

**RSI/DI QUALITY REVIEW CASE ANALYSIS - AUXILIARY/SURVIVOR**

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.

**1. IDENTIFYING AND REVIEW INFORMATION**

A. Study ID Code:	B. NH's SSN:
C. Sample Month Date:	D. Review Amount: \$
E. Review Amount Determined by OQR: \$	
F. Explanation of Review Amount Changes, if OQR Determination is different:	
G. Type of Interview <input type="checkbox"/> Telephone <input type="checkbox"/> Other	
H. NH's Name (As Shown on MBR):	

**I. Beneficiaries in Scope of Review**

1. BIC	2. Name/Address/Phone	3. Payee Name/Address/Phone
	Name:	Name:
	Address:	Address:
	Phone:	Phone:
	Name:	Name:
	Address:	Address:
	Phone:	Phone:
	Name:	Name:
	Address:	Address:
	Phone:	Phone:
	Name:	Name:
	Address:	Address:
	Phone:	Phone:

- Beneficiary Entitled in Closed Year and Subject to Annual Earnings Test (Complete SSA-4281/SSA-4659)
- Additional Beneficiaries In Scope of Review (Complete Separate SSA-2931)

## DESK REVIEW

## 2. DECEASED/NONSAMPLED NUMBER HOLDER

A. Number Holder Information  Deceased NH  Non-Sampled NH

B. Other Names and SSNs Shown in File/Numident  N/A

1. Other Names:

2. Other SSNs:

C. Date of Birth  N/A

1. Date of Birth and Proof Code on MBR:

2. Place of Birth:

3. MN:

FN:

4. Evidence/Documentation in Claims Folder/MCS Screens:

5. Evidence Needing Verification:

6. Date of Birth Established by Desk Review:

D. Date of Death  N/A

1. Date of Death on MBR:

2. Place of Death:

3. Evidence/Documentation in Claims Folder/MCS Screens:

4. Evidence Needing Verification:

5. Date of Death Established by Desk Review:

E. Are there any eligible children of the NH who have not filed for benefits?

YES (Explain)

NO

## TELEPHONE REVIEW

2. DECEASED/NONSAMPLED NUMBER HOLDER	Consolidated Review
<p>A. Number Holder Information</p> <p><input type="checkbox"/> Deceased NH                      <input type="checkbox"/> Non-sampled NH</p>	<p>A. Number Holder Information</p>
<p>B. Other Names and SSNs Used    <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Beneficiary Agrees with DR Summary</p> <p><input type="checkbox"/> Beneficiary Disagrees with DR Summary: (Explain)</p>	<p>B. Other Names/SSNs</p>
<p>C. Date of Birth</p> <p><input type="checkbox"/> Beneficiary Agrees with DR Summary</p> <p><input type="checkbox"/> Beneficiary Disagrees with DR Summary: (Explain)</p>	<p>C. Date of Birth</p>
<p>Evidence Obtained in Field Review:</p>	
<p>D. Date of Death                      <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Beneficiary Agrees with DR Summary</p> <p><input type="checkbox"/> Beneficiary Disagrees with DR Summary: (Explain)</p>	<p>D. Date of Death</p>
<p>Evidence Obtained in Field Review:</p>	
<p>E. Eligible Children                      <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Beneficiary Agrees with DR Summary</p> <p><input type="checkbox"/> Beneficiary Disagrees with DR Summary: (Explain)</p>	<p>E. Eligible Children</p>

## DESK REVIEW

## 2. DECEASED/NON-SAMPLED NUMBER HOLDER

## F. Marital History of NH

## 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:

## TELEPHONE REVIEW

## 2. DECEASED/NON-SAMPLED NUMBER HOLDER

## F. Marital History of NH

- 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

## DESK REVIEW

## 2. DECEASED/NONSAMPLED NUMBER HOLDER

## G. Computation Information

1. Work Issues	Explanation
<input type="checkbox"/> Wages	
<input type="checkbox"/> Self-Employment	
<input type="checkbox"/> Lag Wages/SEI	
<input type="checkbox"/> Gaps	
<input type="checkbox"/> Annual Reports	
<input type="checkbox"/> Duplicates/Incompletes	
<input type="checkbox"/> 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  PREFrom To  ALG  PRV  PREd. 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  NO4. Prior Period(s) of Disability (PPD)  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:

