
MEDICARE SUBSIDY - QUALITY REVIEW CASE ANALYSIS

1. QA Office Code: _____ Sample Cycle: _____ Study ID: _____
Subsidy Level: _____% Interview date: _____
2. Beneficiary's (BN) SSN: _____
Living-with Spouse's SSN (If applicable): _____
Type of Application: Beneficiary Only Beneficiary/Living-with Spouse
Date Application Filed: _____ Protective Filing Date/MOE: _____
If death precluded interview, provide date of death & exclude: _____
 Other Exclusion (see remarks) Interview Incomplete (see remarks)
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<p>Name of BN: _____</p> <p>Address: _____ _____ _____</p> <p>Phone: () _____</p> <p>Living-with Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Name of Spouse: _____</p> <p>Living-with Spouse contacted: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Other Contact:</p> <p><input type="checkbox"/> Representative Payee (if applicable)</p> <p style="margin-left: 40px;">Name: _____</p> <p style="margin-left: 40px;">Address: _____ _____</p> <p style="margin-left: 40px;">Phone: () _____</p> <p><input type="checkbox"/> Third Party</p> <p style="margin-left: 40px;">Name: _____</p> <p style="margin-left: 40px;">Address: _____ _____</p> <p style="margin-left: 40px;">Phone: () _____</p>
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SSA Records

Interview

1. Identity

SSN:
Beneficiary:

Living-with Spouse:

Date of Birth

Beneficiary:

Living-with Spouse:

2. Marital Status

Single, Divorced,
Widow(er),
Married Not
Living-with
Spouse

Married Living-
with Spouse

SSN agrees with systems queries

Beneficiary

Living-with Spouse

_____	Name on Record	_____
_____	Date of Birth	_____
_____	Birthplace	_____
_____	Parents	_____

What was your marital status at the time the application was filed?

Single, Divorced, Widow(er), Married Not Living-with Spouse

Married Living-with Spouse

Has there been any change in marital status since the application date?

Yes No

If yes, indicate type of change below.

Divorce
 Annulment
 Marriage

Separation from Spouse
 Death of your Spouse
 Resumption of cohabitation
after separation

Date of change: _____

Verification	Conclusion
<p>1. Identity verified:</p> <p>Beneficiary: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Living-with Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> No deficiency</p> <p><input type="checkbox"/> Deficiency</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>2. Marital Status</p> <p><input type="checkbox"/> No change/Verification not required</p> <p>Documentary evidence</p> <p><input type="checkbox"/> Divorce Decree <input type="checkbox"/> Separation Agreement</p> <p><input type="checkbox"/> Annulment Decree <input type="checkbox"/> Death Certificate/SSA records</p> <p><input type="checkbox"/> Marriage Certificate</p> <p><input type="checkbox"/> Collateral contact made:</p> <p> Type/Date _____</p> <p> Place _____</p> <p> Name/Title _____</p> <p> Findings _____</p> <p>Documentary evidence unavailable</p> <p> Explanation: _____</p> <p> _____</p> <p> _____</p>	<p><input type="checkbox"/> No change</p> <p><input type="checkbox"/> Marital status Change</p> <p><input type="checkbox"/> No Living-with Spouse</p> <p><input type="checkbox"/> Living-with Spouse</p> <p><input type="checkbox"/> No deficiency</p> <p><input type="checkbox"/> Deficiency</p> <p>_____</p> <p>_____</p> <p>_____</p>

SSA Records

Interview

3. In-kind Support and Maintenance (ISM)

ISM involved:

Yes No

Amount of ISM:
\$ _____

- Lives alone Beneficiary and Living-with Spouse only
 Lives with others Medical Facility Non-Medical Facility
 Beneficiary/Living-with Spouse has Home Ownership/Rental Liability

NAME	CONTRIBUTES TO HOUSEHOLD		AMOUNT
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____

Average Monthly Household Expenses

<u>Type</u>	<u>Amount</u>	<u>Type</u>	<u>Amount</u>
Food	\$ _____	Gas	\$ _____
Rent	\$ _____	Electricity	\$ _____
Property		Property	
Tax	\$ _____	Insurance	\$ _____
Water	\$ _____	Sewer	\$ _____
Mortgage	\$ _____	Heating/Fuel	\$ _____
Garbage Removal	\$ _____		
Total Average Monthly Household Expenses			\$ _____

