at any of the local unit offices around the state. The addresses, phone numbers, and areas covered are listed in Appendix M. An individual may apply on his or her own, or may be
referred by any interested person. An individual interested in applying should call ahead for an appointment. Upon application, an individual will be assigned to a VR counselor who will follow the individual through the process and make the eligibility decision. Individuals applying for VR services are requested to assist the counselor in obtaining the necessary medical or psychological information needed in order to make a determination of eligibility. Applicants should assist this effort by taking copies of existing information to the VR counselor.

**Program Benefits**

**Preliminary Assessment**

All applicants are entitled to a *preliminary assessment*. This will be used by a VR counselor to determine whether the applicant is eligible for VR services (see Personal Eligibility section Part 6 – Page 40). There is no charge for this assessment, regardless of the financial means of the applicant. The assessment will include a review of current medical information if any is available, or will involve examinations by doctors, psychiatrists, or psychologists, as appropriate.

In some cases, a trial work experience/extended evaluation will be undertaken if the preliminary assessment did not reveal enough information about the applicant’s rehabilitation potential for an eligibility decision to be made.

**Comprehensive Assessment**

Those individual who are found eligible for VR services as a result of the preliminary assessment also receive a Comprehensive Assessment to determine the nature and scope of the services needed. Included in this study are areas such as *appraisal of the individual's personality, intelligence level, educational achievement, work experience, personal and social adjustment, and vocational adjustment and employment opportunities*. A VR counselor will be looking at the person’s overall needs as they relate to a person’s potential ability to participate in the workforce. This study might include further psychological testing, vocational assessment, and aptitude testing, or a more detailed medical examination.

**Individualized Plan for Employment (IPG)**
Persons who have been determined to be eligible, and for whom a job goal and needed services have been identified, jointly develop an IPG with their VR counselor. The following items should be included in the IPG:

- Vocational/Job Goal
- The specific vocational rehabilitation services needed to achieve the objectives
- Projected initiation dates for the services and expected completion date of IPG
- Division and Client responsibilities regarding the IPG
- Evaluation Criteria
- Anticipated Services following successful outcome
- Whether services are provided in an integrated setting
- Appeal Rights

The client should be given a copy of the IPG. The plan can be amended if circumstances warrant. A review of the client’s progress toward plan completion must be made at least once a year.

**Vocation Rehabilitation Services**

A wide range of services are potentially available to an eligible individual. The services chosen will be those necessary to carry out the IPG. Among the available services are:

- **Evaluation** of vocational rehabilitation potential
- **Counseling** and guidance, including “personal adjustment counseling”
- Physical and mental **restoration services** (which may include medical, surgical, or psychological treatment; speech or occupational therapy; and medically-related equipment such as prosthetic devices, hearing aids, or glasses)
- **Vocational or other training** (which may include higher education as long as all other sources of payment are exhausted before VR funds are used)
- **Maintenance costs** (food, clothing, shelter, and other necessities) but only when increased expenses are imposed on the client as a result of the rehabilitation program
• Payment of transportation
• Services to family members
• Interpreter services for the deaf
• Reader services for the blind
• Technological aids and devices
• Recruitment and training for opportunities in public services employment
• Job placement
• Post-employment services
• Occupational licenses
• Other goods and services that can be expected to benefit an individual with a disability in terms of employability

Availability of Services

Vocational Rehabilitation is not an “entitlement” program. This means that persons are not legally entitled to the services offered just because they have met the eligibility criteria. There must be sufficient funding available to provide the services. In some circumstances, a limit will be placed on how much will be spent on a particular service. The VR counselor will make numerous discretionary decisions when determining which and what quantity of services will be made available to each client.

The VR counselor and participant are required to access “comparable benefits” to the ones available through VR from other sources in the community before spending VR money. The client must apply for those benefits if they are located. For example, someone wishing to attend a college program would have to apply for grants offered through public and private sources; a person needing particular medical services would have to apply for Medicaid, Medicare, or any available private health insurance benefits before VR funds were used.

Client Assistance Program

The Client Assistance Program (CAP) is a statewide program within VR that provides staff to assist applicants and clients in learning about the VR program and resolving any problems that may arise. The CAP staff can intervene when a disagreement arise between the client and the
VR counselor. It can also advise clients about how to pursue other administrative and legal remedies should that become necessary. Finally, the CAP can be reached at the state VR office number. (See Sources and Related Resources at the conclusion of this chapter.)

**Program Eligibility**

**Personal Eligibility**

Any person who is currently “present in the state” who meets the following criteria is eligible for Vocational Rehabilitation services:

- The person must have a **physical, mental, or emotional impairment that constitutes or results in a substantial impediment to employment**.
- The individual can benefit from VR services in terms of an employment outcome.
- The individual requires VR services to prepare for, secure or retain gainful employment.

An individual cannot be required to meet a residency test, nor can he/she be denied solely because of age or type of disability.

A vocational rehabilitation counselor makes the eligibility determination after either a preliminary assessment or an extended evaluation (described above). The decision of the VR counselor is appealable. (See Appeals section following).

**Advocate Tip:** The VR counselor has a significant amount of discretion in making eligibility decisions. An advocate can play an important role by assuring that all available information about an applicant is provided to VR. Further, if the initial decision is negative because the VR counselor believes there is not enough rehabilitation potential, an advocate should urge that an extended evaluation be undergone to determine employability potential. A trial work experience is one possible element of an extended evaluation that can often provide evidence of the applicant’s potential.

**Financial Eligibility**

There are **no financial eligibility requirements** to have a **preliminary assessment** completed. Persons whose eligibility cannot be determined
through the preliminary assessment are entitled to a trial work experience/extended evaluation without charge, regardless of financial means. (It should be noted, however, that the financial eligibility requirements will be applied if someone in an extended evaluation needs something other than diagnostic services, such as medical treatment or equipment.)

All eligible clients are provided counseling, job placement, referral services, and certain other services without charge and without regard to their financial status.

Other services are considered “cost services”. Clients who meet the financial eligibility criteria described below can receive those services without charge (i.e., VR will pay for them). Clients who are determined to have financial services (Note: Clients never have to pay for services provided by VR staff. It is only when the services have to be purchased from other providers that clients are asked to contribute).

Income

In order to receive “cost services” without charge, an individual’s monthly net family income may not exceed the following amounts:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Net Monthly Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$1064</td>
</tr>
<tr>
<td>2</td>
<td>$1426</td>
</tr>
<tr>
<td>3</td>
<td>$1789</td>
</tr>
<tr>
<td>4</td>
<td>$2151</td>
</tr>
<tr>
<td>5</td>
<td>$2514</td>
</tr>
<tr>
<td>6</td>
<td>$2876</td>
</tr>
<tr>
<td>7</td>
<td>$3239</td>
</tr>
<tr>
<td>8</td>
<td>$3601</td>
</tr>
<tr>
<td>Each Additional</td>
<td>Add $363</td>
</tr>
</tbody>
</table>
Deductions

To determine monthly net family income, all income for the month of application is added together. This includes income from wages, self-employment, government benefits and pensions of all kinds, child support or alimony, rent, interest, or other cash receipts. From this figure, the following items are deducted:

- Mandatory withholdings from wages, such as taxes, Social Security, etc.
- Health insurance premiums
- Payments actually made on medical or dental bills (must show a 3 month history of payment)
- Child care costs, up to $175/month per child
- Disability-related training or vocational expenses not covered by a third party
- Post-secondary training expenses (up to certain maximums)
- Alimony, child support, or other legally required payments

The result of subtracting from the gross income is the net monthly income. This figure should be compared with the chart above. The client will be expected to use his/her “excess income” (i.e., the amount of net income in excess of the amounts listed) toward his/her vocational services. VR may pay the remaining amount of the cost, if any.

Resources

The VR counselor will also look to a client’s available assets to determine eligibility for VR services. As with the income limits, if an individual’s assets do not exceed the amounts listed, he/she may be eligible for VR to sponsor services. If available assets exceed the limits, he/she will be expected to use the excess resources toward the cost of services. VR may make up the deficit, if any.

Three types of resources are evaluated to determine if the client has excess resources (in addition to excess monthly income). They are cash, real property, and contributions (such as scholarships, grants, community funds, lump sum insurance settlements, etc.) The limits are as follows:
Cash: Three times the income limit for the appropriate family size
Real Property: $25,000 in equity value in any real property, not including the home site
Contributions: Scholarships, educational grants, community funds, etc.

The VR counselor will review the client’s income and resources at the time of application and periodically thereafter. The counselor will determine the cost of the services identified in the client’s IPG and work out the appropriate arrangements for the payments of the services.

Program Appeals

An individual receiving or applying for VR services who is dissatisfied with any determination made by the division concerning the provision of services may request a review of those determinations. An individual is provided with information as to their right to an appeal and the procedure involved during the application process. The staff of the Client Assistance Program (CAP) is available to assist a client with an appeal, or that client may retain his/her own attorney or other advocate.

