Benefit Diversion Agreement

County Department of Social Services

Case Number: _____
Date: _____

I, _____ agree that:

- Benefit Diversion will relieve my family's **current, temporary situation**, which does not require long-term assistance and will meet my family's **specific episode of need** at this time.
- Benefit Diversion will help my family become/remain employed, return to employment, and/or assist my family to resolve my current situation until the receipt of other income that will meet the family's needs.
- My family requests Benefit Diversion voluntarily to meet our immediate needs instead of receiving an ongoing monthly payment from Work First Family Assistance.
- My rights and responsibilities were explained and given to me during my interview. I understand the information presented. All my questions were answered.
- I chose Benefit Diversion instead of a monthly payment because _____

_____.

Applicant's Signature: _____ Date: _____

NOTICE OF BENEFITS

- Specific family crisis or episode of need to be met by Benefit Diversion:

_____

_____

- You will receive a one-time payment in the amount of $ _____..
- Any information given during the evaluation for Benefit Diversion such as social security numbers, citizenship, identity, and immigration status, will be used as part of your application for other benefit and services.
- Your family may also qualify for other services, such as Food and Nutrition Services, Medicaid, emergency and energy assistance. You must file a separate application for some of these benefits.

NOTICE OF DENIAL OF BENEFIT DIVERSION

☐ Your application for Benefit Diversion has been **denied** effective this date for the following reason.

YOUR RIGHTS TO A HEARING: If you think the wrong decision was made for your case or you have new information, you have the right to a hearing. You must ask for this hearing by _____ which is 60 days from the date of this notice. If you have good cause for a delay in the hearing, you must ask for a hearing by _____ which is 90 days from the date of this notice. This hearing is a meeting to review your case and give you the correct benefits if appropriate. Call or write your caseworker to ask for a hearing. A local hearing will be held within 5 days of your request unless you ask for it to be postponed. The hearing can be postponed, for good cause, for as much as 10 calendar days. Then, if you think the decision in the local hearing is wrong, call or write your caseworker within 15 days to ask for a second hearing. The second hearing will be held before a state hearing official.

_____	_____	_____
Interviewer's Signature	**Telephone Number**	**Date**

HEARING RIGHTS

Did you know you have the right to be represented? You may have someone speak for you at your hearing, such as a relative, paralegal or attorney obtained at your expense.

Free legal services may be available in your community. Contact your nearest Legal Aid or the Legal Aid Helpline at 1-866-219-5262, toll free.

If you have additional questions or concerns, contact your caseworker for information, or call DHHS Customer Service Center, toll free at 1-800-662-7030. TDD/Voice for the hearing impaired is also available through the number. The hours are 8:00am-5:00pm, Monday – Friday, excluding State holidays.

Did you know you have the right to see your record? If you ask, your caseworker will show you (or the person speaking for you) your benefits record before your hearing. If you ask, you may also see other information to be used at the hearing. You can get free copies of this information. You may see this information again at your hearing.

Do you understand your rights? Do you understand how to get a hearing? If you have any questions, please contact your caseworker as soon as possible.

STATE RULES USED TO MAKE THIS DECISION: The State rules used to make decisions on Benefit Diversion are found in the Work First Manual available online at https://policies.ncdhhs.gov/.