

SUPPLEMENTAL SECURITY INCOME - QUALITY REVIEW CASE ANALYSIS

SSN:	State of Residence:	SM: Title XVI Stewardship
ES SSN:	AIPQB: SSA-FO code:	Case Excluded? <input type="checkbox"/> Yes <input type="checkbox"/> No Exclusion code:

SSR DOCUMENTATION

FIELD REVIEW DOCUMENTATION

1. Name of Sampled Individual

2. Residence Address/Telephone number

3. Mailing Address

4. Material Individual(s) None
- | | |
|---|--|
| <input type="checkbox"/> Payee | <input type="checkbox"/> Ineligible Spouse |
| <input type="checkbox"/> Eligible spouse | <input type="checkbox"/> Parent(s) |
| <input type="checkbox"/> Spouse of Parent | <input type="checkbox"/> Ineligible Child |
| <input type="checkbox"/> Alien Sponsor/spouse | <input type="checkbox"/> Essential Person |

5. Name(s) of MI(s)

6. Address same as SI? Yes No

7. Federal BM

8. State BM

9. Last Effective RZ/LI

1. Interview Date

2. SI's Existence Verified by

- Direct observation
 Other

3. MI(s) listed contacted

- Yes No, Explain

4. Address/Telephone entries correct on SSR

- Yes No (provide correct address)

Residence Address/Telephone Number

Mailing Address

5. Others Contacted: Legal Guardian

Institutional Officer

Interpreter Assistant

6. Federal BM

7. State BM

8. CFR not requested as the only deficiency is recipient caused and information obtained during the review clearly shows deficiency occurred after last official contact and no pertinent data could be obtained by reviewing the casefile.

SYSTEMS

SI/MI INTERVIEW

1. SSN

SI:

ES:

Verified:

- Allegation/evidence agrees with SSR
- Different or additional SSN/names found _____
- Evidence viewed:**
- SSN card Medicare card Photo Identification
- Other _____

2. AGE
CITIZENSHIP/
LEGAL ALIEN
STATUS/IDENTITY

Date of Birth

SI:

ES:

BIC

SI:

ES:

AR CODE

SI:

ES:

Allegation	SI	ES
Name on Record		
Date of Birth		
Place of Birth		
Parents Names	Mth: Fth:	Mth: Fth:
Type of Evidence		
Issuing Agency		
ate Recorded		
Date/Place Issued		
Alien Status		
U.S. Entry Date		
Port of Entry		
Country of Origin		
Alien Reg. # / Class code		
Card Expiration Date		

VERIFICATION

CONCLUSION

- SSN verified via SSN card/Medicare card
- SSN verified via systems query (in file)
Issue date _____

- No SSN discrepancy
- Multiple SSNs found but payment not affected
- S/ES receiving SSI under incorrect or multiple SSN
See: _____

- Allegation accepted. Age is not material.
- Age verified via numident (IDN code of P is indicated)
- Age verified via Title II claim.
MBR proof of age
- Age Verified-other

- Allegation of Age Accepted
- Age Verified
- Does not meet age requirement

- Allegation of Citizenship by U.S. birth accepted
 - Citizenship/Alien status verified? Yes No
Type of verification
 - Collateral Contact Made
- | | |
|------------|--|
| Type/date | |
| Place | |
| Name/Title | |
| Findings | |

- Citizenship/ Legal Alien Status requirement met
- U.S. born
- Naturalized
- Alien
- Refugee
- Other
- Does not meet Citizenship/Alien Status

3. MARITAL STATUS CODE:

Marital History: (including parents of minor child) None

Spouse Shown:

No Yes

Name:

Parents Shown:

No Yes

Names:

Spouse or Parents	Name	SSN <i>if SSN is unknown, provide DOB/POB/mothers maiden name</i>	Event	Date
<input type="checkbox"/> Spouse <input type="checkbox"/> Parents			<input type="checkbox"/> Married <input type="checkbox"/> Divorce <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
<input type="checkbox"/> Spouse <input type="checkbox"/> Parents			<input type="checkbox"/> Married <input type="checkbox"/> Divorce <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
<input type="checkbox"/> Spouse <input type="checkbox"/> Parents			<input type="checkbox"/> Married <input type="checkbox"/> Divorce <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
<input type="checkbox"/> Spouse <input type="checkbox"/> Parents			<input type="checkbox"/> Married <input type="checkbox"/> Divorce <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	