Client Assistance Program

The CAP was developed to assist individuals with disabilities with resolving concerns related to accessing rehabilitation services. CAP provides a number of services, including:

1. Assistance to consumers in resolving concerns related to the application for services as well as the provision or denial of services.
2. Explanation to consumers of rehabilitation policies and procedures.
3. Assistance to consumers in requesting an Administrative Review and/or Appeals Hearing.
4. Provision of legal consultation (if required) in those cases which reach the Appeals Hearing level of the appeal process (in these cases, CAP is empowered to contract with private attorneys for this service)
5. Provision of information/referral services to individuals with disabilities seeking information about independent living, vocational rehabilitation, and other rehabilitation programs.
Initiating the Appeals Process

When any applicant or individual receiving services wishes to request an appeals hearing or administrative review and mediation, the individual shall submit a written request to the appropriate Regional Director. The request must indicate if the individual is requesting either an administrative review, mediation, and appeals hearing together; an administrative review and an appeals hearing; or only an appeals hearing to be scheduled. The written request must contain the following information:

- Name, Address and telephone number of the appellant
- A concise statement of the determination(s) made by the rehabilitation staff for which an administrative review, mediation and/or appeals hearing are being requested and the manner in which the person’s rights, duties or privileges have been affected by the determination.

Appeals Hearing

The hearing will be conducted by a hearing officer selected by the client from a pool of trained hearing officers. The Hearing itself must be scheduled within 45 days of the request. A delay of up to 20 days is allowed if both the client and the agency agree. At the hearing, each side will present its case with testimony and documentary evidence and have an opportunity to cross-examine opposing witnesses. Closing statements will be accepted.

The hearing officer must make a decision on the case within 30 days of the completion of the hearing. The client will receive a copy of the recommendation, together with a report of the findings and grounds for the recommended decision. The decision of the hearing officer is the final decision unless a review by the Secretary of DHHS is requested by either party or if either party brings a civil action for review by the courts.

Administrative Review

To try to obtain a quicker resolution to a dispute, a client may request an administrative review simultaneously with requesting an appeals hearing. This is an informal process that can be undertaken at the same time as the appeals hearing. There is no time limit within which the request for an administrative review must be made. (The client has the option of having disputed services continued during the administrative review. If this is the case, he/she should consult with the counselor about certain deadlines that apply.)
Although the review is informal, it will result in a written decision. It is essentially a discussion of the disputed decision and an attempt to reach a solution with which everyone agrees. The review should occur within 15 days of the request, and a decision made within five working days of the review.

**Judicial Review**

If neither the administrative review nor the appeals hearing produces a result with which the client/applicant is satisfied, he/she can ask the Superior Court to review the final agency decision pursuant to provisions of the Administrative Procedures Act, N.C. Gen. Stat.§150B, Article 4. (Note, however, that the provisions of N.C. Gen. Stat. §150B-51 (a) do not apply.) As a practical matter, this judicial review can rarely be accomplished successfully without the services of an attorney.

**Legal Authority**

- **Federal Statute**: 29 U.S.C §701 *et seq.*
- **Federal Regulations**: 34 C.F.R §361
- **State Regulations**: 10 N.C.A.C Chapter 20B
- **State Policy**: N.C. Vocational Rehabilitation Services Reference Library (Available for review at any Local VR office or at the state office.)

**Sources and Related Resources**

Division of Vocational Rehabilitation Services
N.C. Department of Human Resources
805 Ruggles Drive
P.O. Box 26053
Raleigh, NC 27611-6053
Linda Harrington- Director
(919) 733-3364 (voice)
(919) 733-5924 (TDD)

Client Assistance Program (CAP) (at above address and phone numbers)

CARELINE 1-800-662-7030 (N.C. Department of Health and Human Services information and referral services)
Part 7: Services and Programs for Families with Children

Child Support Enforcement.......................1
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Child Support Enforcement

Program Specifics

Quick Lookup

**What is it?**

CSE is a state-wide program that oversees the responsible financial support of children receiving child support

**Who is it for?**

Children and custodial parents of children in split or divorced families.

**How do you contact it?**

Anyone with a child support case can get information from [http://www.ncchildsupport.com](http://www.ncchildsupport.com) or call the CSE Customer service line at 1-800-992-9457. The CSE line has an automated voice response system active 24 hours as well as personalized assistance between 7:30 am and 7:30 pm.

Introduction

Child Support Enforcement (CSE) works to ensure that both parents are responsible for the financial support of their children to the best of their ability. The CSE program provides CSE Services to the custodians of minor children, regardless of income level.

CSE agents help locate noncustodial parents, establish the paternity of the child(ren), and petition the court to order child support payments. Once a court order has been established, incoming child support payments are receipted at CSE's Centralized Collections Operation, which manages the collection and disbursement of all ordered child support payments in the state. To enforce child support orders, CSE agents can initiate legal action against the NCP, withhold support payments from the NCP's wages, and intercept their tax refunds.

In 1935, Congress enacted the Social Security Act to ease financial problems that had arisen during the Great Depression. Title IV-A of the Social Security Act established a public assistance program that offered financial assistance to families due to death of the father.
In response to increasing numbers of applications for assistance due to parental abandonment, the first actual child support legislation was enacted in 1950. This legislation required welfare agencies to report all applications for assistance due to abandonment by a parent to law enforcement agencies.

In 1975, Title IV-D was added to the Social Security Act to establish a nationwide Child Support Enforcement (CSE) program, with the purpose of recouping money paid out to welfare recipients when at least one parent existed who could provide support. N.C. General Statutes 110-128 through 110-142 established North Carolina’s CSE program. These federal and state laws set forth the requirements for the program.

**Program Benefits**

**Child Support Enforcement Program**

Information available at [http://www.dhhs.state.nc.us/dss/cse/cseservices.htm](http://www.dhhs.state.nc.us/dss/cse/cseservices.htm)

The Services provided by the NC CSE include

- **Location of noncustodial parents** - CSE searches to find where the noncustodial parent lives and/or works.
- **Paternity establishment for children born outside of marriage** - CSE establishes the legal father of the child.
- **Establishment of support obligations** - CSE establishes a court order for the noncustodial parent to provide support for his/her child(ren).
- **Collection and distribution of support** - CSE keeps records of court ordered child support payments processed by the North Carolina Child Support Centralized Collections operation and tracks the distribution and disbursement of those payments.
- **Enforcement of support obligations** - CSE uses as many enforcement remedies as necessary to ensure the noncustodial parent's compliance with the court ordered support.

**Location of Non-custodial parents**

NCPs must be located before any actions to establish paternity and support or to enforce a child support order can take place. Name, date of birth, social security number, address, employer, and vehicle ownership information can assist the CSE program in locating an NCP. Clients are a primary source of information that CSE uses to locate NCPs.
With these types of information, the CSE program can access both state and national computer databases to assist in location efforts. In addition, CSE offices in other states can assist in locating parents and pursuing a support order.

**Paternity Establishment**

Establishing a legal father for a child ensures certain rights for the child, such as a greater sense of identity and access to paternal medical information, social security benefits, death and insurance benefits, and military benefits.

A child support order cannot be established for a child who is born to unmarried parents, unless the alleged father acknowledges paternity or is proven to be the father. Paternity can be established by voluntary acknowledgment of paternity or by court order.

The most convenient time for parents to establish paternity for their child is in the hospital when the child is born. The father must be present and provide identification to have his name placed on the Affidavit of Parentage. When this document is filed with Vital Records, both parents' names are recorded on the birth certificate.

Genetic (DNA) testing is recommended if there are doubts regarding the paternity of the child. Blood or tissue samples may be used for testing. The most common method uses tissue swabbed from the inside of the cheek. This test is highly accurate in determining the probability that a man is the father of a child. Test results may provide peace of mind to parents who establish paternity voluntarily or may be presented as evidence in legal proceedings to establish paternity.

If paternity is not established voluntarily, legal action may be filed with the courts. A formal complaint is served upon the alleged father, initiating court action. A court hearing is held, and the court may enter an order establishing paternity.

**Establishment of Support Obligations**

A legal order must be established that specifies the amount of support to be paid for the benefit of a child. The successful establishment of a support order depends upon several critical areas. The critical areas are:

- Locating the noncustodial parent (NCP)
- Identifying what he or she can pay
- Determining the financial needs of the child

States are required to develop guidelines for determining child support amounts. In North Carolina, CSE Guidelines are determined by the North Carolina Conference of Chief District Court Judges. These guidelines are based on the needs of the child(ren) and on the ability of parents to pay. States must use the guidelines, unless they can be shown to be unfair to the child(ren).

The CSE Guidelines are used to compute a child support obligation based on the combined gross income of the custodial parent/client and NCP. Either the NCP can agree voluntarily to the amount of support or the obligation can be established through court action.

An obligation to provide medical support in the form of health insurance through the NCP’s employer can be obtained either voluntarily or through court action.

**Collection and Distribution of Support**

The collection and distribution of child support payments are the primary objectives of child support services. A court order for child support dictates the amount of support to be paid and how often it should be paid.

