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Benefit Recovery/Benefit Investigation

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3610.0000 Food Stamps

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

In this chapter:

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

3610.0100 BENEFIT RECOVERY/BENEFIT INVESTIGATIONS BACKGROUND (FS)

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

This system is comprised of:

1. the Benefit Investigations Program (BI);
2. the Benefit Recovery (BR) Program; and
3. the Division of Public Assistance Fraud (DPAF).

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

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

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

3610.0101 Legal Basis (FS)

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

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

According to Section 409.325/414.41[1996], Florida Statutes, "Any person who knowingly fails by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose a material fact used in making a determination as to such person's qualification to receive aid or

benefits under any state or federally funded assistance program, or fails to disclose a change in circumstances in order to obtain or continue to receive under such program aid or benefits to which he is not entitled, or who knowingly aids and abets another person in the commission of any such act is guilty of a crime and will be punished as provided in Subsection (5)." This subsection provides that assistance wrongfully sought or received which is valued at less than $200 in a 12-month period will be punishable as a misdemeanor of the first degree. Assistance of $200 or more in a 12-month period will be punishable as a third-degree felony.

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

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

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

3610.0200 STATUTES OF LIMITATION FOR ESTABLISHING CLAIMS (FS)

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

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

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

3610.0300 DEFINITIONS AND TYPES OF OVERPAYMENTS (FS)

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

An overpayment may be the result of:

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

3610.0301 Agency Error Definition (FS)

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

Agency error overpayment can occur as a result of:

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

3610.0302 Agency Errors Not Requiring a Referral (FS)

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

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

3610.0303 Other Instances Not Requiring a Referral (FS)

In addition to the reasons listed in passage 3610.0302 for agency errors not requiring a referral, a claim will not be established for the sole reason that the assistance group or individual failed to report a change that it was not required to report.

3610.0304 Inadvertent Assistance Group Error Definition (FS)

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

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

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

3610.0306 Inadvertent or Agency Errors Not Requiring Referral (FS)

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

3610.0307 Suspected Fraud and Intentional Program Violation Definition (FS)

Fraud exists if:

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

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

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

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

3610.0308 Suspected Fraud Definition (FS)

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

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

3610.0309 Evidence Used to Substantiate Fraud (FS)

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

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

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

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

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

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

3610.0310 Court Determination of Fraud (FS)

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

3610.0311 Hearings Determination of Fraud (FS)

Fraud, or attempted fraud, is also determined by an administrative hearing official. This determination must be stated in the final order of the hearings official, which may either report the

evidence presented in the hearing, the findings and conclusions of the Hearing Officer, or include a waiver signed by the individual charged with intent to commit fraud.

3610.0312 Waiver of an Administrative Disqualification Hearing (FS)

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

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

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

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

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

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

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

3610.0400 OVERPAYMENT AMOUNT (FS)

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

3610.0401 Overpayment (FS)

The beginning date of overpayment is determined as follows:

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

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

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

month of change. The exception would be when the change falls on the 1st day of the month in a 31-day month.

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

3610.0402 Benefit Recovery Overpayment Calculation (FS)

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

3610.0403 Disregards Allowed by Benefit Recovery (FS)

Assistance groups will be allowed the earned income disregards and standard disregards in effect during the overpayment month. The food stamp earned income disregard is not allowed in any household error budgets completed after October 1, 1996. The disregards are also not allowed in suspected fraud budgets.

Dependent care and medical expense disregards may be included in calculating the budget. Verification for these must be recorded in the case file.
Shelter costs disregards and excess shelter disregards will also be considered in the calculation of excess benefits received.

Any deductible expenses which, were previously verified and correctly included in the calculation of benefits will be included in the overpayment budget.

If the assistance group provides adequate verification of deductible expenses which were not included in the calculation of benefits at the time of overpayment, the expenses will be considered in the overpayment calculations.