Evidence Viewed

Contributions from current or prior spouse? Yes No
If yes, indicate name of spouse and amount of contribution

Entitlement for benefits from spouse/former spouse? Yes No
If yes, indicate Name and SSN, or DOB if SSN is unknown

Does SI live with an unrelated member of the opposite sex? Yes No
If yes, provide the following information

Name	Alleged Relationship

If Disabled, Date SI first became disabled
Note: This may not be the same date as that established on the SSR

Name SSN's/ID info for parents either disabled, deceased or age 62 or over.
If SSN is unknown, provide DOB/POB/Mother's Maiden name

Mother	Father

VERIFICATION

CONCLUSION

Allegation agrees with SSR - no reason to doubt.

Documentary evidence viewed.

Collateral contact made:

Type/Date	
Place	
Name Title	
Findings	

Holding out: Established
 Not established

See SSA-795s/4178s in file

Other evidence

Potential Title II Entitlement established:

Name	
SSN	
Type	

During review period SI had:

No living with spouse

Eligible spouse

Ineligible spouse

No living with parents

Eligible parent(s)

Ineligible parent(s)

Potential T2 Entitlement Referral:

Yes No

SYSTEMS

SI/MI INTERVIEW

4. LA/ISM
(Non Household)

NA

Facility Name/Address	
Facility Representative Name/Title	
Type of Contact/Date	

CG:

FEDERAL LA
CODES:

Date of Admissions to the review period facility

Did the SI actively participate in the interview? Yes No

STATE LA CODES:

Is the SI currently residing in the facility? Yes No
If not, date of release from the review period facility

STATE/COUNTY:

INSTITUTIONAL

NON-INSTITUTIONAL CARE

- Public
- Private - profit
- Private - nonprofit
- Penal
- Medical care
- Non-medical care
- Publicly operated community residence
- Public emergency Shelter

- Adult foster care
- Child foster care
- Other

Facility
Precedent:

No Yes

Absence/Multiple Residences:

Dates	From	To

VERIFICATION

CONCLUSION

NA

Interview/contact with facility representative established the following:

INSTITUTION

SI was institutionalized (Date)	
Amount of Payment for Room and Board	\$
Other Third Party Source/Amount	\$

- Medicaid
 SI's own income
 Amount:\$
 Tax-Exempt organization (Church-Key Amendment applies)
 Payment Excluded? Yes No

NON-INSTITUTION

SI was in Non-institution care (Date)	
Facility license number/expiration date	
Amount of Room and Board	\$
Other third Party Source/Amount	\$

Total Cost: \$

- SI's Own Income: Amount
 \$
 Foster Care Amount
 \$
 Other Third Party (provide source and amount)

Other Contact made

Type/Date	
Name/Title	
Place	
Findings	

- INSTITUTIONAL CARE
 Public medical
 Private medical

Substantial Medicaid?
 Yes No

Public or private educational/vocational/technical

Publicly operated community residence

Private nonprofit residential care

Proprietary for profit residential care, educational or vocational training facility

Public emergency shelter

Public correctional/holding facility

NONINSTITUTIONAL CARE

State living arrangement:

ISM

U.S./State residency requirement:

Met Not Met

LA/ISM deficiency:
 Yes No

5. LA/ISM
(Household/
Transient)
- CG
Entries:
- LA 0
(Sharing \$_____)
- LA 20 (Rent)
- LA 22 (PA)
- LA 23 (VTR)
- LA 24 (Room)
- LA _____
- Other _____

Federal LA Codes:

State LA Codes:

State/County Codes:

J/H Income:

Household Members

Name	Relationship to SI	Age	PA income type/SSN

RENTAL LIABILITY/HOME OWNERSHIP

Does SI live alone	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does SI (or living w/spouse) have home ownership interest?	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount of Mortgage: \$
Does SI have rental liability?	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount of Rental payment \$
Provide the name/address/telephone number of the landlord →	
Is the landlord related to any household member as a parent or child? →	<input type="checkbox"/> Yes, (to whom and how?) <input type="checkbox"/> No
Does SI live in a residence owned or rented by a non-resident of SI's household?	<input type="checkbox"/> Yes (provide name) → <input type="checkbox"/> No
Name of person in SI's household with rental liability, if any and amount of payment →	