All child support payments handled by N.C. CSE are sent to the Centralized Collections Operation. Payments are received by various methods, such as:

- Direct payments
- Income withholding
- Interception of tax refunds

Child support payments are distributed and disbursed based on federal regulations and state statutes. Then the NC Department of Health and Human Services (DHHS) mails the checks to the appropriate payees.

**Enforcement of Support Obligations**

Establishing a child support order is no guarantee that the noncustodial parent (NCP) will pay the support as ordered. NCPs could make partial payments, skip payments, or never make a payment. N.C. CSE identifies these cases and uses several enforcement tools to get payment as ordered.
Income withholding by employers is the single most effective method of child support collection. Each pay period, the employer deducts a specified amount from the NCP's income for the child support payment. The deducted amount is sent to the NC Child Support Centralized Collections (NCCSCC) within seven (7) days of the deduction.

Income withholding can also be initiated with entities other than employers when the NCP has other sources of income, such as unemployment insurance benefits (UIB), Worker's Compensation, Social Security benefits, and veteran's disability benefits.

Employers are required to withhold income for child support orders that are enforced by other states, in accordance with the laws of the state where the NCP is employed.

Other enforcement remedies include:

- Monthly billing to NCPs who are not under income withholding;
- Filing court action against NCPs who have not paid support as ordered;
- Credit bureau reporting of all child support obligations handled by CSE;
- Interception of state and federal tax refunds; or
- Liens on real or personal property that the NCP owns.

Role & Responsibilities of the CSE Agency

CSE agencies:

- Gather all available information from individuals and other agencies.
- Evaluate their cases and determine the support activities to be pursued.
- Contract with attorneys to represent cases in civil court actions. These attorneys represent the CSE agency and not the individual client in a case.
- Work with all parties in a case, providing information or explanation of case activities when appropriate.
- Keep the information that they receive confidential. Only information that is public record can be divulged. (N.C. law requires CSE to list the
Social Security numbers of all parties who are involved in a child support case on documents that establish paternity and support.)

- Abide by federal regulations and state laws when handling child support cases. Automation has increased the speed and accuracy of information gathering, taking actions, and disbursing support payments for children.

- Are required to continue providing the necessary services to all cases after Public Assistance is terminated, unless the client requests that services not be provided and no amounts are due and owed to the state.

The ACTS System

The N.C. CSE program uses a statewide computer system called ACTS (Automated Collection and Tracking System) to assist in the performance of its duties. This system receives and shares data with more than thirty (30) state, federal, and private agencies.

ACTS supports the functions needed to perform CSE activities at the local and state level, including case management, financial management, document and report generation, and supervisory functions.

CSE caseworkers use ACTS to add/update cases, enter/modify court order data after a hearing, review payment and collection activities, perform enforcement activities such as income withholding, assets attachment, and tax intercepts, document their activities in the case record online, and interact with CSE agencies in other states.

Program Eligibility

The CSE program provides CSE Services to the custodians of minor children, regardless of income level. Anyone with a child support case may go online or call the customer support line for information.

Program Appeals

Program Appeals are orchestrated through the North Carolina Division of Social Services. See http://www.ncdhhs.gov/dss/cse/index.htm for Details.

Sources and Related Resources

http://www.ncchildsupport.com: The North Carolina eChild Support web site was implemented in February 2002 and has been a tremendous success
with custodial and noncustodial parents. They use this tool to quickly obtain information about their case and payment information. Registered users are up to 76,950. About 6,500 people go to the website daily, and send an average of 100 emails requesting such services as case information or address changes.

**Customer Service at 1-800-992-9457**: The state-of-the-art customer service center assists callers 24 hours a day with an automated voice response system as well as personalized assistance between 7:30 am and 7:30 pm. The facility received an average of 140,000 calls a week. Monthly surveys were conducted from January to July of 2003, and found that 94 percent of callers were satisfied with the service received and 96 percent agreed that the customer service representative was courteous and professional.


CSE Guidelines: [https://nddhacts01.dhhs.state.nc.us/home.jsp?TargetScreen=WorkSheet.jsp](https://nddhacts01.dhhs.state.nc.us/home.jsp?TargetScreen=WorkSheet.jsp)

Centralized Collections: [http://www.dhhs.state.nc.us/dss/cse/collections.htm](http://www.dhhs.state.nc.us/dss/cse/collections.htm)

### Legal Authority

**North Carolina CSE Organization**

The Governor of North Carolina has designated the N.C. Department of Health and Human Services (DHHS) as the CSE Agency. N.C. General Statutes 110-128 through 110-142 authorizes DHHS to supervise the child support program. DHHS has designated the Division of Social Services (DSS) to be responsible for this program. The Child Support Enforcement (CSE) Section exists within DSS.

Some counties have placed their CSE program under the authority of county DSS, some counties have placed it under Revenue or the County Attorney, and recently some counties have elected to offer services by contracting with private companies. Other counties have decided that they cannot operate a CSE program, so N.C. has set up state-operated CSE offices to serve those counties. Regardless of who operates the local CSE office, the same regulation, laws, and state policies apply.

A staff of CSE Consultants and Area Supervisors is responsible for providing consultation and program assistance to the county-operated local programs and supervision of the state-operated local programs in their assigned areas.
N.C. General Statute 110-130 requires the county commissioners to designate a local person or agency to administer the program. The county commissioners can assume responsibility for the administration of existing state-administered local CSE programs by making a request to DHHS between July 1 and September 1 of the then current fiscal year. Commissioners could then assume program responsibility on July 1 of the following year. County commissioners cannot relinquish responsibility for the operation of the program.
Earned Income Credit

Program Specifics

Quick Lookup

What Is It?

A federal tax program through which low-income families can receive a cash benefit—a tax credit—either in their paychecks or as a one-time payment.

Who Is It For?

Families that contain at least one child and that earn less than the maximum amount established by the Internal Revenue Service.

Where Are Applications Taken?

At the Internal Revenue Service, by filing a federal income tax return. Alternatively, families can get the credit in their paychecks by filing a W-5 form with their employers.

Introduction

Originally created by Congress in 1975, the Earned Income Credit provides a tax credit to low-income working families. It was designed to offset the regressive impact of Social Security taxes on low income wage earners and to provide an incentive to work. The credit has been expanded several times since then. The program is administered by the Internal Revenue Service (IRS). There is no state counterpart to the program.

Applications

Application for the EIC is made either by filling a federal tax return or by filing a W-5 form with the employer. When the application is made through the tax form, the family receives a check sometime after the end of the tax year (or a reduction of taxes due). When application is made by filing a W-5 form, the family receives the credit as an advance payment in its paychecks throughout the tax year. (If a family files a W5, it must still file a tax return.)

Federal Tax Return
A family wishing to claim the EIC on its tax return must file either a form 1040 or 1040A after the conclusion of the tax year.

An additional form (Schedule EIC) must be attached to the tax return to claim the EIC. The form will be included in the tax booklet. If the attachment is omitted, the family will not receive the credit. The family need only fill out side 1 of the Schedule. The computation section, on side 2, will be completed by the IRS.

**Advance Payment**

Instead of receiving the credit after the conclusion of the tax year, a family can have the credit added to its payments of the credit must file a federal tax return (form 1040 or 1040A and Schedule EIC) after the conclusion of the tax year. If an employee files a W-5 form with the employer, the employer must include the credit in the employee’s paycheck. If the employer does not have a W-5 form, it can be obtained by calling **1800-TAX-FORM** (1-800-829-3676). The form can be filed at any time during the year.

**Any employee who receives advance payments of the credit must file a federal tax return** (form 1040 or 1040A and Schedule EIC) after the conclusion of the tax year. If too much or too little credit was given throughout the year, it will be treated just like income tax withholdings are treated: either the family will owe the IRS money or the IRS will owe it money.

**Retroactive Application**

An eligible that has failed to apply for an EIC in the last **three years** may apply retroactively if it has not already filed a tax return for those years. If it is entitled to a credit, the family will be penalized for missing the April 15 deadline. In addition, a family that has filed a return but failed to claim the credit can file an amended return.

**Filing Requirements**

To claim the Earned Income Tax Credit, clients must file tax returns, even if they do not owe tax, did not earn enough money to file a return, or did not have income taxes withheld from their pay.
Program Benefits

The Earned Income Credit (EIC) provides eligible individuals with a cash benefit that can be obtained either on a regular basis throughout the year in a paycheck or as a lump sum as if it were a tax refund. If the family owes federal income tax, the EIC can be used to offset the tax owed. If the family owes no tax, or owes tax than the amount of the credit due, the IRS sends the family a check after receiving the tax return.

Amount of the Credit

The amount of the credit each family is entitled to depend both on the size of the family and the amount of income earned.

<table>
<thead>
<tr>
<th>Earned Income Credit</th>
<th>Tax Year 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Children</td>
<td>Maximum credit</td>
</tr>
<tr>
<td>0</td>
<td>$457</td>
</tr>
<tr>
<td>1</td>
<td>$3,043</td>
</tr>
<tr>
<td>2</td>
<td>$5,028</td>
</tr>
<tr>
<td>3 or more</td>
<td>$5,657</td>
</tr>
</tbody>
</table>

Taxpayers with investment income of more than $3,100 are not eligible for the credit.