3610.0500 DEPARTMENT STAFF OVERPAYMENT RESPONSIBILITIES (FS)

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

3610.0501 Eligibility Specialist Responsibilities (FS)

The eligibility specialist must establish that overpayment has occurred by obtaining and recording the following facts in running record comments prior to initiating a referral to BR on the FLORIDA BVBR screen:

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

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

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

The eligibility specialist must:

1. adjust the current benefit if appropriate;
2. complete a referral via the FLORIDA AIFP to the Benefit Investigations for cases in which an error/fraud prone profile match occurs at the application/reapplication; certification/recertification process;
3. complete the Benefit Recovery Referral (BVBR) if an overpayment is determined; and
4. respond to BR requests for any additional information within 10 calendar days.

3610.0503 Benefit Recovery Responsibilities (FS)

BR is responsible for the establishment of all overpayment claims and the maintenance of all recoupment and recovery activities.

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

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

3610.0504 Benefit Investigations Responsibilities (FS)

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

3610.0505 Division of Public Assistance Fraud Responsibilities (FS)

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

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

3610.0600 PERSONS RESPONSIBLE FOR REPAYMENT (FS)

All members who were adult members (18 years of age or older) of the assistance group at the time the overpayment occurred will be jointly and individually liable for the value of any overpayment of benefits.

BR may pursue recovery action against any assistance group which contains a member who was an adult member of the original assistance group at the time the overpayment occurred. This can include retention of restored benefits owed to the assistance group as an offset against the overpayment claim.

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

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

3610.0700 REPAYMENT (FS)

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

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

BR must notify the overpaid assistance group of the amount and cause of overpayment as well as the various repayment methods available.

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

Passages 3610.0701 through 3610.0710 describe methods of repayment.

3610.0701 Benefit Reduction/Recoupment (FS)

Benefit reduction is used to recover overpayment from active recipients.

When a current recipient's court ordered amount is greater than the amount of benefit reduction, the excess must be paid by direct reimbursement.

3610.0702.01 Benefit Reduction (FS)

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

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

3610.0702.03 Amount to be Recovered (FS)

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

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

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

3610.0703 Offset of Claim (FS)

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

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

Exception: Retroactive benefits are not offset against outstanding claims.

3610.0704 Community Service Credit Hours (FS)

Individuals who have been court ordered to complete community service hours as part of their restitution may have the amount of their overpayment "compromised" (reduced) by the dollar value of the service they perform. Each hour is assumed to be worth minimum wage unless specified otherwise by the court. Documentation that all hours ordered have been completed must be received by the State Attorney's office prior to adjusting the overpayment amount.

3610.0707 Civil Action (FS)

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

3610.0710 Hearing Requested (FS)

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

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

3610.0711 Compromising Claims (FS)

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

1. The death or prognosis of death of any liable individual within three years of being notified;

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

Verification of the above criteria is required.

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

3610.0800 TRANSMITTAL OF REPAYMENT (FS)

All repayments must be directed through BR.

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

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

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

3610.0900 DISQUALIFICATION DUE TO COURT/HEARING DECISION (FS)

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

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

If the court makes an adjudication of guilt but fails to impose a disqualification period, or if adjudication of guilt is withheld or the individual enters the pre-trial intervention or diversion program and signs a disqualification consent agreement, the Benefit Recovery unit will impose disqualification penalties in accordance with the policy presented in passage 3610.0902.

Individuals found to have committed fraud by a hearings official through the administrative disqualification hearing process or who sign a waiver of administrative disqualification hearing will be disqualified in accordance with the policy presented in passage 3610.0902.

3610.0901 Disqualification Notice (FS)

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

3610.0902 Disqualification Periods and Implementation (FS)

The disqualification period for an eligible assistance group member will begin with the first month following the date the agency receives written notification of the hearing's decision, the date of the signed Waiver of Administrative Disqualification Hearing or within 45 calendar days from the date of receipt of a state attorney/court disposition. There is no requirement for notification through certified mail. The Department is not required to give the assistance group notice of adverse action prior to imposing the disqualification.

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

FS disqualification periods:

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

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

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

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

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

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

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

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

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

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

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

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

3610.0903 Determining Benefits During Disqualification (FS)

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

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

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

3610.0904 Administrative Disqualification Hearings (FS)

The OSIH will send a written advance notice of administrative disqualification hearing by regular mail to the assistance group member suspected of fraud at least 30 calendar days in advance of the scheduled hearing date. A waiver of administrative disqualification hearing form will be provided with the notice.

