

Instructions for Completing the Means Test Worksheet (MTW)

This form must be completed for “services for non-placed children.” The MTW must be completed annually and must be retained and available for audit or review purposes. Start and complete the 235% MTW. You only need to complete the 400% MTW if you checked “No” in Section II, item 5 of the 235% MTW.

Section-Specific Instructions

Section I – Identifying Information for “Services for Non-Placed Children”

Complete Items 1 through 11 by providing the appropriate information for the child/family.

In item 6 you must list the name of the person with whom the child was living when the Means Test was administered (as identified in Section II, Item 4). Write in item 7 the relationship to the child of the person listed in item 6. An MTW is only valid if the child is living at home with a parent or adult relative. If the person with whom the child is living is not a parent or relative or if the child is living with a relative who is a foster parent, then note that relationship in item 7 and only complete Section I of the MTW.

Section II – Means Test for “Services for Non-Placed Children”

Ask the family if they or the child are receiving one or more of the benefits listed, check all of the boxes that apply and provide the CIS case ID, if available. This is the case number assigned by the Commonwealth and clients may know this as their “ACCESS ID Number.” This child/family meets the means test and is eligible for TANF funding for “services for non-placed children”. Therefore, you do not need to complete item 2, item 3 or item 4. Continue to item 5 and check “**YES**”, child/family is TANF eligible. If the family is not receiving one of the listed public benefits, proceed to Item 2.

2. Is the child a United States citizen or qualified alien? This item is a self declaration by the child’s parent or specified relative. Under federal law, the term “qualified alien” includes, but is not limited to, the following:
- an alien who is lawfully admitted for permanent residency;
 - an alien who is granted asylum;
 - a refugee;
 - an alien who is paroled;
 - an alien whose deportation or removal has been withheld;
 - an alien who is granted conditional entry;
 - an alien who is a Cuban/Haitian Entrant; or
 - an alien who has been battered or subjected to extreme cruelty.

If the family states that their child is a US citizen or qualified alien, then mark “Yes” and proceed to item 3. Otherwise, mark “No” and stop completion of the MTW.

3. Is the child under the age of 21? Look at the child’s date of birth. If the child is under 21, then mark “Yes” and proceed to item 3. Otherwise, mark “No” and stop completion of the MTW.

4. Complete item 4 as follows:

Determine the size of the family unit. Include all of the following living with the TANF child in the same home: biological or adoptive parents and full, half and/or adopted siblings under the age of 18 plus the TANF child.

Ask the parent or specified relative if the income level of the child's family unit (as defined above) **IS LESS THAN** the annual or monthly gross income for their family size.

If the family's income is less than the amount of the annual/monthly income in the corresponding row for their family size, answer **"Yes"** in the box in Column 4 that corresponds to the family size. If the family's income exceeds that amount, answer **"No"**.

If completing the 235% MTW and there are more than 6 family members, add \$7,238 annually (Column 2) and \$604 monthly (Column 3) for each additional member to the amounts on row 6 of Table 1 and place the correct figures in the blank row at the bottom of Table.

If completing the 400% MTW and there are more than 6 family members, add \$12,320 annually (Column 2) and \$1,027 monthly (Column 3) for each additional member to the amounts on row 6 of Table 1 and place the correct figures in the blank row at the bottom of Table.

No verification other than the declaration of the family is required for this item.

Enter the month and year for which the means test was administered. This should be the month and year in which the child first started receiving services from the agency.

5. If one of the boxes in item 1 is checked or a **"Yes"** is entered in items 2 and 3 and in Table 1 in item 4, the child/family is eligible for TANF services, check the **"Yes"** box in item 5. Otherwise, the child is not TANF eligible, check the **"No"** box in item 5.
6. Print the name of the person administering the means test.
7. Signature of the person administering the means test.
8. Enter the date that the form was completed.

PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE
OFFICE OF CHILDREN, YOUTH AND FAMILIES
TEMPORARY ASSISTANCE FOR NEEDY FAMILIES –
“SERVICES FOR NON-PLACED CHILDREN”
MEANS TEST WORKSHEET

COUNTY NUMBER 51

I. IDENTIFYING INFORMATION FOR “SERVICES FOR NON-PLACED CHILDREN”

CHILD'S NAME (LAST, FIRST, M.I.)		SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
CHILD'S DATE OF BIRTH	CHILD'S SSN	COUNTY IDENTIFIER 51
Name of <u>PARENT</u> or <u>SPECIFIED RELATIVE</u> with whom the child is Living	RELATIONSHIP TO CHILD	PARENT OR SPECIFIED RELATIVE'S SSN
AGENCY NAME	PROGRAM NAME	CONTRACT NUMBER

II. MEANS TEST FOR “SERVICES FOR NON-PLACED CHILDREN”

1. Is the child/family receiving TANF (Cash Assistance) SSI FOOD STAMPS MEDICAID

Case No: _____

If the child/family is receiving one of the above services proceed to question 5 and answer “YES.” Otherwise proceed to question 2.