* Increase these amounts by $5,000 for joint return filers.

Effects on Other Benefits

The EIC may not count as income when eligibility is determined for AFDC, Medicaid, Food Stamps, subsidized or public housing, or SSI.

Advanced Earned Income Credit

Clients can decide to receive some of their EIC benefits in advance by filing a W-5 form with their employer. The amount they can get in advance generally depends on their wages; however, the maximum Advance Earned Income Credit an employer is allowed to provide to employee’s pay was $1,750 in 2008. To qualify:

- They must except that earned income and AGI will be less than $35,463 ($38,583 married filing jointly,)
- They must expect to have a qualifying child, and
• They must expect to meet all the aforementioned rules applicable to clients with qualifying children.

**State Earned Income Tax Credit**

North Carolina now offers a State Earned Income Tax Credit. A person who qualifies for the federal credit also qualifies for the state credit.

**Program Eligibility**

**Personal Eligibility**

To qualify for the Earned Income Tax Credit:

• They must have a valid Social Security Number.
• They must have earned income from employment or from self-employment.
• Their filing status cannot be married, filing separately.
• They must be a U.S. citizen or resident alien all year, or a nonresident married to a U.S. citizen or resident alien and filing a joint return.
• They cannot be a qualifying child of another person.
• They cannot file Form 2555 or 2555-EZ (relating to foreign earned income.)
• They cannot have investment income of more than $2,950 for the year.
• If they do not have a qualifying child:\n  ➢ They must at least age 25 but under age 65 at the end of the year,
  ➢ They must live in the United States for more than half the year, and
  ➢ They cannot be the dependent of another person or the qualifying child of another person.

**Financial Eligibility**

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1 A qualifying child must meet the relationship, age and residency tests; cannot be used by more than one person to claim the EIC, and cannot be the qualifying child of another person.
In addition to meeting the aforementioned qualifications, for Tax Year 2008 earned income and adjusted gross income (AGI)\(^2\) must each be less than:

- $38,646 ($41,646 married filing jointly) with two or more qualifying children
- $33,995 ($36,995 married filing jointly) with one qualifying child
- $12,880 ($15,880 married filing jointly) with no qualifying children

The maximum credit for Tax Year 2008:

- $4,824 with two or more qualifying children
- $2,917 with one qualifying child
- $438 with no qualifying children

**Program Appeals**

A taxpayer who thinks that he/she has not received the proper earned income credit can write a letter of protest to the IRS. This will begin an administrative process during which the taxpayer will be allowed to present his/her case at an informal hearing. If the taxpayer is not satisfied with the decision made at the hearing, he/she can file a petition to the U.S tax court within 90 days of the hearing decision.

**Legal Authority**


**Sources and Related Resources**

The Internal Revenue Services

1-800-829-1040

The Center on Budget and Policy Priorities

777 North Capitol Street, NE

Suit 705

Washington, DC 20002

\(^2\) Special rules apply for calculating earned income for members of the U.S. Armed Forces in combat zones, members of the clergy, hurricane victims, and those with disability retirement income.
Note: The Center on Budget and Policy Priorities conducts a nationwide education campaign about the Earned Income Credit. Local groups can request materials and information from the Center.

Volunteer Income Tax Assistance (VITA) Clinics are located in communities around the state and are generally advertised in the local media. The IRS (at the number listed above) can provide information about VITA clinics in a particular community.
Head Start

Program Specifics

Quick Lookup

What Is It?

A free, comprehensive early childhood program including education, meals, social services, medical and dental care, mental health services, and programs for parents.

Who Is It For?

Children aged three and four whose family income does not exceed the federal poverty guidelines. Certain other children may participate.

Where Are Applications Taken?

At local Head Start programs throughout the state.

Introduction

Head Start was established by congress in 1965 as a cornerstone of the Great Society Programs. It is a comprehensive early childhood education program offering a wide array of services both to low-income children and their families. Parental involvement is of particular importance, because parents are acknowledged as the primary educators of their children.

Applications

A family interested in participating in Head Start should contact the local program nearest to them about application procedures. See Appendix C.

Program Benefits

Head Start provides children the opportunity to participate in an interdisciplinary program designed to foster development and remedy problems. Individual programs are allowed flexibility in their own designs for achieving the overall goal of developing a greater of social competence in children of low-income families. Participation in the program is free; no fees can be charged.
Most Head Start programs operate approximately **six hours per day** and generally only during the months school is regularly in session. New federal money may make it possible for some programs to operate “wrap around” programs, allowing them to be open longer hours to accommodate working parents.

Each Head Start program should contain the following components:

**Education**

A **learning environment** should be provided, **individualized to meet each child’s needs** and taking into consideration the ethnic, linguistic, and cultural characteristics of the community.

**Health**

**Medical/Dental**

Each child should receive a **complete physical exam** and follow-up to assure the immunizations are administered regularly. Each child should also receive a **dental exam**.

**Nutrition**

**Free snacks and lunches** are provided to children in Head Start programs, making up at least one third of the daily nutritional requirements. In addition, **nutrition counseling and education** are provided to parents and children.

**Mental Health**

A mental health professional is available in all Head Start programs to provided **mental health training to parents and staff**, and make them aware of the need for early attention to the special problems of children.

**Social Services**

Head Start social services staff work with parents to obtain needed assistance in such area as housing, Food Stamps, job training, income supplements, etc. and may also serve as advocates with area agencies serving the low-income community.

**Parent Involvement**
All Head Start programs strongly encourage parents to participate in a variety of ways. Parents can serve as volunteers in the classroom, make decisions about the direction of the program through the Head Start Policy Council, and take advantage of training opportunities in child development, health, and social services. Also, parents received preference for employment if qualified.

**Program Eligibility**

In order to be eligible for Head Start, a child must be age three to five (up to compulsory school age).

Programs must make at least ten percent of their slots available for handicapped children.

Some local programs may have additional enrollment criteria. When there is a waiting list, preferences is usually given to children from the lowest income families.

**Sources and Related Resources**


Martin County Community Action Inc.: [www.mccai.org](http://www.mccai.org)
Subsidized Child Care

PROGRAM SPECIFICS

Quick Lookup

What Is It?

A program that allows families with children to receive help with the cost of child care for children.

Who Is It for?

Families who are members of the specific need groups, including those for whom it is necessary to allow the parents to work. Most families must also meet financial eligibility criteria.

Where Are Applications Taken?

Usually at county Departments of Social Services. The Child Care Program may have a waiting list for services.

Introduction

Through a combination of federal, state, and county funds, North Carolina administers a program of subsidized day care for children. Because of recent changes in the law, more money is being allocated to child day care subsidies, and the program is expanding. In recent years, the program has not been funded at a level that has allowed all eligible families to be served and long waiting lists have existed.

A family applies for assistance with child care costs locally, usually at the county Department of Social Services. If the family is found eligible and there is money available the local DSS can help with a portion of child care expenses for the family at an approved day care provider. Often the family will be required to contribute to the cost of the care, depending on family income.

At the state level, the program is administered by the Division of Child Development within the N.C. Department of Human Resources. A variety of funding sources is used to subsidize day care.

CHILD CARE PROVIDERS
The family may choose any child care provider, as long as it is approved as meeting the requirements for publicly-funded day care. Parents may choose from among day care centers or day care homes that meet state regulations and agree to accept public funds. Regulated Child Care Providers are issued a star rated childcare licenses. A five star is the highest star rating you can receive. In order to receive stars, providers are evaluated on program standards. Certain informal day care arrangements can also be approved.

**Applications**

Applications are taken at the county Department of Social Services in most counties. In a few counties, another agency has been designated to implement the day care program locally. In those cases, a referral to the correct agency can be obtained from DSS.

The Department of Social Services (or other local agency) will determine eligibility. In many cases, eligible individuals will be put on a waiting list due to insufficient funding. Each county has established policies on how families are prioritized and removed from the waiting list.

**Program Benefits**

**Payment Rates**

The *state sets the rates it will pay for day care* through this program. The payment rate structure is based on county market rates. Market rates for center-based and home-based care are calculated for each county by the Division of Child Development. The market rates vary by age of child and the star rating of the childcare provider.

All payments for child care are limited to the county market rate.

**Amount of Assistance**

The *amount of assistance* will depend on the family situation and/or family income.

**Program Eligibility**

**Personal Eligibility**

There are no personal eligibility requirements.
**Financial Eligibility**

A family’s income must not exceed the maximum limits set by the state in order to participate in the subsidized day care program.

**INCOME LIMITS:**

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<th>Monthly Gross</th>
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<td>6</td>
<td>$4,804</td>
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**Program Appeals**

Clients have the right to appeal decisions made by the county DSS or local agency regarding eligibility for child day care services. Information regarding how to request a hearing and the time frame is provided on the back of the application form and on subsequent change notices which are sent to the parent. Hearings are held with an official of the county department of social services and, if an additional hearing is requested, with an official from the State Department of Human Resources.