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

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

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

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

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

In addition to updating the disqualification hearings update screen on FLORIDA, OSIH will send a copy of the hearing decision to the dedicated BR workgroup in Document Imaging. Each Final Order will be sent to the Collections Unit, who will initiate disqualification action. BR will initiate disqualification upon receipt of notification that the disqualification hearings update screen has been completed by OSIH to show a hearings decision.

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

3610.1000 BENEFIT INVESTIGATIONS (FS)

Benefit Investigations (BI) is an extension of the Department's public assistance eligibility process and operates within the purview of 7 CFR 273, 45 CFR 233, and Sections 414.095(16) and 414.39(10), Florida Statutes. It is a program designed to combat fraud and reduce misspent

dollars in the Department's public assistance programs. Probable error prone cases are identified at the pre-eligibility (application/reapplication, certification/recertification) phase of the public assistance program. Once a case is identified as meeting error prone criteria, it is referred to the BI. BI reviews the information provided by the individual or the authorized representative and verifies and documents the finding of fact as it relates to the information provided by the individual and the eligibility factors used to determine the individual's level of participation. Once verification and documentation are completed, the recipient is given an opportunity to explain contradictory information and an eligibility determination is made.

3620.0000 Temporary Cash Assistance

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

In this chapter:

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

3620.0100 BENEFIT RECOVERY/BENEFIT INVESTIGATIONS BACKGROUND (TCA)

Background information is provided in passage 3610.0100.

3620.0101 Legal Basis (TCA)

The legal basis is provided in passage 3610.0101.

3620.0200 STATUTES OF LIMITATION FOR ESTABLISHING CLAIMS (TCA)

For agency error cases, a claim is limited to 12-months prior to the month the overpayment was initially discovered by, or reported to, an eligibility specialist.

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

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

3620.0203 Statutes of Limitation for Prosecution (TCA)

Possible fraud overpayment is restricted because of the time limitations for criminal prosecution of fraud. A fraud case must be prosecuted no later than two years (misdemeanor) or three years (felony) from the date the fraud occurred. Therefore, the State Attorney will not consider prosecuting any case in which at least part of the fraud period did not occur less than two (or three) years prior to filing with the State Attorney.

3620.0300 DEFINITIONS AND TYPES OF OVERPAYMENT (TCA)

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

An overpayment may be the result of:

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

3620.0301 Agency Error Definition (TCA)

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

Agency error overpayment can occur as a result of:

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

3620.0302 Agency Errors Not Requiring a Referral (TCA)

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

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

3620.0304 Inadvertent Assistance Group Error Definition (TCA)

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

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

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

3620.0306 Inadvertent or Agency Errors Not Requiring Referral (TCA)

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

3620.0307 Suspected Fraud and Intentional Program Violation Definition (TCA)

Fraud exists if:

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

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

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

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

3620.0309 Evidence Used to Substantiate Fraud (TCA)

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

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

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

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

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

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

3620.0310 Court Determination of Fraud (TCA)

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

3620.0400 OVERPAYMENT AMOUNT (TCA)

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

3620.0404 Overpayment (TCA)

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

3620.0405 Reportable Overpayment (TCA)

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

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

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

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

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

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

3620.0406.03 Overpayment - Household Composition Changes (TCA)

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

3620.0407 Change in Income Results in Benefit Reduction (TCA)

Prior to 10/01/96, when a change in income occurs that results in a reduction of the benefits but does not cause ineligibility, reportable overpayment begins the month following the month the income was received.

From 10/1/96 forward, overpayment begins after applying the 10-10-10 rule.