## TELEPHONE REVIEW

## 2. DECEASED/NON-SAMPLED NUMBER HOLDER

## Consolidated Review

## G. Computation Information

## G. Computation Information

## 1. Work Issues

Beneficiary Agrees with DR Summary

Beneficiary Disagrees with DR Summary:

Explain:

Evidence Obtained in Field Review:

## 1. Work Issues

## 2. Military Service

Beneficiary Agrees with DR Summary

Beneficiary Disagrees with DR Summary:

(Explain)

Evidence Obtained in Field Review:

## 2. Military Service

## 3. Railroad Employment

Beneficiary Agrees with DR Summary

Beneficiary Disagrees with DR Summary:

(Explain)

## 3. RR Employment

## 4. Prior Period(s) of Disability

Beneficiary Agrees with DR Summary

Beneficiary Disagrees with DR Summary:

(Explain)

## 4. Prior Period(s) of Disability

## DESK REVIEW

3. SPOUSE/SURVIVING SPOUSE/PARENT

 Spouse Parent

A. Identity

 TELEPHONE OTHER

1. Name:

2. SSN (BOAN):

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

1. Other Names:

2. Other SSNs:

C. Date of Birth/U.S. Citizenship/Alien Status

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. Evidence Documentation in Claims Folder/MCS Screens:

6. Evidence Needing Verification:

7. Date of Birth Established by Desk Review:

8. U.S. Citizenship/Alien Status Established by Desk Review:

Remarks:



TELEPHONE REVIEW

3. SPOUSE/SURVIVING SPOUSE/PARENT	Consolidated Review
A. Identity <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	A. Identity
1. Existence Verified by: <input type="checkbox"/> Telephone _____	
2. SSN Verified by: <input type="checkbox"/> SSN Card <input type="checkbox"/> Medicare Card <input type="checkbox"/> Other _____	
B. Other Names and SSNs Used: <input type="checkbox"/> N/A <input type="checkbox"/> Beneficiary Agrees with DR Summary <input type="checkbox"/> Beneficiary Disagrees with DR Summary: (Explain)	B. Other Names/SSNs:
C. Date of Birth and U.S. Citizenship/Alien Status <input type="checkbox"/> Beneficiary Agrees with DR Summary <input type="checkbox"/> Beneficiary Disagrees with DR Summary: (Explain)	C. DOB and U.S. Citizenship/Alien
Evidence Obtained in Field Review:	

## DESK REVIEW

## 3. SPOUSE/SURVIVING SPOUSE/PARENT

## D. Application

1. Date Claim Filed:

2. MOE and MOEL Option Code:

3. MOE Determined by Desk Review:

E. Multiple Entitlement Involved:  YES (Complete Below)  NO1. Claim Number on  Non-sampled  Sampled SSN2. Scope of Review  Non-sampled  Sampled SSN Full Review Limited Review Not in Scope of ReviewF. Potential Entitlement on Own SSN:  N/A Wages Self-Employment Lag Wages/SEI Gaps Duplicates/Incompletes Other Military Service Foreign Work Insured Status Met

## G. Other Claims Activity

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

 YES (Explain)  NO

(Explain)

2. Unadjudicated Claims Issues:  NONE APPLY Unprocessed Application Deemed Filing Protective Filing Open Application Partial Adjudication Other Potential Entitlement (Leads) Delayed Claim Misinformation

(Explain)

## TELEPHONE REVIEW

## 3. SPOUSE/SURVIVING SPOUSE/PARENT

## Consolidated Review

## D. Application

- Beneficiary Agrees with DR Summary
- Beneficiary Disagrees with DR Summary:  
(Explain)

## D. Application

## E. Multiple Entitlement

- Beneficiary Agrees with DR Summary
- Beneficiary Disagrees with DR Summary:  
(Explain)

## E. Multiple Entitlement

F. Potential Entitlement on Own SSN  N/A

- Beneficiary Agrees with DR Summary

- Beneficiary Disagrees with DR Summary:  
Explain:

## F. Potential Entitlement

Evidence Obtained in Field Review:

## G. Other Claims Activity

- Beneficiary Agrees with DR Summary
- Beneficiary Disagrees with DR Summary:  
(Explain)

## G. Other Claims Activity

## DESK REVIEW

## 3. SPOUSE/SURVIVING SPOUSE/PARENT

## H. Marital History of Spouse/Surviving Spouse

## 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:

## TELEPHONE REVIEW

## 3. SPOUSE/SURVIVING SPOUSE/PARENT

## H. Marital History of Spouse/Surviving Spouse

- 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

## DESK REVIEW

## 3. SPOUSE/SURVIVING SPOUSE/PARENT

## I. Government Pension Offset

COMPLETE IF SPOUSE/SURV SPOUSE WAS ENTITLED/FILED DECEMBER 1,1977 OR LATER.