**Sources and Related Resources**

Division of Child Development  
319 Chapanoke Rd  
Suite 120  
Raleigh, NC 27603  
2201 Mail Service Center  
Raleigh, NC 27699  
1-800-859-0829  
[www.ncchildcare.net](http://www.ncchildcare.net)
Child Care Links Resource and Referral  
111 B Eastbrook Drive  
Greenville, NC 27858  
(252) 758-8885  
www.mppfc.org

Pitt County Department of Social Services  
1717 West Fifth Street  
Greenville, NC 27834  
(252) 902-1111  
ksparker@pittcountync.gov

Local Department of Social Services can be found in Appendix D.

Local Smart Start offices can be found in Appendix O.
# Part 8: General Services

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</tbody>
</table>
Serving individuals or families who have undergone a crisis or emergency related upheaval can be a difficult process. Having someone to advocate for them can be a very important factor in the individual or family’s ability to regain control over their lives. Assuring that critical resources are available to these victims can be a convoluted process. Providing a victim the ability to obtain food, shelter, and clothing is of the foremost importance to anyone who has experienced a crisis or disaster. This section attempts to break down the varied categories of need that individuals or families who have endured emergency and crisis situations and outline a seamless method of rendering aid.

Section Headings:
A: Physical Crisis
   1: Loss of Resources
      1.1: By Natural Disaster
      1.2: By Fire
      1.3: By Other
   2: Loss of Capabilities
      2.1: Through Mental Illness
      2.2: Through Physical Illness
      2.3: Through Physical Injury
      2.4: Other
B: Financial Crisis
   1: Loss of Primary Income Source
      1.1: Disappearance of Primary Wage-earner
      1.2: Loss of Employment
   2: Increase in Cost of Needs
      2.1: Health Care Costs
      2.2: Basic Need Cost Increase
   3: Unexpected costs
      3.1: Funerals
      3.2: Hospitalization
      3.3: Critical Appliance Breakdowns
      3.4: Other

Physical Crisis
A physical crisis is where some emergency or disaster occurs that leaves the victim missing some of the elements that they require to subsist, including loss of
shelter, clothing, food, physical ability and even job opportunities. Physical crises can be generally organized into two categories: Loss of Resources, such as shelter and food, and Loss of Capabilities, such as becoming disabled or being injured. These categories will be further broken down into types of crisis and emergencies that would cause substantial loss.

**Loss of Resources**
Losing shelter, food, clothing and other necessities can be caused by numerous crises both widespread and individual. Generally the more widespread the emergency the more aid that will be available but the more important an advocate role becomes in helping the victim to get hold of the resources they need. For ease of use, the sections will focus on the individual victim party, noting where data might change according to the width and effect of the emergency. In situations where a family’s shelter is temporarily lost, alternate accommodations may be available over the short term. See Appendix R: List of NC Homeless Shelters. Also see Part V Housing Programs for possible longer term alternatives.

**Natural Disaster**
The aid available for those who have endured a natural disaster directly corresponds to the size of the disaster. Some examples include your house getting hit by a tornado to Hurricane Katrina’s damage to New Orleans. The pronouncement of a State of Emergency or a State of Disaster by county, state or national officials opens up different arenas of available aid.

When a victim informs you of their situation the first step is to discover if a State of Emergency/Disaster has been declared for the victim’s area as this will indicate what levels of aid are available. For a declared State of Emergency/Disaster FEMA makes certain amounts of aid available to victims which can be accessed through the FEMA representative overseeing the Disaster aid. Some aid may also be made available through the Red Cross.

Barring aid through FEMA, local Emergency Management Organizations run programs both state and locally funded for emergency food, clothing, housing and other concerns that would face a family or individual suffering from a Natural Disaster.

**Fire/Burn-out**
Aid for families or individuals who have experienced a serious fire is available primarily through the local Emergency Management Office and in certain cases through the office of the local Fire Marshall and Red Cross. Some counties operate specific relief programs for victims of burn-out. Information on any programs available can be obtained through the Local Emergency Management Office, the locations of which can
be found in Appendix R. (Note: Under certain circumstances fire damage can warrant FEMA intervention but only in the case of uncontrolled wildfires.)

Under both burnout and repairable fire damage emergency housing may be available through an EM office, the Red Cross, and the Salvation Army. This may depend on the cause of the fire. See the local Salvation Army for possible exceptions.

Emergency supplies may be available through the Red Cross, the Salvation Army, or any United Way resource organization. Things such as replacement clothing, food, and even furniture could be obtained through these organizations.

Other

Other sources of Loss could include theft, water damage, legal action, etc. Sources of aid in these situations are similar to those mentioned above. Supplies may be gained through working with local organizations such as the Emergency Management Office, The Salvation Army and certain United Way centers. Additional local programs may be available to help deal with most emergencies so an advocate should check with any relevant organization before making aid decisions (ex: the Police Department in the case of theft)

Loss of Capabilities

Losing physical health, economic strength and/or mental capabilities can be a destructive result of many emergencies, often linked with particularly damaging losses of resources and the potential stressors that come along with such an emergency. This section is broken down into several means of loosing capabilities that might be experienced by families.

Through Mental Illness

Having a member of the family undergo a bout of mental illness can be devastating to a family’s ability to cope with everyday requirements. Psychotic episodes, bouts of extreme depression and suicide attempts can destabilize a family, making their need for strong advocacy integral to their success.

Mental Illness that Results in Hospitalization: These situations can not only cause great amounts of emotional turmoil but may also relieve a family of their principal income sources. Aiding these families may require working with a psychologist to help the family make changes to accommodate their missing or incapacitated member(s) Additional training opportunities and psychological evaluations may help both family members and the victim adjust to what changes may have occurred or may need to occur. An advocate should contact the local LME for possible intervention. Both the Red
Cross and the United Way may also offer programs to help individuals and families overcome mental illnesses.

**Mental Illness that does Not Result in Hospitalization:** The impact of these situations can be less intense than those that require hospitalization but they can be no less damaging. In certain situations these can be associated with other emergencies (ex: accidentally lighting the house on fire or breaking an important appliance in a fit of anger. There are dozens of organizations that serve these forms of mental illness from AA to the United Way. Steering families or individuals suffering from mental illnesses into these programs can help them adjust to their new needs. This will allow them to regain as much of their lost capabilities as they can and greatly lessen the impact of the emergency.

**Through Physical Illness**

If a family member falls ill it can place a lot of stress onto the other members of the family, especially if the illness is particularly debilitating. Illnesses that qualify as emergencies are generally either completely or heavily debilitating for a long duration, or terminal. Either of these situations requires careful consideration and assistance from an Advocate. Most notably the Red Cross provides a large quantity of assistance programs and should be the first place an advocate should look for potential aid. In particular circumstances the United Way is also a useful source of aid and assistance. See Part IV Health Programs for what programs the victims might be applicable for.

**Through Physical Injury**

Depending on the severity of the injury the recovery process might include lengthy recuperation or even permanent disability. The Local United Way may have programs that would help a individual come to terms with their injury and numerous recovery and physical therapy programs could be available from local hospitals. PT listings can be found at [www.apta.org](http://www.apta.org). Retraining services may also be available, an advocate should check with the local unemployment office for potential recovery programs. Depending on the nature and cause of the injury the individual may be eligible for Workers Compensation which may help defray the costs of recovery.

**Through Other Means**

Depending on the means by which the family or individual lost their capabilities, a number of potential directions could be taken. Employment problems would likely involve the client entering into some sort of retraining program, a process that would likely involve the local unemployment office and the Employment Security Commission, the offices of which can be found in Appendix E. Issues arising from additional, unexpected responsibilities could be assisted through the help of the United Way and the Salvation Army. (See Vocational Rehabilitation part 6 – page 36)
Financial Crisis

A financial crisis occurs when a family or individual become, through whatever means, unable to adequately provide for themselves. This includes loss of income, increased costs, and loss of cash fluidity. For all financial crises an Advocate should examine the client’s eligibility for EA, a grant program that can supply a low income family in need with some needed funds (see Part 1 - Page 13 for EA program) Financial crises can be organized into several different categories of factors that give rise to them: the loss of primary income source(s), increases in cost of required expenditures, and unexpected but unavoidable expenditures. These sections have also been broken down into broad examples of crisis to better outline the potential aid and assistance possibilities available.

Loss of Primary Income Source

A family that has lost its greatest source of income will almost always be in dire straits as a families saving will very quickly run out if an alternate source of income cannot quickly take up the slack. Often this sort of crisis will be connected to a physical crisis of some sort, which is described in some detail in the previous section.

Disappearance of Primary Wage-Earner

When a family looses a member, especially in such a way as to induce strong emotion, the results can be seriously damaging. If you add the loss of a pivotal member’s income to the mix, you are dealing with a family fraught with stress and emotion. As a result, advocacy for such a family can be very important in helping them to get back to their feet.