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

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

3620.0500 DEPARTMENT STAFF OVERPAYMENT RESPONSIBILITIES (TCA)

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

3620.0501 Eligibility Specialist Responsibilities (TCA)

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

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

The eligibility specialist must take necessary action to ensure that correct payment will be made for the current situation or that cancellation of benefits is effective in accordance with policy prior to referral to BR. This step includes doing a partial eligibility review on the fraudulent factors

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

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

The eligibility specialist must:

1. adjust the current benefit if appropriate;
2. complete a referral via the FLORIDA AIFP to the Benefit Investigations for cases in which an error/fraud prone profile match occurs at the application/reapplication, certification/recertification process;
3. complete the BR Referral (BVBR) screen if an overpayment is determined;
4. respond to BR requests for any additional information within 10 calendar days.

3620.0503 Benefit Recovery Responsibilities (TCA)

BR is responsible for the establishment of all overpayment claims and the maintenance of all recoupment and recovery activities.

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

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

3620.0504 Benefit Investigations Responsibilities (TCA)

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

3620.0505 Division of Public Assistance Fraud Responsibilities (TCA)

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

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

3620.0600 PERSONS RESPONSIBLE FOR REPAYMENT (TCA)

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

1. any adult member included in the AG at the time the overpayment occurred;

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

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

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

3620.0700 REPAYMENT (TCA)

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

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

BR must notify the overpaid assistance group of the amount and cause of overpayment as well as the various repayment methods available.

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

Passages 3620.0701 through 3620.0710 describe methods of repayment.

3620.0701 Benefit Reduction/Recoupment (TCA)

Benefit reduction is used to recover overpayment from active recipients.

When a current recipient's court ordered amount is greater than the amount of benefit reduction, the excess must be paid by direct reimbursement.

3620.0702 Benefit Reduction (TCA)

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

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

3620.0703 Offset of Claim (TCA)

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

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

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

3620.0705 Child Support Credit (TCA)

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

3620.0706 Amount to be Recovered Monthly (TCA)

Active individuals will be required to repay the overpayment at the rate of five percent of the payment standard for the size of the current assistance group. The monthly amount of repayment will be recalculated by the FLORIDA system when the size of the assistance group changes or when a change in shelter obligation results in a change in the payment standard.

3620.0707 Civil Action (TCA)

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

3620.0710 Hearing Requested (TCA)

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

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

3620.0800 TRANSMITTAL OF REPAYMENT (TCA)

All repayments must be directed through BR.

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

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

3620.0900 DISQUALIFICATION DUE TO COURT/HEARING DECISION (TCA)

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

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

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

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

3620.0901 Disqualification Notice (TCA)

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

3620.0902 Disqualification Periods and Implementation (TCA)

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

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

TCA disqualification periods:

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

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

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

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

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

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

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

3620.0903 Determining Benefits During Disqualification (TCA)

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

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

3620.0904 Administrative Disqualification Hearings (TCA)

The OSIH will send a written advance notice of administrative disqualification hearing by regular mail to the assistance group member suspected of fraud at least 30 calendar days in advance of the scheduled hearing date. A waiver of administrative disqualification hearing form will be provided with the notice.

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

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

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

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

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

In addition to updating the disqualification hearings update screen on FLORIDA, OSIH will send a copy of the hearing decision to the dedicated BR workgroup in Document Imaging. Each Final Order will be sent to the Collections Unit, who will initiate disqualification action. BR will initiate disqualification upon receipt of notification that the disqualification hearings update screen has been completed by OSIH to show a hearings decision.

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

3620.0905 Waiver of an Administrative Disqualification Hearing (TCA)

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

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

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

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

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

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

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

3620.1000 BENEFIT INVESTIGATIONS (TCA)

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

3630.0000 Family-Related Medicaid

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

In this chapter:

1. "fraud" encompasses intentional program violation,
2. "suspected fraud" refers to client errors pending determination as the result of a court decision, and
3. "Benefit Investigations" refers to the Department's pre-eligibility fraud screening and investigation program.

3630.0100 BENEFIT RECOVERY/BENEFIT INVESTIGATIONS BACKGROUND (MFAM)

Background information is provided in passage 3610.0100.

3630.0101 Legal Basis (MFAM)

The legal basis is provided in passage 3610.0101.

