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**RSI/DI QUALITY REVIEW CASE ANALYSIS – SAMPLED NUMBER HOLDER**

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## DESK REVIEW

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NOTE TO REVIEWER: In opening the interview, explain that this case is one of a small number selected by chance for review and that the purpose of this review is to find out how well the Social Security program is working. Tell them that the review consists of asking questions about their entitlement to Social Security benefits and that we may need to talk to others who have information about their entitlement. If necessary, point out that the Social Security Administration is authorized by law to review from time to time the entitlement of beneficiaries.

This information collection meets the clearance requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. The beneficiary is not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 30 minutes to read the instructions, gather the necessary facts, and answer the questions. Send only comments relating to our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.

FIELD/TELEPHONE REVIEW

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I. IDENTIFYING AND REVIEW INFORMATION

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A. SIC: \_\_\_\_\_ B. NH's SSN: \_\_\_\_\_

C. Sample Selection Date (As Shown on SCL): \_\_\_\_\_

D. Review Amount on SCL: \$ \_\_\_\_\_

E. Review Amount Determined by QR: \$ \_\_\_\_\_

F. Explanation of SCL Changes, if Any: \_\_\_\_\_

G. NH's Name (As Shown on MBR): \_\_\_\_\_

H. NH's Address/Phone

Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

I. Payee Name Address/Phone

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

NH Under FRA and Entitled to RIB in Closed Year (Complete SSA-4281/SSA-4659)

DESK REVIEW

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II. NUMBER HOLDER

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A. Identity

Type of Interview     Face-to-Face     Telephone

B. Other Names and SSNs Shown in Claims Folder/Numident

1. Other                    \_\_\_\_\_

2. Other SSNs:            \_\_\_\_\_

C. Date of Birth/Citizenship

1. Date of Birth and Proof Code on MBR Printout:    \_\_\_\_\_

2. Place of Birth:        \_\_\_\_\_

3. MN:                    \_\_\_\_\_                    FN:                    \_\_\_\_\_

4. Applications Filed 12/1/96 or Later:     U.S. Citizen/National     Lawfully-Present Alien

5. Evidenc

/Documentation in Claims Folder/MCS Screens:

6. Evidence Needing Verificatio

:

7. Date of Birth Established by Desk Review:    \_\_\_\_\_

8. Citizenship/Alien Status Established by

esk Review:

Remarks:                \_\_\_\_\_

FACE-TO-FACE/TELEPHONE REVIEW

II. NUMBER HOLDER

Consolidated Review

A. Identity

1. Existence Verified by:

Observation     Photo ID \_\_\_\_\_

Other: \_\_\_\_\_

2. SSN Verified by:     SSN Card     Medicare Card

Other: \_\_\_\_\_

B. Other Names and SSN's Used

Number Holder Agrees With DR Summary

Number Holder Disagrees With DR Summary

(Explain) \_\_\_\_\_

C. Date of Birth and Citizenship/Alien Status

Number Holder Agrees With DR Summary

Number Holder Disagrees With DR Summary

(Explain) \_\_\_\_\_

Evidence Obtained in Field Review: \_\_\_\_\_

A. Identity

B. Other Names/SSN's

C. DOB and Citizenship/Alien

DESK REVIEW

II. NUMBER HOLDER

D. Application

1. Benefit Type:  RIB  DIB If DIB, Established Onset Date: \_\_\_\_\_

2. Date Claim Filed: \_\_\_\_\_

3. DOE (and MOEL Option Code if RIB): \_\_\_\_\_

4. DOE Determined by Desk Review: \_\_\_\_\_

Remarks: \_\_\_\_\_

E. Multiple Entitlement Involved

YES (Complete Below)  NO

1. Claim Number on Non-sampled SSN: \_\_\_\_\_

2. Scope of Review on Non-sampled SSN:

Full Review  Limited Review  Not in Scope of Review

F. Other Claims Activity

1. Did the NH ever file for any other benefits (including SSI)?

YES (Explain)  NO

\_\_\_\_\_

2. Does the NH have any eligible children who have not filed for benefits?

YES (Explain)  NO

\_\_\_\_\_

3. Unadjudicated Claims Issues:  NONE APPLY

Unprocessed Application

Deemed Filing

Protective Filing

Open Application

Partial Adjudication

Potential Entitlement (Leads)