Whether the wage earner died, left, or was physically or mentally incapacitated, there are a few steps the family can take that will help speed their recovery. This first step is filing with unemployment (see Part 1 – Page 52). Demonstrating the family’s situation and needs should help the family maintain their lifestyle, and keeping them from eating through whatever savings they have. This is not a permanent situation and at best will only buy the family time to adjust and rebound. Families should apply for services at the local DSS.

If the family has more than one wage-earner, or even a potential wage-earner, effort should be made to enter work experience programs like Work-First (see page Part 1 – Page 1). This will start getting the family back on track by allowing it to earn more income again. The Salvation Army and local churches may have aid for the family to help them through their difficult times, helping the family to partially defray some of their costs like food and clothing, and even utilities.

Besides experience counseling, an advocate should consider suggesting methods of family counseling as it would not only help them get through the turmoil but could also promote their recovery.
These situations can be very trying for a family so an Advocate must be careful to avoid anything that might aggravate the problem and focus on getting the family back to a stable situation

**Loss of Employment**
Similar to the loss of a primary wage-earner, loss of employment is most dangerous when a family only has one major wage-earner or when one wage-earner provides more than half the income needs of a family. In cases where there is more than one major wage-earner an emergency may involve the business employing both going under. Either way, losing a significant amount of the family’s income can result in terrible consequences. Helping the family quickly regain employment is pivotal to the family’s continued success.

If the family is eligible for unemployment (see page Part 1 - page 52) an Advocate should persuade the family to file for the additional income relief and in cases where it may be necessary, suggest work experience programs that could help the wage-earner(s) to quickly regain employment. Even if the employment is merely transitional, maintaining a stable income may help mitigate many of the consequences of employment loss.

Another tool would be retraining programs such as Work First (Part 1 – Page 1) which would increase the chances of successfully regaining employment.

**Increase in Cost of Required Expenditures**
Every family has certain responsibilities that they need to continue to pay in order to maintain their lifestyle and health. When these costs increase beyond expectations it can cause problems, especially if the costs increase substantially.

**Health Care Costs**
If a family member is diagnosed with a particularly expensive condition or becomes injured or disabled in a way that creates a financial toll on the family, finding aid could make a great difference for the family. An advocate should be aware of the volunteer services that are available through the Red Cross to assist with health requirements that would ordinarily be quite costly. Helping the family come to terms with any new problems can smooth the process considerably, and may even lead to a quickened recovery.

Certain aid programs for low income families may be available from local hospitals and clinics. Most of these will be known by the Red Cross or the local DSS. An advocate should also discover whether the family or individual may be eligible for Medicaid (Part 3 - Page 8).
Basic Needs Cost Increase
Generally a result of economic factors, the increased cost of necessities can cause problems for many families, although few of them would find this situation a true emergency. Utilities assistance from local churches or other emergency service providers like the Salvation Army may be viable options but introducing the client(s) to alternate means of lessening their burden may lead to better, long term results.

Ideas such as carpooling, and reducing overused utilities can help a family reorganize their expenditures back to viable levels.

Unexpected and Unavoidable Expenditures
Unexpected costs can spell disaster for a family, even for families not in the low income category. This section covers some of the toughest financial crises that families normally undergo, organized into particularly commonplace occurrences. An advocate’s knowledge of achievable and applicable aid can be highly important in not only managing some of these costs, but also avoiding them.

Funeral Costs
Experiencing a loss in a family can be a time of incredible turmoil, but the aftermath can be even more difficult. The cost of a funeral and the casket and burial plot of the individual can come to a startling toll, and an unknowing and grief stricken family can be completely surprised by the large bill. Unfortunately there are relatively few means of finding relief from this situation besides a large expenditure of savings or taking out a loan to pay for it over time, both of which cause their own problems.

Whole Body Donation services (part 8 – Page 23) can be a viable alternative but cannot always be counted on, especially in cases of unexpected deaths.

The best method of dealing with this problem would be forewarning. An advocate communicating the risk to a family with a sick or dying member could allow the family to recognize the problem before it occurs. This would keep the family from being blindsided by the costs and give them the opportunity to decide upon a method of payment that would cause them the least difficulty.

Hospitalization Costs
If an injury or illness befalls an individual, especially if the problem is a major one, the individual may be required to stay at a hospital for treatment. These costs are rarely completely covered by health insurance plans, and in the absence of health insurance the costs can be staggering.

Setting up payment plans with each medical facility is normally accepted. In the case of mental illness hospitalization the Advocate should inform the client’s family of the local LME’s contact information (available online) and what services might they be able to expect.
Critical Appliance Breakdown

Vehicles, refrigerators, water heaters and other major appliances can all experience unexpected problems and complications leading to costly repairs or even expensive replacements. In these cases the client may need short term assistance to reclaim normal operations as well as a long term fix. Short term resources may be available through the Salvation Army or other community resources depending on the particular appliance.

Other Costs

Depending on the nature of the cost, aid might be available through several means. Some costs might be defrayed by obtaining cheaper replacements from organization like the Salvation Army. And if the cost could be attributed to a larger scale circumstance, emergency state aid might be available through local Emergency Management Centers.

Samaritan’s Purse
http://www.samaritanspurse.org/index.php/where_we_work/United_States/a369d5c1f1ca88c0b2ab6a8159894fb7/

Hearts with Hands http://www.heartswithhands.org/AdditionalPrograms.asp
Information and Referral Services

NCcareLINK:

NCcareLINK is a statewide information and referral database. Any non-profit or governmental agency that provides a human service may be listed. For-profit organizations may also be listed within the database as long as they accept governmental funds for payment or offer a sliding fee scale for payments. Go to https://www.nccarelink.gov to access this information. Searches can be made statewide, countywide, or by city for any human service need.

Once on the homepage, searching the database can be completed in many ways. Quick searches on certain populations can be found in the grouping called “Neighborhoods". The different neighborhoods are entitled: Services for Veterans, Family and Children Resources, Services for Older Adults and People with Disabilities Connection. By choosing a “neighborhood” one can quickly see a variety of topics that may relate to that “neighborhood" and allowing one to narrow the search as needed.

For providers to be listed, each must go to the website and click on "Provider Portal" to register for a username and password. Once registered, NCcareLINK personnel will email a username and password to will allow the individual to fill in their agency's information and be listed as a provider with NCcareLINK.

Toll Free Lines:

There are many toll-free lines available on a myriad of topics and issues. To list them all is prohibitive but by simply doing a simple search on the topic you are looking for, you will be able to find them. Try search on something like “health & toll free numbers“ and you get tons of listings.

United Way:

Some United Way offices across the state operate the 2-1-1 system that may be able to help you find resources you are looking for. To find the local United Way office in your area, go to this website http://www.unitedwaync.org/ and you can either click on the map to find your local office or click on the tab that says 2-1-1 to find the office closest to you.
LEGAL AID OF NORTH CAROLINA, INC.

Legal Aid of North Carolina (LANC) is a statewide, nonprofit 501(c)3 law firm that provides free legal services in civil matters to low-income people in order to ensure equal access to justice and to remove legal barriers to economic opportunity. LANC operates in all 100 counties in North Carolina through 24 geographically based offices. To find the office in your area, refer to Appendix G.

The Greenville Office of Legal Aid represents low-income clients in Pitt, Martin, Washington, Tyrrell, and Hyde Counties.

Eligibility: Generally speaking, LANC’s clients fall below 125% of the federal poverty guidelines. Some exceptions allow for representation of people whose household income is higher. The most important exceptions apply to victims of domestic violence and for persons over the age of 60 seeking representation in certain types of cases.

Also, for most cases LANC clients must be U.S. citizens or be able to establish that they are Legal Permanent Residents. Again, there is an exception for victims of domestic violence (insofar as the representation is necessary to ameliorate the effects of domestic violence).

Every person’s situation is unique and eligibility cannot be determined until an intake is performed.

Types of Cases: LANC provides representation in civil (non-criminal matters) for low-income clients. Specifically, LANC represents clients in the following kinds of cases:

- **Consumer:** Bankruptcy, consumer debt, school loans, defective products, insurance coverage denial, mortgage foreclosure prevention;
- **Education:** school discipline, educational enrollment affidavits;
- **Employment:** Unemployment Compensation;
- **Family:** Domestic Violence
- **Health:** Medicaid eligibility
- **Housing:** defending summary ejectment cases, assisting clients with illegal lockouts or utility cutoffs by landlords, tenants' rights, and subsidized or public housing disputes;
- **Income Maintenance:** SSI/Social Security Disability benefits, food stamps
o **Tax:** Assistance with some disputes with the Internal Revenue Service (Low-Income Taxpayer Clinic)

Due to limited resources, LANC cannot accept for representation every person who applies for representation in the above areas.