3630.0200 STATUTES OF LIMITATION FOR ESTABLISHING CLAIMS (MFAM)

For non-fraud (agency or client) error cases, a claim will not be established in the Medicaid Program.

3630.0203 Statutes of Limitation for Prosecution (MFAM)

Possible fraud overpayment is restricted because of the time limitations for criminal prosecution of fraud. A fraud case must be prosecuted no later than two years (misdemeanor) or three years (felony) from the date the fraud occurred. Therefore, the State Attorney will not consider prosecuting any case in which at least part of the fraud period did not occur less than two (or three) years prior to filing with the State Attorney.

3630.0300 DEFINITION AND TYPE OF OVERPAYMENT (MFAM)

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

An overpayment may be the result of:

1. Fraud or intentional program violation

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

3630.0307 Suspected Fraud and Intentional Program Violation Definition (MFAM)

Fraud exists if:

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

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

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

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

3630.0309 Evidence Used to Substantiate Fraud (MFAM)

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

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

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

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

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

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

3630.0310 Court Determination of Fraud (MFAM)

A court of appropriate jurisdiction must determine fraud. The determination must be an adjudication of guilt.

3630.0400 OVERPAYMENT AMOUNT (MFAM)

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

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

If ineligibility is due to income, overpayment occurs for any month in which the assistance group is ineligible; including the first month income is received. If ineligibility is due to a reason other

than income, it occurs for any month that the individual or assistance group was ineligible during the entire month. The assistance group must be ex parted into any other coverage group the assistance group may be eligible for. If still not eligible, the case is referred to BR.

3630.0410.01 Determination of Medicaid Overpayment (MFAM)

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

1. When an individual is found to have been ineligible for 1931 Medicaid, BR will assess the case to determine whether or not the individual might have been eligible for another Medicaid coverage group if all case situations had been reported appropriately.
2. If the individual would have been eligible for Medicaid under another coverage group, no Medicaid overpayment exists unless the individual or assistance group would have had to meet a share of cost for Medically Needy.
3. If the individual were ineligible for any of the Medicaid coverage groups, Medicaid overpayment would exist if funds were expended. The individual would be ineligible for any Medicaid benefits received during those months of ineligibility.
4. Medicaid Only budgets are computed using income, assets, and circumstances in months it was actually received or occurred.

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

3630.0410.02 Ineligibility Due to Income (MFAM)

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

3630.0410.03 Reasons Other than Income (MFAM)

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

3630.0411 Understated Share of Cost (MFAM)

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

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

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

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

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

3630.0414 Provider Error (MFAM)

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

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

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

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

3630.0500 DEPARTMENT STAFF OVERPAYMENT RESPONSIBILITIES (MFAM)

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

3630.0501 Eligibility Specialist Responsibilities (MFAM)

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

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

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

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

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

The eligibility specialist must:

1. adjust the current benefit if appropriate,
2. complete a referral via the FLORIDA AIFP to the Benefit Investigations for cases in which an error/fraud prone profile match occurs at the application/reapplication process;
3. complete the Benefit Recovery Referral (BVBR) screen; and
4. respond to the BR unit requests for any additional information within 10 calendar days.

3630.0503 Benefit Recovery Responsibilities (MFAM)

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

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

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

3630.0504 Benefit Investigations Responsibilities (MFAM)

The Department will conduct pre-eligibility fraud screening and investigation of suspected fraud cases at the application/reapplication process and prior to benefit approval. Cases in which individuals have received benefits due to suspected fraud will be referred directly to DPAF staff by completion of the FLORIDA BVBR screen.

3630.0505 Division of Public Assistance Fraud Responsibilities (MFAM)

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

DPAF has the responsibility for investigating and referring cases of suspected fraud for prosecution to the State Attorney and for referring cases.

3630.0600 PERSONS RESPONSIBLE FOR REPAYMENT (MFAM)

All persons who were adult members of the assistance group at the time the overpayment occurred will be jointly and individually liable for the value of any overpayment of benefits.

Persons who applied for and/or received on behalf of an overpaid assistance group may be held responsible for repayment of those benefits.