1. Spouse/Surviving Spouse is Entitled to a Government Pension Based on His/Her Own Earnings.

 YES  NO

2. Agency or Organization From Which Government Pension or Annuity Received

a. Name of Agency:

b. Address:

3. Date First Entitled to Pension:

4. Date First Eligible:

5. GPO Exception Met (Check Any that Apply)

- Date First Eligible Prior to 12/01/82 and Entitlement Requirements in Effect in 01/77 Met
- For Benefits 12/82 or Later, First Eligible Prior to 07/83 and One-Half Support Met
- For Benefits 12/84 or Later, Would Have Been Eligible in 11/82 or 6/83 but Payment Delayed
- Federal Employee Filed an Election for Coverage under Social Security or Mandatory Coverage Applies or Worked under Covered Federal Employment for at Least 60 Months before DOE
- For Benefits 1/95 or Later, Receives a Military Pension Based on Non-Covered Reserve Service
- State/Local Govt. Employee Filed for Social Security Prior to 4/04 or Retired from Govt. Service Prior to 7/04 AND Last day of Work Covered under Social Security
- State/Local Govt. Employee Filed for Social Security After 3/04 or Retired from Govt. Service After 6/04 AND Last 60 Months of Work (less if last work prior to 3/09) Covered under Social Security

6. If No Exemptions for GPO Apply, Enter Pension Information:

a. Amount of Pension: \$

b. Frequency of Payment:

c. Amount of Offset in Sample Month: \$

d. Monthly Benefit After Offset: \$

7. Evidence/Documentation in Claims Folder/MCS Screens:

8. Evidence Needing Verification:

TELEPHONE REVIEW

3. SPOUSE/SURVIVING SPOUSE

Consolidated Review

I. Government Pension Offset

I. GPO

- Beneficiary Agrees with DR Summary
- Beneficiary Disagrees with DR Summary:  
(Explain)

Evidence Obtained in Field Review:

## DESK REVIEW

## 3. SPOUSE/SURVIVING SPOUSE

J. Child-in-Care (CIC)

 N/A

## COMPLETE TO ESTABLISH CHILD IS IN THE BENEFICIARY'S CARE

1. Child-in-care Under Age 16 or Mentally Disabled, Beneficiary Exercises Parental Control

 YES (Complete Below) NO

a. BIC(s) of Child-in-Care:

b.  Child-in-Care is Living with the Beneficiary Child-in-Care is Not Living with the Beneficiary (Explain)

2. Child-in-Care Age 16 or Older and Physically Disabled, Beneficiary Performs Personal Services

 YES (Complete Below) NO (Go to J.3)

a. BIC(s) of Child-in-Care:

b.  Child-in-Care is Living with the Beneficiary Child-in-Care is Not Living with the Beneficiary

c. Nature and Frequency of Personal Services:

3. Evidence/Documentation in Claims Folder/MCS Screens:

4. Evidence Needing Verification:



TELEPHONE REVIEW

3. SPOUSE/SURVIVING SPOUSE	Consolidated Review		
<p>J. Child-in-Care <span style="margin-left: 100px;"><input type="checkbox"/> N/A</span></p>	J. Child-in-Care		
<p>1. Child-in-Care Under 16 or Mentally Disabled, Living with Beneficiary</p> <p><input type="checkbox"/> Beneficiary Agrees with DR Summary</p> <p><input type="checkbox"/> Beneficiary Disagrees with DR Summary (Explain)</p>			
<p>a. If CIC, describe the nature and extent of parental control/responsibility:</p>			
<p>b. If CIC, Verification of Child's Existence and Residence</p> <p><input type="checkbox"/> Phone Verification</p> <p><input type="checkbox"/> Other</p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none; text-align: center;">Existence Verified by</td> <td style="width:50%; border: none; text-align: center;">Residence Verified by</td> </tr> </table>	Existence Verified by	Residence Verified by	
Existence Verified by	Residence Verified by		
<p>2. Child-in-Care 16 or Older &amp; Physically Disabled, Living w/ Beneficiary</p> <p><input type="checkbox"/> Beneficiary Agrees with DR Summary</p> <p><input type="checkbox"/> Beneficiary Disagrees with DR Summary (Explain)</p>			
<p>a. If CIC, describe the nature/frequency of personal services and extent beneficiary's presence required because of the child's disability:</p>			
<p>b. If CIC, Verification of Child's Existence and Residence</p> <p><input type="checkbox"/> Phone Verification</p> <p><input type="checkbox"/> Other</p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none; text-align: center;">Existence Verified by</td> <td style="width:50%; border: none; text-align: center;">Residence Verified by</td> </tr> </table>	Existence Verified by	Residence Verified by	
Existence Verified by	Residence Verified by		
<p>c. If CIC, child's description of the nature/frequency of personal services:</p>			
<p>3. Child, as Described in 1. or 2. Above, Not Living with the Beneficiary</p> <p><input type="checkbox"/> Beneficiary Agrees with DR Summary</p> <p><input type="checkbox"/> Beneficiary Disagrees with DR Summary (Explain)</p>			
<p>a. If CIC, SSA-781 Obtained from Beneficiary: <input type="checkbox"/> YES <input type="checkbox"/> NO</p>			
<p>b. Verification of Child's Existence and Child -in-Care (QRM 3612):</p> <p><input type="checkbox"/> Custodian <input type="checkbox"/> School <input type="checkbox"/> Child <input type="checkbox"/> Other _____</p>			

## DESK REVIEW

## 3. SPOUSE/SURVIVING SPOUSE

K. Current DWB or Deemed DWB Entitlement  N/A

## 1. Period(s) of Disability

a. Established Onset Date:

b. Date of Entitlement:

c. Disabled Before End of Prescribed Period:  YES  NO (Explain)d. Prior or Current Entitlement to SSI/SSP Benefits:  YES (If Yes, go to e.)  NOe. Waiting Period(s) Reduced by SSI/SSP Credit:  YES  NO (Explain)

## 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:

## TELEPHONE REVIEW

3. SPOUSE/SURVIVING SPOUSE	Consolidated Review
K. Current DWB or Deemed DWB Entitlement	K. Current DWB Entitlement
1. Period(s) of Disability <input type="checkbox"/> Beneficiary Agrees with DR Summary <input type="checkbox"/> Beneficiary Disagrees with DR Summary (Explain)	1. Period(s) of Disability
2. Disability-Related Work Information <input type="checkbox"/> Beneficiary Agrees with DR Summary <input type="checkbox"/> Beneficiary Disagrees with DR Summary (Explain)	2. Disability-Related Work Info
Evidence Obtained in Field Review:	

DESK REVIEW

4. CHILD

A. Identity

1. BIC	2. Name	3. SSN (BOAN)

B. Application

1. BIC	2. Type of Benefit	3. Date Claim Filed	4. Month of Entitlement

5. Month of Entitlement Determined by Desk Review

BIC	MOE	BIC	MOE

C. Multiple Entitlement Involved

- YES ( BIC \_\_\_\_\_ Claim Number \_\_\_\_\_ )       NO  
           ( BIC \_\_\_\_\_ Claim Number \_\_\_\_\_ )  
           ( BIC \_\_\_\_\_ Claim Number \_\_\_\_\_ )  
           ( BIC \_\_\_\_\_ Claim Number \_\_\_\_\_ )

D. Other Claims Activity

1. Did any child beneficiary ever file for any other benefits (including SSI)?

- YES ( BIC \_\_\_\_\_ )       NO  
 (Explain)

2. Unadjudicated Claims Issues: BIC(s): \_\_\_\_\_

- Unprocessed Application       Deemed Filing       NONE APPLY  
 Protective Filing       Open Application       Delayed Claim  
 Partial Adjudication       Potential Entitlement on Another Parent's SSN  
 Misinformation

(Explain)