Delayed Claim

Misinformation

(Explain) \_\_\_\_\_

FACE-TO-FACE/TELEPHONE REVIEW

II. NUMBER HOLDER	Consolidated Review
<p>D. Application</p> <p><input type="checkbox"/> Number Holder Agrees With DR Summary</p> <p><input type="checkbox"/> Number Holder Disagrees With DR Summary</p> <p>(Explain) _____</p>	<p>D. Application</p>
<p>E. Multiple Entitlement</p> <p><input type="checkbox"/> Number Holder Agrees With DR Summary</p> <p><input type="checkbox"/> Number Holder Disagrees With DR Summary</p> <p>(Explain) _____</p>	<p>E. Multiple Entitlement</p>
<p>F. Other Claims Activity</p> <p><input type="checkbox"/> Number Holder Agrees With DR Summary</p> <p><input type="checkbox"/> Number Holder Disagrees With DR Summary</p> <p>(Explain) _____</p>	<p>F. Other Claims Activity</p>

DESK REVIEW

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II. NUMBER HOLDER

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G. Underpayment on Sampled SSN Needed to Be Addressed

YES (Explain)  NO

\_\_\_\_\_

H. Recovery of Overpayment in Sample Month

YES (Explain)  NO

\_\_\_\_\_

I. SMI Determination

NOT APPLICABLE

The SMI determination, including the premium deduction and penalty amounts (if any), is correct.

YES  NO (Explain)

\_\_\_\_\_

J. Payment Amount

1. Amount of CMA/SM Check: \$ \_\_\_\_\_, Period: \_\_\_\_\_

2. Payment Cycle Indicator (CYI): \_\_\_\_\_

3. Payment Combined with Other Benefit:  YES  NO

4. Check Amount Affected by Other Withholding (e.g., Medicare C/D Premiums, Voluntary Tax Withholding, Garnishment, Treasury Offset Program, etc.):

YES (Explain)  NO

\_\_\_\_\_



FACE-TO-FACE/TELEPHONE REVIEW

II. NUMBER HOLDER

Consolidated Review

G. Underpayment

- Number Holder Agrees With DR Summary
- Number Holder Disagrees With DR Summary

(Explain) \_\_\_\_\_

H. Recovery of Overpayment in Sample Month

- Number Holder Agrees With DR Summary
- Number Holder Disagrees With DR Summary

(Explain) \_\_\_\_\_

I. SMI Determination

- Number Holder Agrees With DR Summary
- Number Holder Disagrees With DR Summary

(Explain) \_\_\_\_\_

J. Payment Amount

- Number Holder Agrees With DR Summary
- Number Holder Disagrees With DR Summary:

(Explain) \_\_\_\_\_

G. Underpayment

H. Overpayment

I. SMI Determination

J. Payment Amount

DESK REVIEW

II. NUMBER HOLDER

NUMBER HOLDER NEVER MARRIED

K. Marital History of Sampled Number Holder

1. Current/Last Marriage to: \_\_\_\_\_

a. Age/Date of Birth: \_\_\_\_\_

b. SSN: \_\_\_\_\_

c. Date of Marriage: \_\_\_\_\_

d. Type: \_\_\_\_\_

e. Place of Marriage: \_\_\_\_\_

f. How Terminated: \_\_\_\_\_

g. Date Terminated: \_\_\_\_\_

h. Place Terminated: \_\_\_\_\_

i. Evidence/Documentation in Claims Folder/MCS Screens: \_\_\_\_\_

j. Evidence Needing Verification: \_\_\_\_\_

2. Prior Marriage to: \_\_\_\_\_

a. Age/Date of Birth: \_\_\_\_\_

b. SSN: \_\_\_\_\_

c. Date of Marriage: \_\_\_\_\_

d. Type: \_\_\_\_\_

e. Place of Marriage: \_\_\_\_\_

f. How Terminated: \_\_\_\_\_

g. Date Terminated: \_\_\_\_\_

h. Place Terminated: \_\_\_\_\_

i. Evidence/Documentation in Claims Folder/MCS Screens: \_\_\_\_\_

j. Evidence Needing Verification: \_\_\_\_\_

3. Prior Marriage to: \_\_\_\_\_

a. Age/Date of Birth: \_\_\_\_\_

b. SSN: \_\_\_\_\_

c. Date of Marriage: \_\_\_\_\_

d. Type: \_\_\_\_\_

e. Place of Marriage: \_\_\_\_\_

f. How Terminated: \_\_\_\_\_

g. Date Terminated: \_\_\_\_\_

h. Place Terminated: \_\_\_\_\_

i. Evidence/Documentation in Claims Folder/MCS Screens: \_\_\_\_\_

j. Evidence Needing Verification: \_\_\_\_\_

FACE-TO-FACE/TELEPHONE REVIEW

II. NUMBER HOLDER

K. Marital History of Sampled Number Holder

Number Holder Agrees With Marital History in DR Summary

Number Holder Disagrees With DR Summary: (Complete Below)

1. Current/Last Marriage to: \_\_\_\_\_

a. Age/Date of Birth: \_\_\_\_\_

b. SSN: \_\_\_\_\_

c. Date of Marriage: \_\_\_\_\_

d. Type: \_\_\_\_\_

e. Place of Marriage: \_\_\_\_\_

f. How Terminated: \_\_\_\_\_

g. Date Terminated: \_\_\_\_\_

h. Place Terminated: \_\_\_\_\_

i. Evidence Obtained: \_\_\_\_\_

2. Prior Marriage to: \_\_\_\_\_

a. Age/Date of Birth \_\_\_\_\_

b. SSN: \_\_\_\_\_

c. Date of Marriage: \_\_\_\_\_

d. Type: \_\_\_\_\_

e. Place of Marriage: \_\_\_\_\_

f. How Terminated: \_\_\_\_\_

g. Date Terminated: \_\_\_\_\_

h. Place Terminated: \_\_\_\_\_

i. Evidence Obtained: \_\_\_\_\_

3. Prior Marriage to: \_\_\_\_\_

a. Age/Date of Birth: \_\_\_\_\_

b. SSN: \_\_\_\_\_

c. Date of Marriage: \_\_\_\_\_

d. Type: \_\_\_\_\_

e. Place of Marriage: \_\_\_\_\_

f. How Terminated: \_\_\_\_\_

g. Date Terminated: \_\_\_\_\_

h. Place Terminated \_\_\_\_\_

i. Evidence Obtained: \_\_\_\_\_

DESK REVIEW

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Consolidated Review: \_\_\_\_\_

DESK REVIEW

II. NUMBER HOLDER

L. Computation Information

1. Work Issues Explanation

Wages \_\_\_\_\_

Self-Employment \_\_\_\_\_

Lag Wages/SEI \_\_\_\_\_

Gaps \_\_\_\_\_

Annual Reports \_\_\_\_\_

Other \_\_\_\_\_

2. Military Service  NONE

a. Branch of Service: \_\_\_\_\_

b. Serial Number: \_\_\_\_\_

c. Dates of Active Military Duty After September 7, 1939:

From \_\_\_\_\_ To \_\_\_\_\_ ALG/PRV/PRE

From \_\_\_\_\_ To \_\_\_\_\_ ALG/PRV/PRE

d. If MS prior to 1957, NH Receives/Eligible for Military/Civilian Federal Pension?  YES  NO

e. Evidence/Documentation in Claims Folder/MCS Screens: \_\_\_\_\_

f. Evidence Needing Verification: \_\_\_\_\_

3. Railroad Employment  NONE

a. Number of Service Months on Earnings Record: \_\_\_\_\_

b. Were 5 or more years of railroad work alleged?  YES  NO

4. Prior Period of Disability  NONE

a. PPD Shown on MBR: Date of Onset: \_\_\_\_\_ Term Date: \_\_\_\_\_

b. Documentation in File: \_\_\_\_\_

c. PPD Established by Desk Review: Date of Onset: \_\_\_\_\_ Term Date: \_\_\_\_\_

FACE-TO-FACE/TELEPHONE REVIEW

II. NUMBER HOLDER	Consolidated Review									
<p>L. Computation Information</p> <p>1. Work Issues</p> <p><input type="checkbox"/> Number Holder Agrees With DR Summary _____</p> <p><input type="checkbox"/> Number Holder Disagrees With DR Summary:</p> <table><thead><tr><th>Year</th><th>Amount on E/R</th><th>Amount Alleged</th></tr></thead><tbody><tr><td>_____</td><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td><td>_____</td></tr></tbody></table> <p><input type="checkbox"/> Evidence Obtained in Field Review: _____</p> <p>2. Military Service</p> <p><input type="checkbox"/> Number Holder Agrees With DR Summary</p> <p><input type="checkbox"/> Number Holder Disagrees With DR Summary: (Explain) _____</p> <p><input type="checkbox"/> Evidence Obtained in Field Review: _____</p> <p>3. Railroad Employment</p> <p><input type="checkbox"/> Number Holder Agrees With DR Summary</p> <p><input type="checkbox"/> Number Holder Disagrees With DR Summary: (Explain) _____</p> <p>4. Prior Period of Disability</p> <p><input type="checkbox"/> Number Holder Agrees With DR Summary</p> <p><input type="checkbox"/> Number Holder Disagrees With DR Summary: (Explain) _____</p>	Year	Amount on E/R	Amount Alleged	_____	_____	_____	_____	_____	_____	<p>L. Computation Information</p> <p>1. Work Issues</p> <p>2. Military Service</p> <p>3. RR Employment</p> <p>4. Prior Period(s) of Disability</p>
Year	Amount on E/R	Amount Alleged								
_____	_____	_____								
_____	_____	_____								

DESK REVIEW

II. NUMBER HOLDER

L. Computation Information

5. Windfall Elimination Provision

COMPLETE IF NUMBER HOLDER BORN JANUARY 2, 1924 OR LATER

a. NH has 30 or More Special Minimum Coverage Years.

YES (Go to II.M.)                       NO

b. NH is Entitled to a Foreign or Domestic Pension, or Lump Sum in Lieu of a Monthly Periodic Pension, Based on Work After 1956 Not Covered by Social Security.

YES     NO (Go to II.M.)

(1) Date of First Eligibility to Pension (Month/Year): \_\_\_\_\_

(2) Date of First Entitlement to Pension (Month/Year): \_\_\_\_\_

(If either date is prior to 1986, go to 5.d.)

(3) Other Exception to WEP Applies:  YES \_\_\_\_\_  NO  
(If Yes, go to 5.d.)

c. Information About the Pension

(1) Agency or Organization from Which the Pension Is Received:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

(2) Period(s) of Employment Upon Which the Pension Is Based (Include Both Employment Covered and Not Covered by Social Security):

From (Month, Year): \_\_\_\_\_ To (Month, Year): \_\_\_\_\_

From (Month, Year): \_\_\_\_\_ To (Month, Year): \_\_\_\_\_

(3) Period(s) of Employment After 1956 Not Covered by Social Security That Is Used to Determine the Pension:

From (Month, Year): \_\_\_\_\_ To (Month, Year): \_\_\_\_\_

From (Month, Year): \_\_\_\_\_ To (Month, Year): \_\_\_\_\_

(4) Amount of the Pension for the First Month the Claimant is Concurrently Entitled to the Pension and the Social Security Benefit:

Monthly Amount: \$ \_\_\_\_\_ (Obtain proof if guarantee applies.)

d. Evidence/Documentation in Claims Folder/MCS Screens: \_\_\_\_\_

e. Evidence Needing Verification: \_\_\_\_\_



FACE-TO-FACE/TELEPHONE REVIEW

II. NUMBER HOLDER

Consolidated Review

L. Computation Information

L. Computation Information.

5. Windfall Elimination Provision

5. WEP

Number Holder Agrees With DR Summary

Number Holder Disagrees With DR Summary:

(Explain) \_\_\_\_\_

Evidence Obtained in Field Review: \_\_\_\_\_

DESK REVIEW

II. NUMBER HOLDER

M. Current DIB Entitlement

NOT APPLICABLE (Go to II.N.)

1. Period(s) of Disability

a. Current Established Onset Date: \_\_\_\_\_

b. Date of Entitlement: \_\_\_\_\_

c. Prior Period of DIB:  YES (Complete Below)

NO

Effect on Current Entitlement:  Waiting Period  Comps  Medicare  Other

2. Disability-Related Work Information

a. Earnings After Current Established Onset Date:  YES (Complete Below)  NO

b. Disability-Related Work Issues

Explanation

Trial Work Period \_\_\_\_\_

Substantial Gainful Activity \_\_\_\_\_

Unsuccessful Work Attempt \_\_\_\_\_

Cessation \_\_\_\_\_

Extended Period of Eligibility \_\_\_\_\_

Termination \_\_\_\_\_

Expedited Reinstatement \_\_\_\_\_

Other \_\_\_\_\_

c. Evidence/Documentation in File: \_\_\_\_\_

d. Evidence Needing Verification: \_\_\_\_\_

FACE-TO-FACE/TELEPHONE REVIEW

II. NUMBER HOLDER

Consolidated Review

M. Current DIB Entitlement

M. Current DIB Entitlement

1. Period(s) of Disability

1. Period(s) of Disability

Number Holder Agrees With DR Summary

Number Holder Disagrees With DR Summary

(Explain) \_\_\_\_\_

2. Disability-Related Work Information

2. Disability-Related Work Info

Number Holder Agrees With DR Summary

Number Holder Disagrees With DR Summary

(Explain) \_\_\_\_\_

Evidence Obtained in Field Review: \_\_\_\_\_

FACE-TO-FACE/TELEPHONE REVIEW

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II. NUMBER HOLDER

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3. Worker's Compensation/Public Disability Benefit (WC/PDB)

a. NH Filed for WC/PDB:  YES  NO (Go to II.M.4)

b. Status of Claim:  Awarded (Complete Below)  Denied  Pending

c. Employer Name and Address Payer Name and Address

\_\_\_\_\_

d. Describe Type of Payments Received: \_\_\_\_\_

e. WC/PDB Affects Review Period Payment:  YES  NO

(Explain) \_\_\_\_\_

f. Documentation in Claims Folder/MCS Screens: \_\_\_\_\_

g. Evidence Needing Verification: \_\_\_\_\_

4. Child-Care Dropout (Less than 3 Regular Drop-Out Yrs):  YES  NO (Go to II.N)

a. Child Under Age 3 Lived With NH During a Year That NH Had No Earnings:

YES  NO

b. Documentation in Claims Folder/MCS Screens: \_\_\_\_\_

c. Evidence Needing Verification: \_\_\_\_\_

FACE-TO-FACE/TELEPHONE REVIEW

II. NUMBER HOLDER	Consolidated Review
<p>3. Worker's Compensation/Public Disability Benefit (WC/PDB)</p> <p><input type="checkbox"/> Number Holder Agrees With DR Summary</p> <p><input type="checkbox"/> Number Holder Disagrees With DR Summary: (Explain) _____</p>          <p><input type="checkbox"/> Evidence Obtained in Field Review: _____</p>	<p>3. WC/PDB</p>
<p>4. Child-Care Dropout Years</p> <p><input type="checkbox"/> Number Holder Agrees With DR Summary</p> <p><input type="checkbox"/> Number Holder Disagrees With DR Summary: (Explain) _____</p>          <p><input type="checkbox"/> Evidence Obtained in Field Review: _____</p>	<p>4. Child-Care Dropout</p>

DESK REVIEW

II. NUMBER HOLDER

N. Fugitive Felon

a. Are there any unsatisfied felony warrants for NH's arrest or for violations of probation/parole?

YES  NO (Go to II.O)

b. Evidence/Documentation in Claims Folder/MCS Screens: \_\_\_\_\_

c. Evidence Needing Verification: \_\_\_\_\_

O. Criminal Activities

NH Not Involved in Any Criminal Activities Listed Below

Removal (formerly Deportation)  Subversive Activities

Offenses Against the National Security (Hiss Act)  Confined for a Criminal Offense

Disability Determination Based on a Condition That Occurred During the Commission of a Felony After October 19, 1980

Disability Determination Based on a Condition That Occurred During Confinement for a Felony Conviction

Evidence/Documentation in Claims Folder/MCS Screens: \_\_\_\_\_

Evidence Needing Verification: \_\_\_\_\_

P. Representative payee

Does the claims folder indicate an unresolved representative payee issue (need for payee change, etc.) for the sampled number holder?

YES (Explain)  NO

FACE-TO-FACE/TELEPHONE REVIEW

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\_\_\_\_\_

FACE-TO-FACE/TELEPHONE REVIEW

II. NUMBER HOLDER

Consolidated Review

N. Fugitive Felon

NH states/desk review summary shows that there are no unsatisfied felony warrants for arrest or for violations of probation/parole.

YES  NO (Explain)

\_\_\_\_\_

Evidence Obtained in Field Review: \_\_\_\_\_

O. Criminal Activities

If any of the criminal activities listed in II.O. of the desk review summary are involved, discuss and resolve below.

\_\_\_\_\_

P. Representative Payee

There is an indication that an unresolved representative payee issue exists (need for payee change, etc.) for the sampled number holder.

YES (Explain)  NO

\_\_\_\_\_

N. Fugitive Felon

O. Criminal Activities

P. Representative Payee



CASE SUMMARY

II. NUMBER HOLDER

Q. Consolidated Review Summary

- Desk and field review findings are in agreement.
- Desk and field review findings are not in agreement. Indicate the section(s) where the disagreement exists.

- |                                    |                                    |                                    |                                    |
|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Section A | <input type="checkbox"/> Section B | <input type="checkbox"/> Section C | <input type="checkbox"/> Section D |
| <input type="checkbox"/> Section E | <input type="checkbox"/> Section F | <input type="checkbox"/> Section G | <input type="checkbox"/> Section H |
| <input type="checkbox"/> Section I | <input type="checkbox"/> Section J | <input type="checkbox"/> Section K | <input type="checkbox"/> Section L |
| <input type="checkbox"/> Section M | <input type="checkbox"/> Section N | <input type="checkbox"/> Section O | <input type="checkbox"/> Section P |

Additional Development/Findings/Remarks:

\_\_\_\_\_

Signature of Reviewer(s)

\_\_\_\_\_  
Desk Reviewer

Date: \_\_\_\_\_

\_\_\_\_\_  
Field Reviewer

Date: \_\_\_\_\_

\_\_\_\_\_  
Consolidated Reviewer

Date: \_\_\_\_\_