**Statewide Projects:**

o Advocates for Children's Service, Durham, NC
o Domestic Violence Prevention Initiative
o Battered Immigrant Project
o Farmworker Unit, Raleigh, NC
o Mortgage Foreclosure Project
o Senior Law Project

**Contact LANC:**

Website: [http://www.legalaidnc.org](http://www.legalaidnc.org)

Central Intake Unit: 1-866-219-5262

Administrative Office: (919)-856-2564

Greenville Office: (252)-758-0113
  Fax: (252)-758-1843
  301 S. Evans St., Suite 200
  Greenville, NC 27858

  P.O. Box 7283
  Greenville, NC 27835

Farmworker Unit: 1-800-777-5869

Battered Immigrant Project: 1-866-204-7612
Social Services

Program Specifics

Quick Lookup

What are they?

A number of service programs designed to provide for and enable county residents to build capabilities and function at their maximum capacity, to become self-sufficient, to improve their standard of living, to learn to cope adequately with their problems, and to provide preventive services that will avoid family breakup and enable individuals to remain in their own homes.

Who are they for?

Any county residents who meet the eligibility criteria.

Where are applications taken?

At county Departments of Social Services

Introduction

The Department of Social Services provides financial assistance and social services to all County residents who meet eligibility criteria. The two main program areas providing services are Income Maintenance Programs and the Services/Social Work Program.

Each of the 100 counties in North Carolina is served by a Department of Social Services (DSS). Each department is independent, with the director hired by a county Board of Social Services appointed by the County Commissioners. State law requires each department to make available certain services and allows each to offer certain additional services at county option. Funding for the services offered by the county departments comes from a combination of local, state, and federal funds. Much of the funding for the services described in this chapter comes through the federal Title XX (20) Social Services Block Grant and through federal title IV-B Child Welfare funds.

Despite their independence, county departments receive supervision and technical assistance from the state Division of Social Services within the N.C. Department of Human Resources.
This chapter briefly describes the major services that are available through DSS offices. As noted above, not every service is offered in every county. In addition, there is insufficient funding to allow the staff to provide the services to all those eligible. Thus, for many of the services there are waiting lists. Some of the services are offered free without regard to the client’s income; others are offered free to those who meet certain financial criteria and to other for a fee; yet others are offered only to those who meet an income test.

Programs and service that are offered by DSS offices but have been described in separate chapters (such as subsidized day care, utility programs, Medicaid, and cash assistance programs) are not included here.

**Applications**

*Applications are taken at county Departments of Social Services.* Some services, such as Protective Services for Adults and Children, do not require applications. Applications can be taken in person at the county DSS office, or by mail, in some cases, a DSS worker can make a home visit to take an application.

A written application should be taken from anyone desiring to apply. An application can also be taken from someone acting on behalf of the individual.

An application may be denied if the applicant fails to meet the eligibility requirements or if there are insufficient resources to provide the service promptly (i.e., within 15 days of eligibility decision).

**Program Benefits**

**Adoption Services**

These services include the selection of adoptive homes to meet the needs of children awaiting adoption and support to birth parent(s), adoptive parent(s), and children involved in the adoption process. Services are available in every county, but some counties have elected not to recruit families for waiting children since recruitment is not a mandated service.

*There are no financial eligibility criteria for these services.*

**Community Alternatives Program for Disabled Adults**

Community Alternatives Program for Disabled Adults (CAP/DA) provides a package of services to allow adults (age 18 and older) who qualify for nursing
facility care to remain in their private residences. The program is available in all North Carolina counties.

**Foster Care Service for Adults**

Aged, blind, or disabled adults (over age 18) who are unable to stay in their own homes or who are moving out of state institutions or nursing homes can receive assistance in finding a licensed substitute home suitable to their needs. In addition, service to support the social, emotional, and physical well-being of the individual are offered. Services are available in every county.

*Adult foster care services are provided regardless of income.*

**Foster Care Services for Children**

Foster care is substitute care for children. A plan for substitute care appropriate to a child’s needs is evaluated, arranged, maintained, and supervised. Social workers also recruit and provide training and technical assistance to foster families.

*There are no financial eligibility criteria to obtain these services.*

**Individual and Family Adjustment Services**

Counseling is offered to individuals to enable them to recognize, understand, and cope with problems and conflicts and to achieve adequate levels of functioning. Needed services are also arranged for individuals and families who are unable to fully and appropriately utilize community services. Specifically targeted populations are those with alcoholism, drug addiction, mental retardation, emotional disturbance, and school-related problems. In some counties, day or residential camp experience is provided for children. Therapeutic camp may be available for developmentally disabled or handicapped individuals.

*There are no financial criteria for these services.*

**In-Home Aide Services**

These services are a combination of what were formally called Chore Services and Homemaker Services. Individuals and their families are assisted with home management, personal care, and supervision so that they can function effectively at home for as long as possible. The service may also be used to provide a respite for a primary caregiver.
In-Home Aide Services are available without regard to family income. Voluntary contributions are accepted.

Protective Services for Adults

Protective services are those services necessary to protect disabled adults from abuse, neglect, or exploitation. The Department of Social Services is responsible for investigating all reports that an adult is in need of protective services. If the report is confirmed, DSS must immediately provide or arrange for needed essential services. These include medical care for physical and mental health needs; assistance in personal hygiene, food, clothing, and adequately heated and ventilated shelter; protections from health and safety hazards; protection from physical mistreatment; protection from exploitation. Procedures are in place to allow DSS to initiate court action to assure the provision of services to persons who lack the capacity to consent and in emergency situations.

There are no financial eligibility criteria to obtain these services.

Protective Services for Children

Protective services are those services necessary to protect children from abuse, neglect, or dependency. The Department of Social Services is responsible for receiving and investing all reports that allege that a child may be abused, neglected, or dependent. If the report is substantiated, DSS must provide services to the child and his/her family to ensure that the child is protected. Service activities may include use of the court when necessary; counseling and planning with the child’s family toward solution and prevention of the problems causing neglect, abuse, or dependency; arranging for the provision of, and assisting families in utilizing appropriate services and community resources such as foster care, day care, health and mental health care services, in-home aide services, etc. as needed. Protective services for children are available in all counties.

These services are provided without regard to income.

Transportation

Transportation may be provided as part of a service plan for an individual who is not otherwise able to have access to medical and health resources, shopping facilities, education, employment and training opportunities, or other community resources.
Other Child Welfare Services

Additional social work intervention to protect and promote the welfare of children is generally available. Gathering information, assessing children’s needs, assisting families in understanding their children’s needs, and providing referral information to other resources are among the activities performed by DSS staff.

*No financial criteria apply to these services.*

Program Eligibility

As noted above, some services are available only on the basis of income. Other services are available regardless of income.

Sources and Related Resources

The address and phone numbers of all the county Departments of Social Services are located in Appendix D.
Workforce Investment Act (WIA)

Program Specifics

Quick Lookup

What is it?

Job Placement Assistance and Job Training Services individually tailored to help adults and Dislocated Workers get a job.

Who is it for?

Adults (ages 21-) and dislocated workers

Where are Applications Taken?

JobLink Career Centers and other Workforce Investment Act Training Provider’s offices.

Introduction

The Workforce Investment Act provides a three-tiered process with each tier designed to help individuals get a job. These tiers are defined as:

- Core services
- Intensive services
- Training services.

Applications

Adults and dislocated workers should visit their nearest JobLink Career Center to get started.

Program Benefits

Employment and Training Services

The Workforce Investment Act outlines a three-tiered process with each tier designed to help you get a job. These tiers are defined as:

- Core services
- Intensive services
- Training services.

Core Services
Core services that are available to adults who are dislocated workers through the JobLink Career Centers include at a minimum:

- Determinations of whether you are eligible to receive assistance under this law
- Outreach, intake (which may include worker profiling), and orientation to the information and other services available through the JobLink Career Centers
- Initial assessment of your skill levels, aptitudes, abilities, and supportive service needs
- Job search and placement assistance, and where appropriate, career counseling
- Provision of employment statistics information, including the provision of accurate information relating to local, regional, and national labor market areas, including:
  - Job vacancy listings in such labor market areas
  - Information on job skills necessary to obtain the jobs described previously
  - Information relating to local occupations in demand and the earnings and skill requirements for such occupations
- Provision of performance information and program cost information on eligible providers of training services
- Provision of information regarding how the local area is performing on local performance measures
- Provision of accurate information relating to the availability of supportive services, including child care and transportation, available in the local area, and referral to such services, as appropriate
- Provision of information regarding filing claims for unemployment compensation
- Assistance in establishing eligibility for:
  - Welfare-to-Work activities authorized under section 403(a)(5) of the Social Security Act (as added by section 5001 of the Balanced Budget Act of 1997) available in the local area
  - Programs of financial aid for training and education programs that are not funded under WIA and are available in the local area
- Follow-up services in workforce investment activities may be provided to participants who are placed in unsubsidized employment, for not less than 12 months after the first day of the employment, as appropriate.

**Intensive Services**
JobLink Career Centers also make intensive services available as needed to adults and dislocated workers who are:

- Unemployed and are unable to obtain employment through core services
- Determined to be in need of more intensive services in order to obtain employment
- Employed but are determined to be in need of intensive services in order to obtain or retain employment that allows for self-sufficiency.