2. Is the child a U.S. Citizen or qualified alien? YES NO

3. Is the child under 21 years of age? YES NO

4. In order to be eligible under TANF the family in which the child is living must have gross income below 235 percent of the Federal Poverty Level (FPL) for the Family Unit size. Using Table 1 below, provide a “Yes” in Column 4 in the corresponding row for the Family Unit size if the family’s income **is less than** the annual or monthly amount for the Family Unit size. Otherwise place a “No” in Column 4. (Family Unit includes biological or adoptive parents and full, half, and/or adopted siblings living in the home under the age of 18 plus the TANF child). This is a self-declared means test. No verification except the response of the family is required.

Table 1: 235 Percent of Federal Poverty Level

(1) Family Unit Size	(2) 235% of FPL (gross) (Annually)	(3) 235% of FPL (gross) (Monthly)	(4) Less than 235% of the FPL (Yes or /No)
1	Less than \$20,821	Less than \$1,734	
2	Less than \$28,059	Less than \$2,338	
3	Less than \$35,297	Less than \$2,941	
4	Less than \$42,535	Less than \$3,544	
5	Less than \$49,773	Less than \$4,148	
6	Less than \$57,011	Less than \$4,751	

Note: For family units of more than 6 members, add \$7,238 annually (Column 2) and \$603 monthly (Column 3) for each additional member and place the correct figures in the blank row at the bottom of Table 1.

Means Test Administered for: Month: _____ **Year:** _____

5. If the child/family is receiving one of the benefits in question 1 or answers to questions 2, 3 and 4 are ALL “Yes” the child is TANF eligible and check the “Yes” box, otherwise check the “No” box. YES NO If the family meets the 235% of FPL level, you do not need to complete an MTW for 400% FPL.

6. Name of staff person administering this means test (Please Print) _____

7. Signature of staff person administering this means test _____

8. Date this form was completed: _____

PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES –

“SERVICES FOR NON-PLACED CHILDREN”

Means Test Worksheet

COUNTY NUMBER 51

I. IDENTIFYING INFORMATION FOR “SERVICES FOR NON-PLACED CHILDREN”

CHILD'S NAME (LAST, FIRST, M.I.)		SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
CHILD'S DATE OF BIRTH	CHILD'S SSN	COUNTY IDENTIFIER 51
Name of <u>PARENT</u> or <u>SPECIFIED RELATIVE</u> with whom the child is Living	RELATIONSHIP TO CHILD	PARENT OR SPECIFIED RELATIVE'S SSN
AGENCY NAME	PROGRAM NAME	CONTRACT NUMBER

II. MEANS TEST FOR “SERVICES FOR NON-PLACED CHILDREN”

1. Is the child/family receiving TANF (Cash Assistance) SSI FOOD STAMPS MEDICAID

Case No: _____

If the child/family is receiving one of the above services proceed to question 5 and answer “YES.” Otherwise proceed to question 2.

2. Is the child a U.S. Citizen or qualified alien? YES NO

3. Is the child under 21 years of age? YES NO

4. In order to be eligible under TANF the family in which the child is living must have gross income below 400 percent of the Federal Poverty Level (FPL) for the Family Unit size. Using Table 1 below, provide a “Yes” in Column 4 in the corresponding row for the Family Unit size if the family’s income **is less than** the annual or monthly amount for the Family Unit size. Otherwise place a “No” in Column 4. (Family Unit includes biological or adoptive parents and full, half, and/or adopted siblings living in the home under the age of 18 plus the TANF child). This is a self-declared means test. No verification except the response of the family is required.

