

Department of Human Resources 311 W. Saratoga St.

Baltimore, MD. 21201-3521

FIA ACTION TRANSMITTAL

Issuance Date: October 3, 1997

Effective Date: Upon Receipt

Control Number: 98-15

TO:

DIRECTORS, LOCAL DEPARTMENTS OF SOCIAL SERVICES

DEPUTY/ASSISTANT DIRECTORS FOR FAMILY INVESTMENT

FAMILY INVESTMENT SUPERVISORS

FROM:

KEVIN MAHON, EXECUTIVE DIRECTOR, FIA

RE:

VERIFICATION OF FORTY QUARTERS FOR LEGAL IMMIGRANTS

PROGRAMS AFFECTED: TEMPORARY CASH ASSISTANCE AND FOOD STAMPS

ORIGINATING OFFICE: OFFICE OF POLICY AND RESEARCH

SUMMARY

Provisions of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 changed the food stamp eligibility criteria for legal immigrants. One of those criteria establishes eligibility for legal permanent residents who have 40 quarters of coverage through the Social Security Administration (SSA). Certification pending verification was allowed for all households who were considered likely to have 40 quarters of work until the SSA's Quarters of Coverage History System (QCHS) was operational. QCHS is not currently operational. The projected implementation date is December, 1997. Effective immediately, local departments must request and obtain verification of earnings from customers before determining eligibility for legal immigrants who claim 40 quarters of work.

NEW POLICY

Verify earnings when determining eligibility for legal permanent residents who claim 40 quarters of work. Use covered earnings, wages or self-employment income which do require payment of FICA/SECA (Social Security) taxes, and non-covered earnings, wages or self-employment income which do not require payment of FICA/SECA taxes, when determining 40 quarters of work.

parent. If the dates are consistent with having 10 or more years of work, request verification of earnings from your customer to establish 40 quarters of coverage.

If the dates of entry into the country are inconsistent with having 10 or more years of work, the immigrant is ineligible.

REMINDER

Beginning January 1, 1997, do not count any quarter in which the immigrant received any Federal means-tested public benefit as part of the 40 quarters of coverage.

AIMS PROCESSING

AIMS processing remains unchanged.

CARES PROCESSING

CARES processing remains unchanged.

CLEARLY DOCUMENT ALL CASE ACTIVITIES

ACTION DUE

The new policy and procedure is effective immediately upon receipt of this Action Transmittal. Review cases certified pending verification prior to this date and request the necessary verification to establish 40 quarters of work history.

INQUIRIES

Please direct inquiries to Steve Sturgill at (410) 767-7733.

Attachments

cc: FIA Management Staff Constituent Services

Social Security Administration

Consent for Release of Information

How To
Complete
This Form

This consent form must be completed and signed only by:

the person to whom the information or record applies, or

the parent or legal guardian of a minor to whom the information or record applies, or

the legal guardian of a legally incompetent adult to whom the information or record applies

To complete this form:

Fill in the name, date of birth, and social security number of the person to whom the information applies.

Fill in the name and address of the individual or group to which we will send the information.

Fill in the reason you are requesting the information.

Check the type(s) of information you want us to release.

Sign and date the form. If you are not the person whose record we will release, please state you relationship to that person.

Social Security Administration Consent for Release of Information TO: Social Security Administration Name Date of Birth Social Security Number I authorize the Social Security Administration to release information or records about me to: NAME **ADDRESS** I want this information released because: (There may be a charge for releasing information.) Please release the following information: _ Social Security Number ___ Identifying information (includes date and place of birth, parents' names) Monthly Social Security benefit amount Monthly Supplemental Security Income payment amount _____ Information about benefits/payments I received from ______ to _____ Information about my Medicare claim/coverage from ______ to ____ (specify) _ Medical records Record(s) from my file (specify)_____ Other (specify)___ I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both. Signature: (Show signatures, names, and addresses of two people if signed by mark.) Relationship:____

SSA-3288