SI/ES DO NOT HAVE HOME OWNERSHIP INTEREST OR RENTAL LIABILITY

Is SI a Transient	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is SI a child living in parents HH?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is SI in an all PA household?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does SI purchase/consume food separately?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Amount of Shelter Contribution, if any →	\$
Does SI Contribute towards the total HH expenses in a sharing arrangement?	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount of contribution \$
Does SI Earmark Contribution towards the food and/or shelter expense?	<input type="checkbox"/> Yes <input type="checkbox"/> No Food\$ Shelter\$
SI lives with others and makes no contribution towards the HH expenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are services required by owner?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SI/MI HOUSEHOLD INTERVIEWS

Average Household Expenses

Type	Amount (\$)	Description of Evidence
Food		
Rent		
Mortgage (including property Insurance)		
Property Tax (Yr/Monthly amount)		
Heating/Fuel		
Gas		
Electricity		
Water		
Sewer		
Garbage Removal		
TOTAL		

Above Averages are for:

If SI or living w/spouse has ownership interest or rental liability, what is the amount of contributions from other HH members if any?

\$

Does SI receive contributions from outside the HH? Yes No

If yes, provide the following:

Name/Address/Telephone of person that SI is receiving contributions from (SSA 795 in file)	Amount
	\$

Does SI receive a housing subsidy? If so, what is the source of the subsidy →	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
What is the amount of the subsidy, if known? →	
What is the length of time at the review period residence? →	
Last date SI/ES was out of the U.S.	

Temporary absence by SI or any HH member	
--	--

SI/MI HOUSEHOLD INTERVIEWS

Has the SI resided at the current residence address for the entire review period? Yes No
If not, complete the applicable living arrangement changes below:

Changes in household composition in review period:

Changes in household expenses in review period:

Changes in LA in review period:

VERIFICATION

CONCLUSION

LA/ISM/Residency established during interview with SI/other household members.

Collateral sources contacted

Name/Telephone #	
Date	
Type of contact	
Findings	

SSA 795 in file pertaining to HH expenses

Bills/Receipts of HH expenses were requested for the past 12 months, but were not available

Bills/Receipts were available for

QRA Determination

Number of HH members	
Total HH Expenses	
SI's Pro-rata share	
SI's Contribution	
Other HH Member's Contribution	
Inside ISM (including VTR)	
Outside ISM	

LA/ISM FOR:

Review Period Month	Living Arrangement	ISM \$
CM		
IM		
BM		

Last Date SI/ES outside U.S.

Basis for Federal LA

Home ownership:
Title
Life estate
Unprobated estate
Trust

Rental liability
Rent \$ _____
CMRV \$ _____
Flat fee \$ _____
Room rental
Commercial establishment
Non-commercial

PA household

Separate consumption
 Separate purchase

Sharing

Earmarked sharing food/shelter

Transient

Intervening A

VTR applies

Child who lives in household with parent, and who is not subject to VTR

Basis for State LA: _____

Inside ISM: \$ _____

Outside ISM: \$ _____

U.S./State Residency

Requirement:

Met Not Met

LA/ISM deficiency:

No Yes

SYSTEMS

SI/MI INTERVIEW

6. UNEARNED INCOME

NOTE: Only BM allegations need be shown if no income changes are alleged for review period.