TELEPHONE REVIEW

4. CHILD			Consolidated Review
A. Identity			A. Identity
1. BIC	2. Existence Verified By	3. SSN Verified By	
B. Application			B. Application
<input type="checkbox"/> Beneficiary Agrees with DR Summary <input type="checkbox"/> Beneficiary Disagrees with DR Summary (Explain)			
C. Multiple Entitlement			C. Multiple Entitlement
<input type="checkbox"/> Beneficiary Agrees with DR Summary <input type="checkbox"/> Beneficiary Disagrees with DR Summary (Explain)			
D. Other Claims Activity			D. Other Claims Activity
<input type="checkbox"/> Beneficiary Agrees with DR Summary <input type="checkbox"/> Beneficiary Disagrees with DR Summary (Explain)			

## DESK REVIEW

## 4. CHILD

## E. Date of Birth

1. BIC:	a. Date of Birth and Proof Code on MBR Printout:	
b. Place of Birth:	c. MN:	FN:
c. Applications Filed 12/1/96 or Later: <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Lawfully-Present Alien		
d. Evidence/Documentation in Claims Folder/MCS Screens:		
e. Evidence Needing Verification:		
f. Date of Birth Established by Desk Review:		
g. U.S. Citizenship/Alien Status Established by Desk Review:		
2. BIC:	a. Date of Birth and Proof Code on MBR Printout:	
b. Place of Birth:	MN:	FN:
c. Applications Filed 12/1/96 or Later: <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Lawfully-Present Alien		
d. Evidence/Documentation in Claims Folder/MCS Screens:		
e. Evidence Needing Verification:		
f. Date of Birth Established by Desk Review:		
g. U.S. Citizenship/Alien Status Established by Desk Review:		
3. BIC:	a. Date of Birth and Proof Code on MBR Printout:	
b. Place of Birth:	MN:	FN:
c. Applications Filed 12/1/96 or Later: <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Lawfully-Present Alien		
d. Evidence/Documentation in Claims Folder/MCS Screens:		
e. Evidence Needing Verification:		
f. Date of Birth Established by Desk Review:		
g. U.S. Citizenship/Alien Status Established by Desk Review:		
4. BIC:	a. Date of Birth and Proof Code on MBR Printout:	
b. Place of Birth:	MN:	FN:
c. Applications Filed 12/1/96 or Later: <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Lawfully-Present Alien		
d. Evidence/Documentation in Claims Folder/MCS Screens:		
e. Evidence Needing Verification:		
f. Date of Birth Established by Desk Review:		
g. U.S. Citizenship/Alien Status Established by Desk Review:		

TELEPHONE REVIEW

4. CHILD

Consolidated Review

E. Date of Birth and U.S. Citizenship/Alien Status

- Beneficiary Agrees with DR Summary
  - Beneficiary Disagrees with DR Summary
- (Explain)

E. DOB and U.S. Citizenship/Alien Status

Evidence Obtained in Field Review:

## DESK REVIEW

## 4. CHILD

## F. Relationship and Dependency

1. BIC:	a. Type of Child Relationship:		
b. Child Adopted or Equitably Adopted by Someone other than NH:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
c. Deemed Dependency:	<input type="checkbox"/> YES (Go to d.)	<input type="checkbox"/> NO	Support Period:
Dependency Requirement(s) that Applies:	<input type="checkbox"/> Living With	<input type="checkbox"/> Contributions	<input type="checkbox"/> 1/2 Support
d. Evidence/Documentation of Relationship/Dependency in Claims Folder/MCS Screens:			

e. Evidence Needing Verification:

2. BIC:	a. Type of Child Relationship:		
b. Child Adopted or Equitably Adopted by Someone other than NH:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
c. Deemed Dependency:	<input type="checkbox"/> YES (Go to d.)	<input type="checkbox"/> NO	Support Period:
Dependency Requirement(s) that Applies:	<input type="checkbox"/> Living With	<input type="checkbox"/> Contributions	<input type="checkbox"/> 1/2 Support
d. Evidence/Documentation of Relationship/Dependency in Claims Folder/MCS Screens:			

e. Evidence Needing Verification:

3. BIC:	a. Type of Child Relationship:		
b. Child Adopted or Equitably Adopted by Someone other than NH:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
c. Deemed Dependency:	<input type="checkbox"/> YES (Go to d.)	<input type="checkbox"/> NO	Support Period:
Dependency Requirement(s) that Applies:	<input type="checkbox"/> Living With	<input type="checkbox"/> Contributions	<input type="checkbox"/> 1/2 Support
d. Evidence/Documentation of Relationship/Dependency in Claims Folder/MCS Screens:			

e. Evidence Needing Verification:

4. BIC:	a. Type of Child Relationship:		
b. Child Adopted or Equitably Adopted by Someone other than NH:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
c. Deemed Dependency:	<input type="checkbox"/> YES (Complete d.)	<input type="checkbox"/> NO	Support Period:
Dependency Requirement(s) that Applies:	<input type="checkbox"/> Living With	<input type="checkbox"/> Contributions	<input type="checkbox"/> 1/2 Support
d. Evidence/Documentation of Relationship/Dependency in Claims Folder/MCS Screens:			

e. Evidence Needing Verification:



TELEPHONE REVIEW

4. CHILD

Consolidated Review

F. Relationship and Dependency

- Beneficiary Agrees with DR Summary
- Beneficiary Disagrees with DR Summary

(Explain)

F. Relationship and Dependency

Evidence Obtained in Field Review:

## DESK REVIEW

## 4. CHILD

## G. Marriage

1. Has any child beneficiary ever been married?  YES (Complete Below)  NO

a. BIC:

b. Current/Last Marriage to:

c. Age/Date of Birth:

d. SSN:

e. Date of Marriage:

f. Type:

g. Place of Marriage:

h. How Terminated:

i. Date Terminated:

j. Place Terminated:

k. Evidence/Documentation in Claims Folder/MCS Screens:

I. Evidence Needing Verification:

2. Child's spouse is a Title II Beneficiary:  YES  NO (If Yes, Claim Number):

## H. School Attendance

 N/A

1. BIC(s)

2. Name and Address of School:

3. Full-Time Attendance or Deemed Full-Time Attendance in Sample Month:  YES  NO

(If NO, Explain)

4. School is "Educational Institution":

 YES  NO

(If NO, Explain)

5. Student Beneficiary Paid by Employer:

 YES  NO

(If YES, Explain)

6. Evidence/Documentation in Claims Folder/MCS Screens:

7. Evidence Needing Verification:

## TELEPHONE REVIEW

## 4. CHILD

## Consolidated Review

## G. Marriage

- Beneficiary Agrees with DR Summary
- Beneficiary Disagrees with DR Summary
- (Explain)

## G. Marriage

Evidence Obtained in Field Review:

## H. School Attendance

- Beneficiary Agrees with DR Summary
- Beneficiary Disagrees with DR Summary
- (Explain)

## H. School Attendance

Evidence Obtained in Field Review:

DESK REVIEW

4. CHILD

I. Current DAC Entitlement  N/A

1. Period(s) of Disability?

a. BIC(s):

b. Established Onset Date:

c. Disabled before Age 22 or Re-Entitled & Disabled Within Applicable Timeframe:  YES

NO

(Explain)

2. Disability-Related Work Information:

a. Earnings After Current Established Onset Date:

YES (Explain)

NO

b. Disability-Related Work Issues	Explanation
<input type="checkbox"/> Trial Work Period	
<input type="checkbox"/> Substantial Gainful Activity	
<input type="checkbox"/> Unsuccessful Work Attempt	
<input type="checkbox"/> Cessation	
<input type="checkbox"/> Extended Period of Eligibility	
<input type="checkbox"/> Termination	
<input type="checkbox"/> Expedited Reinstatement	
<input type="checkbox"/> Other	

c. Evidence/Documentation in Claims Folder/MCS Screens:

d. Evidence Needing Verification:

3. Potential Entitlement on Own SSN:

CURRENTLY ENTITLED

<input type="checkbox"/> Wages	
<input type="checkbox"/> Self-Employment	
<input type="checkbox"/> Lag Wages/SEI	
<input type="checkbox"/> Gaps	
<input type="checkbox"/> Duplicates/Incompletes	
<input type="checkbox"/> Other	
<input type="checkbox"/> Insured Status Met	