3630.0700 REPAYMENT (MFAM)

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

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

BR must notify the overpaid assistance group of the amount and cause of overpayment as well as the various repayment methods available.

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

Passages 3630.0706 through 3630.0710 describe methods of repayment.

3630.0706 Amount to be Recovered Monthly (MFAM)

Individuals will be required to repay the overpayment.

3630.0707 Civil Action (MFAM)

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

3630.0708 Medicaid Recovery (MFAM)

Collection of Medicaid overpayment must be attempted in all cases by contacting the overpaid individual using the Notice of Overpayment/Intent to Recover notice. Benefit reduction cannot be used to recover Medicaid overpayment.

3630.0709 Amount to be Recovered (MFAM)

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

3630.0710 Hearing Requested (MFAM)

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

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

3630.0800 TRANSMITTAL OF REPAYMENT (MFAM)

All repayments must be directed through BR.

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

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

3630.1000 BENEFIT INVESTIGATIONS (MFAM)

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

3640.0000 SSI-Related Medicaid, State Funded Programs

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

In this chapter:

1. "fraud" encompasses intentional program violation,
2. "suspected fraud" refers to client errors pending determination as the result of an court decision,
3. "overpayment" will mean both overpayment and overissuance, and
4. "Benefit Investigations" refers to the Department's pre-eligibility fraud screening and investigation program.

3640.0100 BENEFIT RECOVERY/BENEFIT INVESTIGATIONS BACKGROUND (MSSI, SFP)

Background information is provided in passage 3610.0100.

3640.0101 Legal Basis (MSSI, SFP)

The legal basis is provided in passage 3610.0101.

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

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

3640.0300 DEFINITION AND TYPE OF OVERPAYMENT (MSSI, SFP)

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

An overpayment may be the result of:

1. Fraud or intentional program violation

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

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

Fraud exists if:

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

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

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

1. misrepresenting information,

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

3640.0309 Evidence Used to Substantiate Fraud (MSSI, SFP)

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

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

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

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

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

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

3640.0310 Court Determination of Fraud (MSSI, SFP)

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

3640.0400 OVERPAYMENT AMOUNT (MSSI, SFP)

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

3640.0411 Understated Share of Cost (MSSI)

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

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

1. an undetected mathematical error occurs,
2. the individual fails to report an increase in income,

3. the individual misrepresents his situation, or
4. the Department fails to timely act on a report change.

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

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

3640.0412 Overpayment (MSSI, SFP)

The amount of the overpayment for a given month is the difference between the amount of benefits received and the amount of benefits the individual was actually eligible to receive.

If an individual is ineligible, the total amount of benefits paid, including all Medicaid benefits, is considered an overpayment.

3640.0413 Determination of Overpayment (MSSI, SFP)

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

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

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

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

3640.0414 Provider Error (MSSI)

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

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

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

3640.0500 DEPARTMENT STAFF OVERPAYMENT RESPONSIBILITIES (MSSI, SFP)

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

3640.0501 Eligibility Specialist Responsibilities (MSSI, SFP)

The eligibility specialist must establish that overpayment has occurred by obtaining and recording the following facts in running record comments prior to initiating a referral to BR on the BVBR screen:

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

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

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

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

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

The eligibility specialist must:

1. adjust the current benefit if appropriate,
2. complete a referral to Benefit Investigations via the FLORIDA AIFP for cases in which an error/fraud prone profile match occurs at the application/reapplication process;
3. complete the Benefit Recovery Referral (BVBR) screen; and
4. respond to the BR unit requests for any additional information within 10 calendar days.

3640.0503 Benefit Recovery Responsibilities (MSSI, SFP)

BR is responsible for the establishment of all overpayment claims and the maintenance of all recoupment and recovery activities.

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

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

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

3640.0504 Benefit Investigations Responsibilities (MSSI, SFP)

The Department will conduct pre-eligibility fraud screening and investigation of suspected fraud cases at the application/reapplication, certification/recertification process and prior to benefit approval. Cases in which individuals have received benefits due to suspected fraud will be referred directly to DPAF by completion of the BVBR screen.

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

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

DPAF has the responsibility for investigating and referring cases of suspected fraud for prosecution to the State Attorney.