SI Allegation	CM	IM	BM	MI Allegation	CM	IM	BM
Title XVI	\$	\$	\$	Title XVI	\$	\$	\$
Title II	\$	\$	\$	Title II	\$	\$	\$
VA Pension	\$	\$	\$	A Pension	\$	\$	\$
VA Compensation	\$	\$	\$	VA Compensation	\$	\$	\$
Railroad Retirement	\$	\$	\$	Railroad Retirement	\$	\$	\$
Govt. Pension	\$	\$	\$	Govt. Pension	\$	\$	\$
Black Lung	\$	\$	\$	Black Lung	\$	\$	\$
State Disability Payments	\$	\$	\$	State Disability Payments	\$	\$	\$
Foster Care	\$	\$	\$	Foster Care	\$	\$	\$
Energy Assistance	\$	\$	\$	Energy Assistance	\$	\$	\$
Unemployment Compensation	\$	\$	\$	Unemployment Compensation	\$	\$	\$
Workers Comp	\$	\$	\$	Workers Comp	\$	\$	\$
Sick P y	\$	\$	\$	Sick Pay	\$	\$	\$
Education Assistance	\$	\$	\$	Education Assistance	\$	\$	\$
Dividends/Royals	\$	\$	\$	Dividends/Royals	\$	\$	\$
Rental Income	\$	\$	\$	Rental Income	\$	\$	\$
Interest	\$	\$	\$	Interest	\$	\$	\$
Gifts	\$	\$	\$	Gifts	\$	\$	\$
Loans	\$	\$	\$	Loans	\$	\$	\$
Support from absent parent	\$	\$	\$	Support from absent parent	\$	\$	\$
Other Cash Support	\$	\$	\$	Other Cash Support	\$	\$	\$
Gambling Income	\$	\$	\$	Gambling Income	\$	\$	\$
Miscellaneous	\$	\$	\$	Miscellaneous	\$	\$	\$

Title XVI

SI:

Fed:

State:

CM:

IM:

BM:

Retro:

MI:

CM:

IM:

BM:

Retro:

Title II

SI:

CM:

IM:

BM:

Retro:

MI:

CM:

IM:

BM:

Retro:

Other

SI:

CM:

IM:

BM:

Retro:

MI:

CM:

IM:

BM:

Retro:

1099 ALERT:

Title XVI Recoup:

Evidence Viewed:

VERIFICATION

CONCLUSION

FINDINGS

- Title XVI Title II RRB Black Lung
 VA OPM Verified by SSR - no reason to doubt
 Verified by award letter or other evidence in SI's possession
 Collateral Contact Made

Type/Date			
Name/Title/Organization			
Income/Income Exclusion established			
Amounts	CM: \$	IM: \$	BM:\$

Type/Date			
Name/Title/Organization			
Income/Income Exclusion established			
Amounts	CM: \$	IM: \$	BM:\$

- Interest income, see Element 8.

CM	\$
IM	\$
BM	\$

- Ineligible child with unearned income

Name of Child			
Source of Income			
Type of Income			
Verified by			
Amounts	CM: \$	IM: \$	BM: \$

- Excluded court ordered support payments made by ineligible spouse/parent

- Unstated income suspected/confirmed:

- Unearned income did not cause an error in the sampled payment.

- The following unearned income amount caused a payment error:
\$ _____

- Type R/Type S income received by SI/ES in budget month:

- Unearned income exclusion applies to SI/ES's budget month income:

- Deeming applies

**7. WORK HISTORY
EARNED INCOME**

Last date of employment: SI _____ MI _____
 Employment history for 3 yrs. ending with sample month:

Sampled Individual

Employer Name/Address or Self Employment	Dates

Material Individual

Employer Name/Address or Self Employment	Dates

Review Period	Earnings

Earned Income Exclusions? None

- Work expenses of BWE IRWE Student child earned income
- PASS Cafeteria Plan
- Court Ordered Payments

Type	
Amount	
Frequency	
Source	

Employment history prior to last 3 years

Employer Name/Address or Self Employment	Dates

Does the SI have a Union membership? →	<input type="checkbox"/> Yes (union ID) <input type="checkbox"/> No
Does the SI have Military Service?	<input type="checkbox"/> Yes (dates of service) <input type="checkbox"/> No
Does the SI have a pending claim/prior denial for benefits based on work/military services? →	<input type="checkbox"/> Yes (explain) <input type="checkbox"/> No

VERIFICATION

CONCLUSION

- Potential entitlement not suggested by SI/MI's allegations, no reason to doubt.
- Potential entitlement suggested:
 - Title II/VA - made referral to file
 - Collateral contact below - made referral to file
 - Ruled out by development in file

Collateral contact made:

Source			
Type			
Date			
Findings	CM: \$	IM: \$	BM:\$

- No earned income alleged, no reason to doubt.
- Earned income established:
 - See employer contact in file.
 - See summary of SI/MI's records.
 - See SSA-795
 - See summary/copy of other business record in file.