## TELEPHONE REVIEW

4. CHILD	Consolidated Review
I. Current DAC Entitlement	I. Current DAC Entitlement
1. Period(s) of Disability <input type="checkbox"/> Beneficiary Agrees with DR Summary <input type="checkbox"/> Beneficiary Disagrees with DR Summary (Explain)	1. Period(s) of Disability
2. Disability-Related Work Information <input type="checkbox"/> Beneficiary Agrees with DR Summary <input type="checkbox"/> Beneficiary Disagrees with DR Summary (Explain)	2. Disability-Related Work Info
Evidence Obtained in Field Review:	
3. Potential Entitlement on Own SSN <input type="checkbox"/> Beneficiary Agrees with DR Summary	3. Potential Entitlement
<input type="checkbox"/> Beneficiary Disagrees with DR Summary (Explain)	
Evidence Obtained in Field Review:	

## DESK REVIEW

## 5. PARENT

## A. Relationship

1. Type of Parent relationship:  Natural Parent  Step-Parent  Adoptive Parent

2. Evidence/Documentation of Relationship in Claims Folder/MCS Screens:

3. Evidence Needing Verification:

## B. One-Half Support

1. Support Period

2. Proof of Support Filed Timely:  YES  NO  
(Explain)

3. One-Half Support Met:  YES  NO  
(Explain)

4. Evidence/Documentation of Support in Claims Folder/MCS Screens:

5. Evidence Needing Verification:

## C. Other

1. Beneficiary Married after NH's Death:  YES  NO

a. Parent's Spouse is a Title II Beneficiary:  YES  NO

b. If Yes, Spouse's Claim Number:

2. Beneficiary Entitled to RIB Equal to/Exceeds Parent Original Benefit Amount:  YES  NO

## TELEPHONE REVIEW

5. PARENT	Consolidated Review
<p>A. Relationship</p> <p><input type="checkbox"/> Beneficiary Agrees with DR Summary</p> <p><input type="checkbox"/> Beneficiary Disagrees with DR Summary</p> <p>(Explain)</p>	<p>A. Relationship</p>
<p>Evidence Obtained in Field Review:</p>	
<p>B. One-Half Support</p> <p><input type="checkbox"/> Beneficiary Agrees with DR Summary</p> <p><input type="checkbox"/> Beneficiary Disagrees with DR Summary</p> <p>(Explain)</p>	<p>B. One-Half Support</p>
<p>Evidence Obtained in Field Review:</p>	
<p>C. Other</p> <p><input type="checkbox"/> Beneficiary Agrees with DR Summary</p> <p><input type="checkbox"/> Beneficiary Disagrees with DR Summary</p> <p>(Explain)</p>	<p>C. Other</p>

DESK REVIEW

6. PAYMENT FOR THE SAMPLE MONTH

A. Underpayment on Sampled SSN Needed to be Addressed:  N/A  YES (Explain)  NO

B. Recovery of Overpayment in Sample Month:  N/A  YES (Explain)  NO

C. SMI Determination

The SMI determination, including the premium deduction and penalty amounts (if any), is correct.  N/A  YES  NO (Explain)

D. Payment Amount(s)

1. BIC	2. Amount of CMA/SM Check	3. Sample Month	4. Payment Cycle Indicator (CYI)
	\$		
	\$		
	\$		
	\$		

5. Payment Combined with Other Benefit:  YES  NO

6. Check Amount Affected by Withholding/Deductions (e.g., Medicare Premiums, Voluntary Tax Withholding, Alien Tax, Garnishment, Treasury Offset Program, etc):  YES (Explain)  NO



## TELEPHONE REVIEW

6. PAYMENT FOR THE SAMPLE MONTH	Consolidated Review
<p>A. Underpayment on Sampled SSN</p> <p><input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Beneficiary Agrees with DR Summary</p> <p><input type="checkbox"/> Beneficiary Disagrees with DR Summary</p> <p>(Explain)</p>	A. Underpayment
<p>B. Recovery of Overpayment in Sample Month</p> <p><input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Beneficiary Agrees with DR Summary</p> <p><input type="checkbox"/> Beneficiary Disagrees with DR Summary</p> <p>(Explain)</p>	B. Overpayment
<p>C. SMI Determination</p> <p><input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Beneficiary Agrees with DR Summary</p> <p><input type="checkbox"/> Beneficiary Disagrees with DR Summary</p> <p>(Explain)</p>	C. SMI Determination
<p>D. Payment Amount</p> <p><input type="checkbox"/> Beneficiary Agrees with DR Summary</p> <p><input type="checkbox"/> Beneficiary Disagrees with DR Summary</p> <p>(Explain)</p>	D. Payment Amount

## DESK REVIEW

## 7. ADDITIONAL ISSUES

## A. Fugitive Felon

BICs over Age 12:

Are there any unsatisfied felony warrants for arrest or for violations of probation/parole?