Outside Contributor:

Name: _____
 Address: _____
 Phone: () _____
 Monthly Amount: \$ _____

Non-Household Situation:

Beneficiary

Type: Medical Non-Medical

Address: _____

Date of Admission: _____

Date of Discharge: _____

Care Rate: \$ _____ Facility/3rd Party Payment: \$ _____

Living-with Spouse

Type: Medical Non-Medical

Address: _____

Date of Admission: _____

Date of Discharge: _____

Care Rate: \$ _____ Facility/3rd Party Payment: _____

\$ _____

Verification

Conclusion

3. In-Kind Support and Maintenance (ISM)

Home Ownership/Rental Liability

No ISM involved

Total Yearly ISM: \$ _____

Average Monthly Household Expenses

No deficiency

Deficiency: _____

<u>Type</u>	<u>Amount</u>	<u>Type</u>	<u>Amount</u>
Food	\$ _____	Gas	\$ _____
Rent	\$ _____	Electricity	\$ _____
Property Tax	\$ _____	Property Insurance	\$ _____
Water	\$ _____	Sewer	\$ _____
Mortgage	\$ _____	Heating/Fuel	\$ _____
Garbage Removal	\$ _____		

Total Monthly Household Expenses \$ _____

Type of evidence submitted: _____

Contribution amount from other household member(s): \$ _____

Food/shelter contributions from outside HH: \$ _____

Contributor(s):

Name: _____

Address: _____

Phone: () _____

Type/Date: _____

Findings: _____

Non-Household Situation:

Beneficiary

Type: Medical Non-Medical

Address: _____

Date of Admission: _____

Date of Discharge: _____

Care Rate: \$ _____ Facility/3rd Party

Payment: \$ _____

Living-with Spouse

Type: Medical Non-Medical

Address: _____

Date of Admission: _____

Date of Discharge: _____ Care Rate: \$ _____ Facility/3 rd Party Payment: \$ _____	
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SSA Records

Interview

4. Family Size

Number of relatives living with the beneficiary and/or living-with spouse for whom they allege providing at least 1/2 financial support:

Beneficiary

Living-with Spouse

Total Alleged Family Size: _____

Beneficiary/living-with spouse does not provide 1/2 support to relatives in household.

Indicate below: the name, relationship, income and whether or not 1/2 support is alleged for each relative in the household of the beneficiary or living-with spouse.

NAME	RELATION-SHIP	INCOME	1/2 SUPPORT ALLEGED	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No

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Verification

Conclusion

<p>4. Family Size</p> <p>Collateral Contact(s):</p> <p style="margin-left: 40px;">Name: _____</p> <p style="margin-left: 40px;">Address: _____</p> <p style="margin-left: 40px;">_____</p> <p style="margin-left: 40px;">_____</p> <p style="margin-left: 40px;">Phone: () _____</p> <p style="margin-left: 40px;">Findings: _____</p> <p style="margin-left: 40px;">_____</p> <p style="margin-left: 40px;">Name: _____</p> <p style="margin-left: 40px;">Address: _____</p> <p style="margin-left: 40px;">_____</p> <p style="margin-left: 40px;">_____</p> <p style="margin-left: 40px;">Phone: () _____</p> <p style="margin-left: 40px;">Findings: _____</p> <p style="margin-left: 40px;">_____</p>	<p>Verified Family Size:</p> <p style="text-align: center;">_____</p> <p><input type="checkbox"/> ½ support met for:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> ½ support not met for:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> No Deficiency</p> <p><input type="checkbox"/> Deficiency:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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SSA Records

Interview

5. Liquid Resources

None

Bank Accounts:

\$ _____

Stocks, bonds, savings
bonds, mutual funds,
IRA or similar
accounts: \$ _____

Cash: \$ _____

Other: _____

\$ _____

Computer Match:

\$ _____

Indicate the type(s) of liquid resources involved and the amount.
Provide the information needed to contact collateral sources.