Gross wages:

CM	\$
IM	\$
BM	\$

Net Earnings from Self-Employment

Amount	\$
Year	

Earned Income Exclusions Established:

Type	
Amount/frequency	
Established by	

Ineligible Child with Earnings

Name			
Amount	CM \$	IM \$	BM \$
Verified by			

- No potential entitlement to other benefits
- Potential entitlement established for: _____
- No earned income in the review period
- Review period earnings - no payment error
- Earned income caused payment error: \$ _____
- No earned income exclusions apply
- Following earned income exclusions apply:
- Deeming applies

8. LIQUID RESOURCES

Direct Deposit
BCR:
BCA:
Name:

1099 Alert:

CG Entries:

- RE01 SV
- RE04 CK
- RE08 CD
- RE21 Svgs Bds
- RE_____

Allegations	SI	MI
Patient Account	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Checking account	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Savings account	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Credit Union	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Oth. Bank accts (Christmas club, etc).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
CD	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Savings Bonds	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Promissory Notes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stocks/Bonds	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mutual Funds	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prepaid burial plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Safe Deposit	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trusts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
401(k) plans/Keough accts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
LI Dividend Accumulations	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cash on hand →	CM:\$	CM:\$
	IM: \$	IM: \$
	BM:\$	BM:\$

Positive Allegation

Account Type/ Account Number	Financial Institution	Balances (\$)	Owner Name
			<input type="checkbox"/> SI <input type="checkbox"/> MI
			<input type="checkbox"/> SI <input type="checkbox"/> MI
			<input type="checkbox"/> SI <input type="checkbox"/> MI
			<input type="checkbox"/> SI <input type="checkbox"/> MI

SSI Direct Deposit T2 Direct Deposit

Check Cashing Location, if no Direct Deposit alleged	
If SI/MI do not have SSN, Provide the Tax ID Number (TID)	
Is SI/MI's name on anyone else's bank account? If so, provide name	
Prior accounts in the last 24 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, show FI name and location):
Place where funds are kept for burial <input type="checkbox"/> NA	
Other financial institutions used to transact business i.e., personal loans, mortgages	
Deposits made by joint owner?	<input type="checkbox"/> Yes <input type="checkbox"/> No if yes, provide Name/Date/Amt

VERIFICATION

CONCLUSION

Findings

Acct Type/Acct #	Financial Institution	Owner Name	Balances
			CM IM BM Interest <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, see element 6
			CM IM BM Interest <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, see element 6
			CM IM BM Interest <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, see element 6
			CM IM BM Interest <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, see element 6
			CM IM BM Interest <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, see element 6
			CM IM BM Interest <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, see element 6
			CM IM BM Interest <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, see element 6

- Total countable liquid resources did not exceed resource limit during review period
- Liquid resources caused or contributed to ineligibility for the sampled payment
- Total countable liquid resources on first day of sample month:

	SI	MI
Checking:	_____	_____
Savings:	_____	_____
Other:	_____	_____
Total:	_____	_____

Geo Search did not identify additional accounts

Other Liquid Resource Findings

TYPE	BALANCES		
	CM: \$	IM: \$	BM: \$

9. REAL PROPERTY

Allegation of real property ownership by SI/MI:

Home Property Ownership Yes No

RE Field Entries

Home Property Type

Non-Farm Farm Trailer/Mobile Home Other

Ownership

SI is Sole Owner (non-life estate) MI is Sole Owner (non-life estate)
 Jointly owned with Spouse Jointly owned with relative (non-spouse)
 Jointly owned with non-relative Life Estate
 Unprobated Estate Other

(equitable ownership, remainder interest, etc)

Non-Home Property Ownership Interest: Yes No

CG Entries

Type	Owner	Loan Alleged	CMV
Farmland (rented)		\$	\$
Farmland (used by SI)		\$	\$
Commercial (non-farm) or residential property, rented		\$	\$
Non-Excluded previous or second residence (not rented)		\$	\$
Unimproved land, idle		\$	\$
Foreign property		\$	\$
Other (mineral, timber, water rights, easements, etc)		\$	\$
Unknown (type cannot be determined)		\$	\$
Evidence of Ownership/Value		\$	\$
Burial Plot/Crypt/Location/ Value Designated for			

Transfer of property since 12/14/1999?
 Yes No

If transfer of ownership alleged, provide the following: Type of real property/Name and address of recipient of property/date of transfer/Reason for the transfer/monetary or other compensation received.
 (Document on SSA 795)

Attempt to Dispose of Property?