3640.0600 PERSONS RESPONSIBLE FOR REPAYMENT (MSSI, SFP)

All persons who were adult members of the assistance group at the time the overpayment occurred will be jointly and individually liable for the value of any overpayment of benefits.

Persons who applied for and/or received on behalf of an overpaid assistance group may be held responsible for repayment of those benefits.

3640.0700 REPAYMENT (MSSI, SFP)

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

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

BR must notify the overpaid assistance group of the amount and cause of overpayment as well as the various repayment methods available.

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

Passages 3640.0708 through 3640.0710 describe methods of repayment.

3640.0708 Medicaid Recovery (MSSI)

Collection of Medicaid overpayment must be attempted in all cases, by contacting the overpaid individual using the Notice of Overpayment/Intent to Recover notice.

3640.0709 Amount to be Recovered (MSSI)

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

3640.0710 Hearing Requested (MSSI, SFP)

When an individual requests a fair hearing regarding an overpayment, the request for hearing screen (CLFH) must be completed by the BR Hearing Specialist team within three working days of the date the request was received. When the request is in writing, a copy must be sent to the

OSIH along with a copy of the "statement of matters" form (i.e., a Notice of Decision, Intent to Recover, etc.).

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

3640.0800 TRANSMITTAL OF REPAYMENT (SFP)

For OSS cases, payments must be forwarded to the contracted vendor. Repayment should be made by check or money order.

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

3640.1000 BENEFIT INVESTIGATIONS (MSSI, SFP)

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

3650.0000 Child In Care

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

In this chapter:

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

3650.0100 BENEFIT RECOVERY/BENEFIT INVESTIGATIONS BACKGROUND (CIC)

Background information is provided in passage 3610.0100.

3650.0101 Legal Basis (CIC)

The legal basis is provided in passage 3610.0101.

3650.0300 DEFINITIONS AND TYPES OF OVERPAYMENT (CIC)

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

An overpayment may be the result of:

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

3650.0301 Agency Error Definition (CIC)

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

Agency error overpayment can occur as a result of:

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

3650.0302 Agency Errors Not Requiring a Referral (CIC)

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

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

3650.0304 Inadvertent Assistance Group Error Definition (CIC)

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

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

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

3650.0306 Inadvertent or Agency Errors Not Requiring Referral (CIC)

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

3650.0309 Evidence Used to Substantiate Fraud (CIC)

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

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

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

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

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

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

3650.0310 Court Determination of Fraud (CIC)

Fraud must be determined by a court of appropriate jurisdiction. The determination must be an adjudication of guilt.

3650.0400 OVERPAYMENT AMOUNT (CIC)

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

3650.0414 Provider Error (CIC)

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

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

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

3650.0700 REPAYMENT (CIC)

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

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

BR must notify the overpaid assistance group of the amount and cause of overpayment as well as the various repayment methods available.

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

Passages 3650.0701 through 3650.0710 describe methods of repayment.

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

3650.0710 Hearing Requested (CIC)

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

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

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

3650.1000 BENEFIT INVESTIGATIONS (CIC)

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

3660.0000 Refugee Assistance Program

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

In this chapter:

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

3660.0100 BENEFIT RECOVERY/BENEFIT INVESTIGATIONS BACKGROUND (RAP)

Background information is provided in passage 3610.0100.

3660.0101 Legal Basis (RAP)

The legal basis is provided in passage 3610.0101.

3660.0200 STATUTES OF LIMITATION FOR ESTABLISHING CLAIMS (RAP)

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

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

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

3660.0203 Statutes of Limitation for Prosecution (RAP)

Possible fraud overpayment is restricted because of the time limitations for criminal prosecution of fraud. A fraud case must be prosecuted no later than two years (misdemeanor) or three years (felony) from the date the fraud occurred. Therefore, the State Attorney will not consider prosecuting any case in which at least part of the fraud period did not occur less than two (or three) years prior to filing with the State Attorney.