 YES (Complete below) NO

Evidence/Documentation in Claims Folder/MCS Screens:

## 3. Evidence Needing Verification:

## B. Criminal Activities

BICs:

 Not Involved in Criminal Activities Listed Below

BICs:

 Are Involved in Criminal Activities Listed Below Homicide of NH Subversive Activities Removal (formerly Deportation) Confined for a Criminal Offense Offenses Against the National Security (Hiss Act) 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:

## C. Representative Payee

Does the desk review indicate that an unresolved representative payee issue exists (need for payee change, etc.) for a sampled beneficiary(ies)?

 YES BIC: (Explain) NO BIC: (Explain)



CASE SUMMARY

7. ADDITIONAL ISSUES

D. 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.

Number Holder:	<input type="checkbox"/> 2.A.	<input type="checkbox"/> 2.B.	<input type="checkbox"/> 2.C.	<input type="checkbox"/> 2.D.	<input type="checkbox"/> 2.E.	<input type="checkbox"/> 2.F.	<input type="checkbox"/> 2.G.
Spouse/Parent:	<input type="checkbox"/> 3.A.	<input type="checkbox"/> 3.B.	<input type="checkbox"/> 3.C.	<input type="checkbox"/> 3.D.	<input type="checkbox"/> 3.E.	<input type="checkbox"/> 3.F.	<input type="checkbox"/> 3.G.
	<input type="checkbox"/> 3.H.						
Spouse:	<input type="checkbox"/> 3.I.	<input type="checkbox"/> 3.J.	<input type="checkbox"/> 3.K.				
Child:	<input type="checkbox"/> 4.A.	<input type="checkbox"/> 4.B.	<input type="checkbox"/> 4.C.	<input type="checkbox"/> 4.D.	<input type="checkbox"/> 4.E.	<input type="checkbox"/> 4.F.	<input type="checkbox"/> 4.G.
	<input type="checkbox"/> 4.H.	<input type="checkbox"/> 4.I.					
Parent:	<input type="checkbox"/> 5.A.	<input type="checkbox"/> 5.B.	<input type="checkbox"/> 5.C.				
Payment for SM:	<input type="checkbox"/> 6.A.	<input type="checkbox"/> 6.B.	<input type="checkbox"/> 6.C.	<input type="checkbox"/> 6.D.			
Additional Issues:	<input type="checkbox"/> 7.A.	<input type="checkbox"/> 7.B.	<input type="checkbox"/> 7.C.				

Additional Development/Findings/Remarks:

Signature of Reviewer(s):

Desk Reviewer	Date:
Field Reviewer	Date:
Consolidated Reviewer	Date:

Privacy Act Statement  
Collection and Use of Personal Information

Sections 205(a), 228(a), 1614(a), and 1836 of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from verifying your eligibility for benefits.

We will use the information to check data for accuracy and to verify documentation used to establish your eligibility for benefits. We may also share your information for the following purposes, called routine uses:

1. To third party contacts in situations where the party to be contacted has, or is expected to have, information relating to the individual's capability to manage their affairs or eligibility for or entitlement to benefits under the Social Security program when the data are needed to establish the validity of evidence or to verify the accuracy of information presented by the individual; and
2. To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration (SSA) in the efficient administration of its programs. We will disclose information under the routine use only in situations in which SSA may enter into a contractual or similar agreement with a third party to assist in accomplishing an agency function relating to this system of records.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0040, entitled Quality Review System; and, 60-0090, entitled Master Beneficiary Record. Additional information and a full listing of all our SORNs are available on our website at [www.socialsecurity.gov/foia/bluebook](http://www.socialsecurity.gov/foia/bluebook).

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 control number. We estimate that it will take about 30 minutes to read the instructions, gather the facts, and answer the questions.

**SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at [www.socialsecurity.gov](http://www.socialsecurity.gov). Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.***