Yes No

Income producing Property?

Yes No

VERIFICATION

CONCLUSION

Allegations Verified by Government Records:

Alpha listing Contact method: Personal Visit Letter Telephone Internet

Date of Contact	
Name of Contact	
Title of contact	

Findings:

No property ownership found Ownership Discovered

Owner		Owner	
Location		Location	
CMV (duration of ownership)		CMV (duration of ownership)	

Other Collateral contact made:

Type Contact/Date	
Findings	

No real property ownership established for SI/MI

SI/MI owns excluded home property

SI/MI owns nonexcluded real property valued at:
\$ _____

SI/MI owns excluded other property (ex. burial plot)

SYSTEMS

SI/MI INTERVIEW

10. VEHICLES

Positive allegation None alleged

RE Field Data

Year/Make		Year/Make	
Model		Model	
Condition		Condition	
Owner		Owner	
Use		Use	
VIN		VIN	
License #		License #	
Transfer Alleged	<input type="checkbox"/> Yes <input type="checkbox"/> No	Transfer Alleged	<input type="checkbox"/> Yes <input type="checkbox"/> No
Evidence Viewed		Evidence Viewed	
Encumbrances		Encumbrances	

CG Entries

Year/Make		Year/Make	
Model		Model	
Condition		Condition	
Owner		Owner	
Use		Use	
VIN		VIN	
License #		License #	
Transfer Alleged	<input type="checkbox"/> Yes <input type="checkbox"/> No	Transfer Alleged	<input type="checkbox"/> Yes <input type="checkbox"/> No
Evidence Viewed		Evidence Viewed	
Encumbrances		Encumbrances	

VERIFICATION

CONCLUSION

FINDINGS:

No reason to doubt negative allegations

N.A.D.A. value(s):

Vehicle #1	\$
Vehicle #2	\$
Vehicle #3	\$
Vehicle #4	\$

See SSA-795 regarding vehicle use.

Collateral contact made:

Name	
Type/Contact/Date	
Findings	

No vehicle ownership by SI/MI

Vehicle exclusion applies:
 Transportation
 Employment
 Other

Total vehicle value
\$ _____

Non-excluded value
\$ _____

SYSTEMS

SI/MI INTERVIEW

11. LIFE INSURANCE

Positive Allegation None Alleged

RE Field Data

CG Entries

Insurance Company Name		Insurance Company Name	
Policy Number		Policy Number	
Issue Date		Issue Date	
Owner		Owner	
Face Value	\$	Face Value	\$
Cash Value	\$	Cash Value	\$
Outstanding Loans?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Outstanding Loans?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Age at Issue		Age at Issue	
Premium amount/frequency		Premium amount/frequency	
Type of Policy		Type of Policy	
Fully paid Policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fully paid Policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Policy Viewed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Policy Viewed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does policy produce Dividend additions or div accumulations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does policy produce Dividend additions or div accumulations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Transfer alleged	<input type="checkbox"/> Yes <input type="checkbox"/> No	Transfer alleged	<input type="checkbox"/> Yes <input type="checkbox"/> No
Accelerated life insurance payments?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Accelerated life insurance payments?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Insurance Company Name		Insurance Company Name	
Policy Number		Policy Number	
Issue Date		Issue Date	
Owner		Owner	
Face Value	\$	Face Value	\$
Cash Value	\$	Cash Value	\$
Outstanding Loans?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Outstanding Loans?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Age at Issue		Age at Issue	
Premium amount/frequency		Premium amount/frequency	
Type of Policy		Type of Policy	
Fully paid Policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fully paid Policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Policy Viewed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Policy Viewed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does policy produce Dividend additions or div accumulations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does policy produce Dividend additions or div accumulations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Transfer alleged	<input type="checkbox"/> Yes <input type="checkbox"/> No	Transfer alleged	<input type="checkbox"/> Yes <input type="checkbox"/> No
Accelerated life insurance payments?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Accelerated life insurance payments?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SYSTEMS

