Form Approved
OMB No. 0960-0189

RSI/DI QUALITY REVIEW CASE ANALYSIS — PARENT

NOTE TO REVIEWER: In opening the interview, ask if the beneficiaries received an appointment letter. If the letter was not received, show the beneficiaries a copy of the letter. Explain that this case is one of a small number collected by chance for review, and that the purpose of this review is to find out how well the social security program is working. Stress that this case was not selected because there was any question about it. Tell them that the review consists of asking questions about their entitlement to social security benefits and that we 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.

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 20 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.

I. IDENTIFYING AND REVIEW INFORMATION

A. SIC: ________________________ B. NH's SSN: ________________________

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

D. Review Amount on SCL: $ ________________________

E. SSI Offset Involved in Determining the Sample Dollars ☐ YES ☐ NO

F. Review Amount Determined by QR: $ ________________________

G. Explanation of SCL, Changes, if Any: ________________________

____

H. NH's Name (As Shown on MBR): ________________________

I. Beneficiary in Scope of Review

1. BIC ____________

2. Name: ________________________

   Address: ________________________

   ____

   Phone: (______) ____________________

3. Representative Payee

   Name: ________________________

   Address: ________________________

   ____

   Phone: (______) ____________________

II. PARENT

A. Identity

1. Name: ____________ 2. SSN (BOAN) ____________

B. Other Names and Corresponding SSN's Shown in Claims Folder/Numident

1. Other Names: ____________ ____________

2. Other SSNs: ____________ ____________

C. Application

1. Date Claim Filed: ____________

2. DOE and MOEL Option Code: ____________ ____________

3. Was the beneficiary previously entitled to benefits (including SSI) on this or any other SSN?

☐ YES (Explain) ☐ NO

____

____

4. Unresolved Claims Issues: ☐ NONE APPLY

☐ Unprocessed Application ☐ Deemed Filing

☐ Protective Filing ☐ Open Application

☐ Partial Adjudication ☐ Potential Entitlement (Leads)

☐ Delayed Claim ☐ Totalization

Explain: ____________

____

5. Month Of Entitlement Determined by Desk Review: ____________

D. Multiple Entitlement Involved

☐ YES (Complete Below) ☐ NO

1. Claim Number on Nonsampled SSN: ____________

Remarks:

FIELD/TELEPHONE REVIEW

II. PARENT

A. Identity

1. Existence Verified by:

☐ Observation ☐ Other: ______

2. SSN Verified by: ☐ SS Card ☐ Medicare Card

☐ Other: ______

B. Other Names and SSN's Used in Reporting Earnings

☐ Beneficiary Agrees With DR Summary

☐ Beneficiary Disagrees With DR Summary:

(Explain) ______

C. Application

☐ Beneficiary Agrees With DR Summary

☐ Beneficiary Disagrees With DR Summary:

(Explain) ______

D. Multiple Entitlement Involved

☐ Beneficiary Agrees With DR Summary

☐ Beneficiary Disagrees With DR Summary.

(Explain) ______

Consolidated Review

A. Identity

B. Other Names/SSN's

C. Application

D. Multiple Entitlement

II. PARENT

E. Recovery of Prior Overpayment in Sample Month/Review Period

☐ YES (Complete Below) ☐ NO

Total Amount of Overpayment: $ ____________________

F. Prior Underpayment on Sampled SSN Needed to Be Addressed

☐ YES (Explain) ☐ NO

____

G. Payment Amount(s)

1. Amount of PMA Check: $____________ , for Period(s): ____________________
2. Amount of CMA/SM Check: $ ____________ , for Period: ____________________
3. Payment Combined with Other Benefit

   ☐ YES ☐ NO

H. Date of Birth

1. Date of Birth and Proof Code on MBR Printout: ____________ ____________
2. Evidence/Documentation in Claims Folder/MCS Screens: ____________________
3. Evidence Needing Verification: ____________________
4. Date of Birth Established by Desk Review: ____________________