Intensive services are intended to identify obstacles to employment through a comprehensive assessment or individual employment plan in order to determine specific services needed to obtain employment.

**Intensive services** may include the following:

- Comprehensive and specialized assessments of the skill levels and service needs of adults and dislocated workers, which may include:
  - Diagnostic testing and use of other assessment tools; and
  - In-depth interviewing and evaluation to identify employment barriers and appropriate employment goals.
- Development of an individual employment plan, to identify the employment goals, appropriate achievement objectives, and appropriate combination of services for the participant to achieve the employment goals
- Group counseling
- Individual counseling and career planning
- Case management for participants seeking training services
- Short-term prevocational services, including development of learning skills, communication skills, interviewing skills, punctuality, personal maintenance skills, and professional conduct, to prepare individuals for unsubsidized employment or training.

Additional examples of intensive services include:

- Out-of-area job search expenses
- Relocation expenses
- Internships
- Paid or unpaid work experience.

**Training Services**

Training services may be made available to employed and unemployed adults and dislocated workers who meet the following conditions:
• Have met the eligibility requirements for intensive services, have received at least one intensive service and have been determined to be unable to obtain or retain employment through such services
• Following an interview, evaluation or assessment, and case management, have been determined by a JobLink Career Center operator or JobLink Career Center partner to be in need of training services and to have the skills and qualifications to successfully complete the selected training program
• Select a program of training services that is directly linked to the employment opportunities either in the local area or in another area to which the individual is willing to relocate
• Are unable to obtain grant assistance from other sources to pay the costs of such training, including Federal Pell Grants
• For individuals whose services are provided through the adult funding stream, are determined eligible in accordance with the State and local priority system.

Training services may include:

• Occupational skills training
• On-the-job training
• Programs that provide workplace training with related instruction, which may include cooperative education programs
• Private sector training programs
• Skill upgrading and retraining
• Entrepreneurial training
• Job readiness training
• Adult education and literacy training in conjunction with other training services
• Customized training.

**Program Eligibility**

**Personal Eligibility**

To receive employment and training services under the Workforce Investment Act, one must meet certain eligibility requirements.

Adults must be:

• At least 18 years of age or older
• A U.S. citizen or eligible non-citizen
A male must be in compliance with the registration provisions of the Military Selective Service Act.

A variety of employment and training services may be available based on individual needs:

- Job search and placement assistance
- Career counseling
- Labor market information
- Assessment of skills and needs
- Development of individual employment plans
- Occupational skills training
- On-the-job training
- Skills upgrading
- Entrepreneurial training
- Job readiness training
- Support services, including transportation.

Based on an individual assessment, more intensive services may be developed under the guidance of an employment counselor.

**Dislocated Worker Eligibility Criteria**

To be eligible for dislocated worker programs, an individual must meet at least one of the following criteria in addition to the adult eligibility criteria above:

1. An individual who has been terminated or laid off, or has received notice of termination or layoff from employment, and is eligible for or has exhausted entitlement to unemployment compensation, and is unlikely to return to a previous industry or occupation;

2. An individual who has been terminated or laid off, or has received notice of termination or layoff, from employment, and has been employed for a duration sufficient to demonstrate, to the appropriate entity at a one-stop center referred to in section 134(c) of the Workforce Development Act (WIA), attachment to the workforce, but not eligible for unemployment compensation due to insufficient earnings or having performed services for an employer that were not covered under a State unemployment compensation law, and is unlikely to return to a previous industry or occupation;

3. An individual who has been terminated or laid off, or has received a notice of termination or layoff, from employment as a result of any
permanent closure of, or any substantial layoff at, a plant, facility, or enterprise;

4. An individual who is employed at a facility at which the employer has made a general announcement that such facility will close within 180 days;

5. For purposes of eligibility to receive services other than training, intensive, or supportive services, You must be employed at a facility at which the employer has made a general announcement that such facility will close;

6. An individual who has been self-employed (including employment as a farmer, rancher, or fisherman) but is unemployed as a result of general economic conditions in the community in which the individual resides or because of a natural disaster; and

7. An individual who is a dislocated homemaker.

**Financial Eligibility**

Adults - Must meet income requirements, based on family size and income.

Dislocated Workers - Must meet requirements as shown in the preceding section.

**Program Appeals**

Appeals processes vary by each Local Area/Workforce Development Board. In all cases, the appeals process must provide for appeals to the Program Operator, Workforce Development Board, Division of Workforce Development, and final resolution by the US Department of Labor.

**Legal Authority**

Federal Statute: 20 U.S.C §9201 et seq.

**Sources and Related Resources**
Whole Body Donations

PROGRAM SPECIFICS

Quick Lookup

What is it?

A service designed to allow individuals another means of dealing with costly death procedures like burial.

*Advocate Tip:* For individuals with no insurance, this may be an avenue to explore. Some institutions will pay for the body to be transported to them and some will return the cremated remains to the family at no cost.

Who is it for?

Any person (some programs require the person to be 18 years of age) wishing to donate their body for science.

*Advocate Tip:* Although a person plans to donate their body and has completed the registration paperwork in advance (the preferred method) the medical school or institution cannot guarantee that they will accept the body at the time of death (or donation).

Individuals who have registered with a school or program in advance are strongly encouraged to have alternate plans in the event the body is not accepted by the school or institution at the time of death (or donation).

Where are Applications Taken?

At the medical school or institution.

Introduction

Human bodies are often accepted at medical schools, teaching colleges and other institutions for anatomical study, teaching surgery or other specialty fields; to support medical research and education.
Program Benefits

Policies and procedures regarding donations, transportation of the body, disposition of the remains, and any associated costs differ by school/institution. Persons interested in donating their bodies to science are highly encouraged to register in advance with the institution of their choice. Although a person has pre-registered, they can withdraw their registration at anytime.

Advocate Tip: Although pre-registration is encouraged (and required by some institutions), there are other institutions that will accept donations without prior registration. Contact should be made with the institution as soon as possible after death. The school or institution will only make a decision at the time of donation.

Program Eligibility

Any person wishing to donate their body to science can do so; however each school or institution has different policies and procedures that affect donation. The school or institution has the legal authority to accept or decline the body for any reason and a determination will be made at the time of death (or donation whichever we prefer).

It is important that the school or institution be contacted as soon as possible after the individual’s death because they must ask questions about the cause of death and the condition of the body. Each institution has different criteria for acceptance, but some reasons donations are sometimes declined include: autopsied body, removal of organs and tissues (except for eyes), embalming, death from a contagious or communicable disease, obesity, extreme emaciation, or a badly damaged body as a result of an accident, suicide, homicide, or invasive surgery.

Some programs require advance registration, while others do not. If pre-registration is not completed, a surviving next of kin will have to authorize the donation. If there is no family member or next of kin, other arrangements can sometimes be made. Again, it all depends on the school’s or institution’s policies.

Program Appeals

Decisions made by the institutions may be appealable through the institution itself, for specific details on the appeals process contact the institution.
Sources and Related Resources

For potential uses of donated bodies, contact the specific institution for information

Note: The following schools and institutions are listed for informational purposes only. Their listing does not imply an endorsement.

Four medical schools that accept donations in North Carolina are listed below:

**Department of Anatomy and Cell Biology**
The Brody School of Medicine
At East Carolina University
Greenville, NC  27834
Telephone:  252-744-2843
http://www.ecu.edu/anatomy/donations.cfm

**The Duke Anatomical Gifts Program**
Department of Medical Education
Box 3952
Duke University Medical Center
Durham, NC  27710
Telephone:  919-681-5471
http://medschool.duke.edu/modules/som_anat_gft_pgm/index.php?id=1

**UNC-CH School of Medicine**
Body Donation Program
323 MacNider Hall, Campus Box 7520
333 South Columbia Street
Chapel Hill, NC 27599-7520
Telephone:  919-966-1134
http://www.med.unc.edu/mstl/body-donation

**Department of Neurobiology and Anatomy**
Wake Forest University School of Medicine
Winston-Salem, NC 27157-1010
Telephone: (336) 716-4368

Colleges in NC that Accept Whole Body Donations for Funeral Service Study:
Institutions that Accept Whole Body Donations for Research:

Anatomy Gifts Registry
500 McCormick Drive, Suite E
Glen Burnie, MD 21061
Toll Free: 1-800-300-LIFE (5433) (24 hours)
Fax: 410-863-0497
Email: info@anatomicgift.com
Website: http://www.anatomicgift.com/index.cfm?page=about

Living Bank
Physical Address: 4545 Post Oak Place Drive, #215
Houston, TX 77027
Mailing Address: PO Box 6725
Houston, TX 77265-6725
Toll Free: 1-800-528-2971 or 1-866-670-1799 (24 hours)
FAX: 713-961-0979
Email: info@livingbank.org
Website: www.livingbank.org

MedCure
12013 NE Marx Street
Portland, OR 97220
Toll Free: 1-866-560-2525
FAX: 503-257-9101
Email: Info@medcure.org
Website: http://www.medcure.org/