Table 1: 400 Percent of Federal Poverty Level

(1) Family Unit Size	(2) 400% of FPL (gross) (Annually)	(3) 400% of FPL (gross) (Monthly)	(4) Less than 400% of the FPL (Yes or /No)
1	Less than \$35,440	Less than \$2,953	
2	Less than \$47,760	Less than \$3,980	
3	Less than \$60,080	Less than \$5,007	
4	Less than \$72,400	Less than \$6,034	
5	Less than \$84,720	Less than \$7,061	
6	Less than \$97,040	Less than \$8,088	

Note: For family units of more than 6 members, add \$12,320 annually (Column 2) and \$1,027 monthly (Column 3) for each additional member and place the correct figures in the blank row at the bottom of Table 1.

Means Test Administered for: Month: _____ **Year:** _____

5. If the child/family is receiving one of the benefits in question 1 or answers to questions 2, 3 and 4 are ALL “Yes” the child is TANF eligible and check the “Yes” box, otherwise check the “No” box. YES NO

6. Name of staff person administering this means test (Please Print) _____

7. Signature of staff person administering this means test _____

8. Date this form was completed: _____

DOCUMENTATION OF ATTEMPTS TO GATHER SOCIAL SECURITY NUMBER

REMBER: SECURIING A SOCIAL SECURITY NUMBER FOR THE CHILD AND PARENT/CAREGIVER IS REQUIRED. AGENCIES WILL BE MONITORED ON THEIR SUCCESS IN SECURING SSN FOR BILLING PURPOSES AND FUNDING MAY BE REDUCED OR TERMINATED IN THE EVENT OF SIGNIFICANT FAILURE TO OBTAIN THIS INFORMATION FOR ALL CHILDREN.

I. Background

Provider/Site Name _____

Child's Name _____

Caregiver's Name _____

Caregiver relationship to child _____

II Request for SSN Child Parent/Caregiver

Date(s) SSN requested _____

Name and Title of person making request _____

How was request made (in person, by telephone, by mail)? _____

Reason SSN not provided; if child or parent has no SS card, indicate what assistance has been provided to secure a new card.

Additional steps taken to gather SSN:

Information on this document may be verified by the program director, supervisor, or representative of the Dept. of Human Services. A copy of this form must be submitted with a Means Test Worksheet for any child/family for which a SSN cannot be obtained, and a copy kept in the child/family's file.

III. STAFF INFORMATION

Printed name

Title

Date

Signature

CITY OF PHILADELPHIA CHILDREN'S INVESTMENT STRATEGY
Intake/Discharge Form

Provider/Site (code): _____ Intake Date: _____

Child's Name: _____

Child's Social Security Number: _____ Date of Birth: _____

Child's Pupil Identification Number: _____

Child's School: _____ Child's Gender: Male
Child's Grade: _____ Female

Caregiver's Name: _____

Caregiver's Relationship to child (mother, uncle, etc): _____

Home Address: _____
_____ Zip Code: _____

Caregiver's Telephone Number: Home - _____
Work - _____

Emergency Contact: _____ Phone Number: _____

Child's Race: African American Asian or Pacific Islander Latino/Latina
 White Multi-Ethnic
 African Other (specify) _____

Child's Special Needs: Deaf /hard of hearing Developmentally delayed
 Homeless Behavioral/mental health Substance Abuse Linguistic Minority
 Other (specify) _____

Funding Source Eligibility Status:
TANF Eligible: Yes No If Yes, check all that apply: Assistance Recipient
 At or below 400% of Federal Poverty Level At or below 235% of Federal Poverty Level
NCEZ Eligible: Yes No Other Status (please explain): _____
Please make sure all required paperwork for eligibility status accompanies intake form.

Date Informed Consent Form Received: _____ **Date Agency Consent Form Received:** _____

Date Health Assessment Form Received: _____

Discharge Date: _____

Reason for Discharge: Moved Medical Family Situation
 Outside Activity Participation Poor Attendance Behavioral
 Other (please explain) _____

**CITY OF PHILADELPHIA CHILDREN'S INVESTMENT STRATEGY
2002-2003
STAFF DATA FORM**

Provider _____ Program(s) _____
 Name _____
 Position Title _____ Hire Date _____
 Paid _____ Volunteer _____ Language(s) spoken _____
 Date child abuse check received _____
 Date criminal record check received _____

TRAINING RECORD

Training Date	Title of Training	Hours of Training	*Core Standard Training Category*	Training Provider

- * 1 = youth and child development
- 2 = curriculum and activity planning and implementation
- 3 = core standards