Applicant

None

Living-with Spouse

None

Cash	\$ _____	\$ _____
Checking Account	\$ _____	\$ _____
Savings Account	\$ _____	\$ _____
Cert. of Deposit	\$ _____	\$ _____
Mutual Funds	\$ _____	\$ _____
Credit Union Accts.	\$ _____	\$ _____
Other Bank Account (Christmas Club, etc.)	\$ _____	\$ _____
Patient Accounts	\$ _____	\$ _____
Savings Bonds	\$ _____	\$ _____
Stocks/Bonds	\$ _____	\$ _____
Promissory Notes	\$ _____	\$ _____
401K Plans/Keogh Accounts	\$ _____	\$ _____
Trusts	\$ _____	\$ _____
Other (Explain)	\$ _____	\$ _____
_____	\$ _____	\$ _____

Account type _____ Account ID _____

Name of Source: _____

Address: _____

Owner(s): _____

Balance: \$ _____

Account type _____ Account ID _____

Name of Source: _____

Address: _____

Owner(s): _____

Balance: \$ _____

Remarks: _____

Verification

Conclusion

5. Liquid Resources

Evidence viewed: Yes No

Account type _____ Account ID _____

Owner(s): _____

Balance: \$ _____

Account type _____ Account ID _____

Owner(s): _____

Balance: \$ _____

Account type _____ Account ID _____

Owner(s): _____

Balance: \$ _____

Collateral contact made?: Yes No

Name of Source: _____

Address: _____

Account type _____ Account ID _____

Owner(s): _____

Balance: \$ _____

Name of Source: _____

Address: _____

Account type _____ Account ID _____

Owner(s): _____

Balance: \$ _____

Name of Source: _____

Address: _____

Account type _____ Account ID _____

Owner(s): _____

Balance: \$ _____

None

Total Countable Liquid Resources:

Cash: \$ _____

Checking: \$ _____

Savings: \$ _____

Other: \$ _____

Total: \$ _____

Total countable liquid resources did not exceed resource limit during the Evidentiary Period.

Liquid resources caused or contributed to ineligibility or affected the Subsidy Level.

No deficiency

Deficiency _____

SSA Records

Interview

<p>6. Life Insurance Policy</p> <p>Have policies with total face value of more than \$1,500?</p> <p><u>Beneficiary:</u></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cash Surrender Value (CSV): \$ _____</p> <p><u>Living-with Spouse:</u></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cash Surrender Value (CSV): \$ _____</p>	<p>Life Insurance Policies owned by Beneficiary or Living-with Spouse? <input type="checkbox"/> Yes, indicate below <input type="checkbox"/> No</p> <p>Type of Policy: <input type="checkbox"/> Whole Life <input type="checkbox"/> Term Life <input type="checkbox"/> Other Face Value: _____ CSV: _____ Dividend Accumulations: _____ Date of Issue: _____ Name of Insured Individual: _____ Owner of Policy: _____ Policy Number: _____ Name of Insurance Carrier: _____ Address of Carrier: _____ Phone: () _____</p> <p>Type of Policy: <input type="checkbox"/> Whole Life <input type="checkbox"/> Term Life <input type="checkbox"/> Other Face Value: _____ CSV: _____ Dividend Accumulations: _____ Date of Issue: _____ Name of Insured Individual: _____ Owner of Policy: _____ Policy Number: _____ Name of Insurance Carrier: _____ Address of Carrier: _____ Phone: () _____</p> <p>Type of Policy: <input type="checkbox"/> Whole Life <input type="checkbox"/> Term Life <input type="checkbox"/> Other Face Value: _____ CSV: _____ Dividend Accumulations: _____ Date of Issue: _____ Name of Insured Individual: _____ Owner of Policy: _____ Policy Number: _____ Name of Insurance Carrier: _____ Address of Carrier: _____ Phone: () _____</p>
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Verification

Conclusion

6. Life Insurance Policy

Beneficiary

No policies

No policies

Collateral contact:

Face Value exceeds \$1500

Name: _____

Yes No

Address: _____

CSV: \$_____

Phone: () _____

Dividend Accumulations:

Total Face Value: _____ CSV: _____

\$_____

Dividend Accumulations: _____

Total countable value of Life Insurance:

Owner(s): _____

\$_____

Name: _____

No Deficiency

Address: _____

Deficiency _____

Phone: () _____

Total Face Value: \$_____ CSV: \$_____

Dividend Accumulations: \$_____

Owner(s): _____

Living-with Spouse

Name: _____

No policies

Address: _____

Face Value exceeds \$1500

Phone: () _____

Yes No

Total Face Value: \$_____ CSV: \$_____

CSV: \$_____

Dividend Accumulations: \$_____

Dividend Accumulations:

Owner(s): _____

\$_____

Total countable value of Life Insurance:

Name: _____

No Deficiency

Address: _____

Deficiency _____

Phone: () _____

Total Face Value: \$_____ CSV: \$_____

Dividend Accumulations: \$_____

Owner(s): _____

SSA Records

Interview

7. Non-home Real Property

Ownership:

Yes No

CMV \$ _____

Allegation of Non-Home Real Property ownership by Beneficiary/Living-with Spouse:

Yes No

Sole Ownership
 Beneficiary Living-with Spouse
 Joint ownership

Joint owner's Name: _____

Address: _____

Phone: () _____

Property Address: _____

CMV: \$ _____ Mortgage balance: \$ _____

Property Essential for Self-Support: \$ _____

Lien Holder:

Name/Source: _____

Address: _____

Phone: () _____

Encumbrances: _____

Sole ownership
 Beneficiary Living-with Spouse
 Joint ownership

Joint owner's Name: _____

Address: _____

Phone: () _____

Property Address: _____

CMV: \$ _____ Mortgage balance: \$ _____

Property Essential for Self-Support: \$ _____

Lien Holder:

Name/Source: _____

Address: _____

Phone: () _____

Encumbrances: _____

Verification

Conclusion

7. Non-Home Real Property

Allegations verified by:

- Government records
- Tax Assessment Statement
- Other (i.e. deed, sales contract, etc.) _____

Collateral contact made:

Name of Source: _____
Address: _____
Owner(s): _____
Verified CMV: \$ _____ Equity Value: \$ _____

Name of Source: _____
Address: _____
Owner(s): _____
Verified CMV: \$ _____ Equity Value: \$ _____

Encumbrances: _____

Property Essential for Self-Support: \$ _____

No Non-Home Real Property ownership for Beneficiary or Living-with Spouse

Beneficiary or Living-with Spouse owns excluded Non-Home Real Property

Beneficiary or Living-with Spouse owns countable Non-Home Real Property with a total equity value of: \$ _____

Property Essential for Self Support: \$ _____

No deficiency

Deficiency: _____

SSA Records

Interview

8. Funeral/Burial Expenses

Funds expected to be used for funeral or burial expenses?

Yes No

Funds expected to be used for funeral or burial expenses?

Yes No

Verification	Conclusion
8. Funeral/Burial Funds	<input type="checkbox"/> Exclusion does not apply <input type="checkbox"/> Exclusion applies <input type="checkbox"/> Beneficiary only <input type="checkbox"/> Living-with Spouse only <input type="checkbox"/> Both <input type="checkbox"/> No deficiency <input type="checkbox"/> Deficiency: _____ _____ _____ _____

Total Countable Resources Summary

<u>Type of Resource</u>	<u>Total Value</u>	
Liquid Resources	\$ _____	<input type="checkbox"/> No deficiency <input type="checkbox"/> Deficiency: _____ _____ _____ _____
Life Insurance Policies	\$ _____	
Non-Home Real Property	\$ _____	
Subtotal	\$ _____	
Minus Burial Fund Exclusion (If applicable)	\$ _____	Resources caused ineligibility or affected the subsidy level:
Total	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

SSA Records

Interview

9. Unearned Income

Indicate the type(s) of unearned income involved and provide the amount and source of verification.

Beneficiary

None

Income type:

Amount: \$ _____

Income type:

Amount: \$ _____

Computer Match:
\$ _____

Living-with Spouse

None

Income type:

Amount: \$ _____

Income type:

Amount: \$ _____

Computer Match:
\$ _____

Beneficiary

Living-with Spouse _

Title II	\$ _____	\$ _____
Title XVI	\$ _____	\$ _____
Bank Deposits	\$ _____	\$ _____
VA Pension	\$ _____	\$ _____
VA Compensation	\$ _____	\$ _____
Gov't Pension	\$ _____	\$ _____
Private Pension	\$ _____	\$ _____
Railroad Retire.	\$ _____	\$ _____
Black Lung	\$ _____	\$ _____
Educational Assistance	\$ _____	\$ _____
State Dib. Pymt	\$ _____	\$ _____
Unemployment	\$ _____	\$ _____
Worker's Comp.	\$ _____	\$ _____
Sick Pay	\$ _____	\$ _____
Royalties	\$ _____	\$ _____
Rental Income	\$ _____	\$ _____
Gifts	\$ _____	\$ _____
Alimony	\$ _____	\$ _____
Patrimony	\$ _____	\$ _____
Gambling Proceeds	\$ _____	\$ _____
Child Support	\$ _____	\$ _____
Cash	\$ _____	\$ _____
Other	\$ _____	\$ _____