3660.0300 DEFINITIONS AND TYPES OF OVERPAYMENT (RAP)

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

An overpayment may be the result of:

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

3660.0301 Agency Error Definition (RAP)

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

Agency error overpayment can occur as a result of:

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

3660.0302 Agency Errors Not Requiring a Referral (RAP)

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

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

3660.0304 Inadvertent Assistance Group Error Definition (RAP)

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

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

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

3660.0306 Inadvertent or Agency Errors Not Requiring Referral (RAP)

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

3660.0307 Suspected Fraud and Intentional Program Violation Definition (RAP)

Fraud exists if:

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

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

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

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

3660.0309 Evidence Used to Substantiate Fraud (RAP)

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

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

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

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

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

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

3660.0310 Court Determination of Fraud (RAP)

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

3660.0400 OVERPAYMENT AMOUNT (RAP)

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

3660.0404 Overpayment (RAP)

The amount of RAP or RAP Medicaid overpayment for a given month is the difference between the amount an individual received and the amount the individual should have received.

3660.0405 Reportable Overpayment (RAP)

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

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

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

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

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

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

3660.0406.03 Overpayment - Household Composition Changes (RAP)

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

3660.0407 Change in Income Results in Benefit Reduction (RAP)

Prior to 10/01/96, when a change in income occurs that results in a reduction of the benefits but does not cause ineligibility, reportable overpayment begins the month following the month the income was received.

From 10/1/96 forward, overpayment begins after applying the 10-10-10 rule.

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

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

3660.0500 DEPARTMENT STAFF OVERPAYMENT RESPONSIBILITIES (RAP)

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

3660.0501 Eligibility Specialist Responsibilities (RAP)

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

1. how the overpayment was discovered,
2. the date of discovery,
3. who received the income/asset/status change,
4. the date the income or change started and/or stopped,
5. the cause of overpayment,
6. the estimated length and amount of overpayment,

7. any explanation given for failure to provide information accurately or in a timely manner, and
8. corrective action taken and the date such action(s) was taken.

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

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

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

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

The eligibility specialist must:

1. adjust the current benefit if appropriate,
2. complete a referral via FLORIDA AIFP to BI for cases in which an error/fraud prone profile match occurs at the application/reapplication process;
3. complete the BR Referral (BVBR) screen; and
4. respond to the BR unit requests for any additional information within 10 calendar days.

3660.0503 Benefit Recovery Responsibilities (RAP)

BR is responsible for the establishment of all overpayment claims and the maintenance of all recoupment and recovery activities.

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

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

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

3660.0504 Benefit Investigations Responsibilities (RAP)

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

3660.0505 Division of Public Assistance Fraud Responsibilities (RAP)

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

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

3660.0600 PERSONS RESPONSIBLE FOR REPAYMENT (RAP)

All persons who were adult members of the assistance group at the time the overpayment occurred will be jointly and individually liable for the value of any overpayment of benefits.

Persons who applied for and/or received on behalf of an overpaid assistance group may be held responsible for repayment of those benefits.

3660.0700 REPAYMENT (RAP)

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

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

BR must notify the overpaid assistance group of the amount and cause of overpayment as well as the various repayment methods available.

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

Passages 3660.0701 through 3660.0710 describe methods of repayment.

3660.0701 Benefit Reduction/Recoupment (RAP)

Benefit reduction is used to recover RAP overpayment from active RAP recipients.

When a current recipient's court ordered amount is greater than the amount of benefit reduction, the excess must be paid by direct reimbursement.

3660.0702 Benefit Reduction (RAP)

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

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

3660.0706 Amount to be Recovered Monthly (RAP)

Active individuals will be required to repay the overpayment at the rate of five percent of the payment standard for the size of the current assistance group. The monthly amount of repayment will be recalculated by the FLORIDA system when the size of the assistance group changes or when a change in shelter obligation results in a change in the payment standard.

3660.0707 Civil Action (RAP)

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

3660.0710 Hearing Requested (RAP)

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

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

3660.0800 TRANSMITTAL OF REPAYMENT (RAP)

All repayments must be directed through BR.

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

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

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

3660.1000 BENEFIT INVESTIGATIONS (RAP)

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