Termination Date _____

**PHILADELPHIA SAFE AND SOUND
CHILDRENS INVESTMENT STRATEGY
2532-34 N. Broad Street. Philadelphia, PA 19132**

INFORMED CONSENT FORM

The Children’s Investment Strategy (CIS) is a Philadelphia effort to improve the well-being of children and youth through effective youth development activities during non-school hours and provide preventive services to strengthen families, particularly the relationship between parents and children. The success of CIS is related to the following:

- Children need safe and constructive activities when they are out of school.
- Increasing the number of quality and affordable non-school hours programs is a part of the Mayor’s Children’s Investment Strategy (CIS).
- Good non-school hours programs will help children do better in school.
- We need to see if children who attend non-school hours programs are doing better in school.
- **The CIS needs your permission to collect information regarding your child’s school performance.**
- We may collect grades, standardized tests information, achievement levels, report cards, school attendance, suspension, and other school relevant records.
- We will not share your child’s school information with any agency outside of CIS.
- Your child’s school information will be added to the school information from all the other children who participate in your child’s non-school hours program.
- We will report information by non-school hours program, not by individual children. No one will be able to use this information to identify your child.

When you sign the informed consent form you voluntarily give consent and authorization that will remain valid for **ONE Year** from the date signed:

- to let your child answer questions about the non-school hours program or community
- to let your child’s school give his/her records to the Children’s Investment Strategy
- that the non-school hours program gave you information about you and your child’s rights
- that your child will be supervised by professional staff.

I understand that the Buckley Amendment to the Family Education Rights and Privacy Act of 1974 guarantees that my/my child’s academic record will not be discussed with or disclosed to any third party without my written consent. I hereby authorize officials of the School District of Philadelphia or other school entity to release my/my child’s educational records only to CIS and to any corresponding partner agency or agencies with which I/my child will be placed or referred by CIS.

I understand that this information will not be provided to any entity other than those indicated above. I agree not to hold the City of Philadelphia, the Children’s Investment Strategy, Philadelphia Health Management Corporation (PHMC), and _____ responsible for injuries and/or damages to my child’s person and/or property.

Youth’s Name: _____ SS#: _____
Youth’s School and Grade: _____ Date of Birth: _____
Time my child will arrive at the CIS Program: _____
Time my child will depart from the CIS Program: _____
Youth’s Signature: _____ Date: _____
(If 18 or older or an emancipated minor)
Parent’s/Guardian’s Signature: _____ Date: _____
(If youth is under age 18)
Provider Witness’ Signature: _____ Date: _____
Provider Agency Name: _____

EQUAL OPPORTUNITY IS THE LAW

Let me tell you something about **YOUR CIVIL RIGHTS UNDER FEDERAL LAW**. The provider operating this program is prohibited from discriminating on the grounds of race, color, religion, sex, national origin, age disability, political affiliation or belief and, for beneficiaries only, citizenship, or participation in programs funded under the Temporary Assistance For Needy Families (TANF) or the Workforce Investment Act (WIA). If you think that you have been subjected to discrimination in the operation of this program or any activity conducted therein, you may file a complaint within **180 days** from the date of the alleged violation with the Director, Civil Rights Center (CRC), U.S. Department of Labor, 200 Constitution Avenue, NW, Room N-4123, Washington D.C. 20210, or with the Commonwealth of Pennsylvania, Department of Labor and Industry's (L&I) Office of Affirmative Action (OAA).

If you elect to file your complaint with the Commonwealth's Office of Affirmative Action, you must wait until the Office of Affirmative Action issues a decision or until 60-days has passed, whichever is sooner, before filing with the CRC. If the Commonwealth's Office of Affirmative Action has not provided you with a written decision within 60-days of filing of the complaint, you need not wait for a decision to be issued, but may file a complaint with the US Department of Labor's CRC within 30-days of the expiration of the 60-day period. If you are dissatisfied with the Commonwealth's Office of Affirmative Action resolution of the complaint, you may file a complaint with the US Department of Labor's CRC. Such complaint should be filed within 30-days of the date you receive notice of the Commonwealth's Office of Affirmative Action proposed resolution.

If you have any questions, regarding the above, or wish to file a discrimination complaint, please contact:

**Commonwealth of Pennsylvania
Department of Labor and Industry
Office of Affirmative Action
Room 1415 Labor and Industry Building
Seventh and Forster Streets
Harrisburg, Pennsylvania 17120
(717) 787-1767 • 1-800-622-5422 • TDD 1-800-654-5984 • VOICE 1-800-654-5988**