SI/MI INTERVIEW

12. RESOURCES
SUMMARY/OTHER
NONLIQUID
RESOURCES

Does SI own any other non-liquid resources, (items of unusual value)? Yes No
If so, indicate below:

Transfer alleged

Income producing

Encumbrances

SI/MI alleges following resource(s) are to be used for burial expenses:

13. REPRESENTATIVE
PAYEE

Selection Date:
T:
CO:
CU:
Name:

No alleged or observed need for payee development/change.

Payee development suggested by:

14. FRAUD

No fraud suspected

Fraud suspected before or during interview due to:

VERIFICATION

CONCLUSION

No reason to doubt negative allegation

Collateral contacts made:

Name	
Type contact/Date	
Findings	

Resources excluded due to burial designation, PASS, etc.:

Total non excluded resource values:

Liquid
SI MI

CM
IM
BM
Retro

Non Liquid
SI MI

CM
IM
BM
Retro

Deeming applies

Resources cause ineligibility:

No Yes

No payee development required

Referred to field office for payee development

Name	
Contact type/date	
Findings	

FO payee development required

No development required

No development required

Fraud referred due to:

No fraud suspected

Fraud referral made

SUPPLEMENTAL DOCUMENTATION

15. DEATH OF MI
DH _____

Name	
Relationship to SI	
Date of Death	
Evidence viewed	

16. STUDENT STATUS

Student Name		Student Name	
Sch. Name		Sch. Name	
Sch. Address		Sch. Address	
Dates of Attendance		Dates of Attendance	
Full time	<input type="checkbox"/> Yes <input type="checkbox"/> No	Full time	<input type="checkbox"/> Yes <input type="checkbox"/> No
Evidence Viewed		Evidence Viewed	

17. AGE

Evidence presented by SI/MI, or derived from collateral contact

Eligible Children

Name		Name		Name	
SSN		SSN		SSN	
DOB		DOB		DOB	

Ineligible Children

Name		Name		Name	
SSN		SSN		SSN	
DOB		DOB		DOB	
Mth Name		Mth Name		Mth Name	
Fth Name		Fth Name		Fth Name	
Evidence Viewed		Evidence Viewed		Evidence Viewed	

18. RELATIONSHIP

- Ineligible child of SI _____ Birth record (see above/pg.2)
- Ineligible sibling of SI
- Parent to eligible child
- Spouse as parent to eligible child
- Alien sponsor to spouse/dependents
- Other _____

Marriage record
Name _____
Date _____ Place _____
Issued by _____

VERIFICATION

CONCLUSION

None required

Collateral Contact made

Name	
Contact type/date	
Finding	
Evidence Viewed	

Payment effect
\$

PYMT deficiency

Nonpayment
deficiency

None required

Collateral Contact made

Name	
Contact type/date	
Finding	
Evidence Viewed	

No discrepancy

Student Status
verified

Numident in file IDN _____

Collateral Contact Made

Name	
Contact type/date	
Finding	
Evidence Viewed	

No discrepancy

Age Verified

Numident in file

Collateral Contact made

Name	
Contact type/date	
Finding	
Evidence Viewed	

No discrepancy

Relationship
verified

Privacy Act Statement Collection and Use of Personal Information

Sections 205(a), 1611(c)(1), 1631(d) and (e)(1)(B) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to help us determine the individual's eligibility for benefits.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent us from making an accurate and timely decision on any claim for benefits.

We rarely use the information you supply for any purpose other than to complete our claims process. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,
2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices 60-0040, entitled Quality Review System, 60-0042, entitled Quality Review Case Files, and 60-0057, entitled Quality Evaluation Data Records. Additional information about these and other system of records notices and our programs is available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

SSA will insert the following revised PRA Statement into the form at its next scheduled reprinting:

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