I. Parent's Relationship

1. Type: ____________________
2. Support Period: ____________________
3. Parent's Income: ____________________
4. NH's Contributions: ____________________
5. 1/2 Support Determination in Claims Folder

   ☐ YES ☐ NO

6. Evidence Documentation in Claims Folder/MCS Screens: ____________________
7. Evidence Needing Verification: ____________________

FIELD/TELEPHONE REVIEW

II. PARENT

E. Recovery of Prior O/P in SM/Review Period

☐ Beneficiary Agrees With DR Summary

☐ Beneficiary Disagrees With DR Summary

(Explain) ______________________________

____

F. Prior Underpayment on Sampled SSN

☐ Beneficiary Agrees With DR Summary

☐ Beneficiary Disagrees With DR Summary

(Explain) ______________________________

G. Payment Amount(s)

☐ Beneficiary Agrees With DR Summary

☐ Beneficiary Disagrees With DR Summary

(Explain) ______________________________

____

H. Date of Birth

☐ Beneficiary Agrees With DR Summary

☐ Beneficiary Disagrees With DR Summary

(Explain) ______________________________

____

Evidence Obtained in Field Review: ______________________________

____

I. Parent's Relationship

☐ Beneficiary Agrees With DR Summary

☐ Beneficiary Disagrees With DR Summary

(Explain) ______________________________

____

Evidence Obtained in Field Review: ______________________________

____

Consolidated Review

E. Recovery of Prior Overpayment in SM/Review Period

F. Prior U/P on Sampled SSN

G. Payment Amount(s)

H. Date of Birth

I. Parent's Relationship

II. PARENT

J. Marital History of Parent

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:
   ____

4. Is the parent's spouse a title II beneficiary?

   ☐ YES (Spouse's SSN: ____________ ☐) NO

II. PARENT

J. Marital History of Parent

☐ Beneficiary Agrees With Marital History in DR Summary

☐ Beneficiary 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: ____________________

Consolidated Review:

II. PARENT

K. SMI Determination

☐ NOT APPLICABLE

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

☐ YES ☐ NO (Explain)

L. Misinformation/Contact With SSA Prior to Date Claim Filed

Would it have been to the beneficiary's advantage to file for benefits at an earlier date?

☐ YES (Explain) ☐ NO

M. Criminal Activities

☐ Parent Beneficiary Not Involved in Any Criminal Activities Listed Below

☐ Homicide of NH

☐ Subversive Activities

☐ Deportation

☐ Imprisonment for a Felony

☐ Offenses Against the National Security (Hiss Act)

☐ Beneficiary Entitled on Basis of His Own Disability and that Disability Appears to Have Occurred or Was Aggravated by the Commission of a Felony After October 19, 1980, and for which the Person Was Convicted

Evidence Needing Verification ______

N. Representative payee

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

☐ YES (Explain) ☐ NO

FIELD/TELEPHONE REVIEW

II. PARENT

K. SMI Determination

☐ Beneficiary Agrees With DR Summary

☐ Beneficiary Disagrees With DR Summary:

(Explain) ______________________

____

____

L. Misinformation/Contact With SSA Prior to Date Claim Filed

If II.L. of the desk review summary is answered YES, did the beneficiary inquire about filing at an earlier time but did not file because of misinformation provided by SSA?

(Explain) ______________________

____

____

M. Criminal Activities

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

____

____

____

N. Representative Payee

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

☐ YES (Explain) ☐ NO

____

____

____

____

Consolidated Review

K. SMI Determination

L. Misinformation/Contact With SSA Prior to DCF

M. Criminal Activities

N. Representative Payee

II. PARENT

O. 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.

☐ Section A	☐ Section B	☐ Section C	☐ Section D
☐ Section E	☐ Section F	☐ Section G	☐ Section H
☐ Section I	☐ Section J	☐ Section K	☐ Section L
☐ Section M	☐ Section N		

Additional Development/Findings/Remarks:

Signature of Reviewer(s):

Date:

Desk Reviewer

Date:

Field Reviewer

Date:

Consolidated Reviewer