Source:

Name: _____

Address: _____

Phone: () _____

Claim #: _____

Name: _____

Address: _____

Phone: () _____

Claim #: _____

Verification

Conclusion

<p>9. Unearned Income</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Title II (verified by the MBR)</p> <p><input type="checkbox"/> Title XVI (verified by the SSR - <i>Informational only</i>)</p> <p><input type="checkbox"/> Verified by award letter or other evidence in Beneficiary's/living-with Spouse's possession.</p> <p><input type="checkbox"/> Collateral contact made: Source: _____ Addr: _____ _____ Phone: () _____ Findings: _____ _____</p> <p><input type="checkbox"/> Collateral contact made: Source: _____ Addr: _____ _____ Phone: () _____ Findings: _____ _____</p> <p><input type="checkbox"/> Collateral contact made: Source: _____ Addr: _____ _____ Phone: () _____ Findings: _____ _____</p> <p><input type="checkbox"/> Unearned Income exclusion established per HI 03020.ff</p> <p>Type: _____ Amount: \$ _____ Type: _____ Amount: \$ _____ Type: _____ Amount: \$ _____</p>	<p>Total Yearly Unearned Income</p> <p>\$ _____</p> <p>Total Yearly Excludable Unearned Income</p> <p>\$ _____</p> <p>Total Yearly Countable Unearned Income</p> <p>\$ _____</p>
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SSA Records

Interview

10. Earned Income

Beneficiary

None

Wages: \$ _____
SEI : \$ _____

Amounts decreased:
 Yes No

Stopped or plans to stop work?
 Yes No
When? _____

Work expenses?
 Yes No

Computer Match:
\$ _____

Living-with Spouse

None

Wages: \$ _____
SEI : \$ _____

Amounts decreased:
 Yes No

Stopped or plans to stop work? Yes No
When? _____

Work expenses?
 Yes No

Computer Match:
\$ _____

Date last worked: Beneficiary _____ Spouse _____
Date plans to stop work: Beneficiary _____ Spouse _____

Beneficiary

Living-with Spouse

Wages	\$ _____	\$ _____
NESE	\$ _____	\$ _____
Sheltered Workshop Earnings	\$ _____	\$ _____
Royalties	\$ _____	\$ _____
Honoraria	\$ _____	\$ _____
In-Kind Earned Income	\$ _____	\$ _____

Source Name: _____
Address : _____
Phone : () _____

Source Name: _____
Address : _____
Phone : () _____

Explanation of decrease in earnings: _____

Work Expenses

IRWE/BWE Yes No

Type(s): _____

Amount: \$ _____

Frequency: Weekly Monthly Yearly

Verification

Conclusion

10. Earned Income and Earned Income Exclusions

- None
- Earned Income established:
 - See employer contact in file
 - See systems query (DEQY, SEQY)
 - See SSA-4201
 - See tax return
 - See copy of other business record
 - See summary of beneficiary's/living-with Spouse's records (i.e. pay stubs)

Collateral contact made:
 Source: _____

Date of Contact: _____
 Finding: _____

Source: _____

Date of Contact: _____
 Finding: _____

- Earned Income Exclusion established per HI 03020.ff:
 - Type: _____ Amount: \$ _____
 - Type: _____ Amount: \$ _____
 - Type: _____ Amount: \$ _____

Work Expense(s) established:

- IRWE BWE

Type: _____

Amount: \$ _____

Frequency: Weekly Monthly Yearly

Findings: _____

Neither Beneficiary nor Living-with Spouse has Earned Income

Beneficiary has yearly Earned Income of:
 \$ _____

Living-with Spouse has yearly Earned Income of:
 \$ _____

Total Yearly Earned Income:
 \$ _____

Total Earned Income Exclusion:
 Type: _____
 Amount: \$ _____

Work Expense(s):
 IRWE BWE:
 \$ _____

Total Yearly Countable Earned Income:
 \$ _____

