Department of Human Resources 311 West Saratoga Street Baltimore MD 21201	**FIA ACTION TRANSMITTAL**
Control Number: #00-07 Revised	**Effective Date: November 1, 1999** **Issuance Date:**

TO: **DIRECTORS, LOCAL DEPARTMENTS OF SOCIAL SERVICES**
DEPUTY/ASSISTANT DIRECTORS FOR FAMILY INVESTMENT
PURCHASE OF CARE ADMINISTRATORS
FAMILY INVESTMENT SUPERVISORS AND ELIGIBILITY STAFF

FROM: **ROBERT J. EVERHART, EXECUTIVE DIRECTOR, FIA**
LINDA HEISNER, EXECUTIVE DIRECTOR, CCA

RE: **COMPREHENSIVE PROGRAM REVIEW SYSTEM MODIFICATION**

PROGRAM AFFECTED: ALL FAMILY INVESTMENT PROGRAMS

ORIGINATING OFFICE: BUREAU OF CONTINUOUS IMPROVEMENT

SUMMARY

The Comprehensive Program Review System's (CPRS) primary purpose is to ensure program accuracy by assessing case manager's adherence to laws and regulations through the identification and correction of errors. Additionally, the system provides an effective management tool for evaluation, performance appraisals, and determining training needs.

The intent of the CPRS is to ensure program integrity by randomly selecting cases for an in-depth program supervisory review. CPRS is utilized to validate payment accuracy, identify error trends and to provide information that can be used to develop Corrective Action initiatives.

Current Procedure

Except in local jurisdictions that have an approved local plan, each supervisor responsible for Family Investment Administration (FIA) Programs is required to complete 60 program reviews per month, in accordance with State established standards, for review and data collection purposes. When Medical Assistance (MA),

Food Stamps (FS) or other program cases are selected for review and child care is received, the Purchase of Care (POC) case is also reviewed. This Action Transmittal (AT) obsoletes AT 96-53 and provides new procedures to local departments using a state CPRS plan.

In September 1997, local departments were given the opportunity to develop local CPRS plans that specified the process they intended to use to implement the state initiatives to ensure program integrity. Local departments that developed a local CPRS plan developed the criteria to meet the requirements of a local plan as specified by DHR.

NEW PROCEDURES

PAYMENT ACCURACY GOAL

DHR and the local departments of social services are committed to ensuring program integrity and to developing a CPRS process that provides for statistical validity and accountability in all benefit programs. To support that goal:

- DHR and local departments of social services have worked together to establish payment accuracy performance standards for case managers and supervisors.
- Case reading sample sizes have been revised.
- A random selection process has been established.
- PEP evaluations for FIP Case Managers are to include a payment accuracy performance standard. This evaluative measure will be incorporated into the first Performance Planning Phase of the PEP process following the establishment of the standard (see page 11). Case managers are exempt from the established standard during their first year of employment. Local offices will establish a separate performance standard for probationary employees (see page 4).
- The Bureau of Continuous Improvement (BCI) will report CPRS error data to local departments monthly from the error data recorded on the Comprehensive Program Review Forms (102, 102P) sent to BCI by the local departments. The report will include the number of errors by element and by cause for the district office.

SAMPLE SIZE

- Local offices will establish the case reading sample sizes based on the number of eligibility staff who perform eligibility functions. (Lead workers/assistant supervisors are excluded from this calculation.) The monthly case reading sample size per case

manager will be six (6) heads of household including all associated assistance units (including POC) handled by that case manager.

A CARES report of randomly selected cases will be provided to all local departments monthly for the selection of the first three (3) sample cases. Cases should be selected from each case manager's random list in the order presented. If it is necessary to skip any of the cases, document the reason on the list and then select the next case on the list For case managers whose caseload is primarily POC, CCAMIS reports are to be utilized to randomly select cases for their case reading sample size (see page 11 for additional information).

The local department may choose whether the remaining three (3) case samples are selected from the random lists (CARES or CCAMIS) or targeted to error prone cases, actions or staff. Local departments may select the second three (3) cases from current activities for pre-authorization or post-authorization reviews. However, local departments are encouraged to use a random selection process for the additional three (3) cases. The random selection process used by the local department must be included in the Standard Operating Procedure as described below.

If a case on the CARES or CCAMIS report of randomly selected cases is selected for review and the case was reviewed in the current or prior month, another case may be selected from the random report. Case closures should not be a reason to skip any of the cases on the list.

- Local departments were to have developed a Standard Operating Procedure (SOP) for implementing the CPRS on or before September 1, 1999. Local departments will update their SOP as necessary when changes are made in the local department or in the required elements of the SOP. The SOP will include the following:

    - What the selection process will be for selecting the second three cases;
    - How many case managers the local department has assigned to eligibility functions;
    - The total monthly case reading commitment for each district office. (Multiply the number of case managers assigned to eligibility functions by six (6) to establish the district office's case reading sample size.); and
    - How Non-TCA POC cases will be selected for review.

- Local departments will develop a revised SOP to include the required elements above as well as the added elements below by November 15, 1999. The added elements include:

    - How the first three cases for each case manager will be randomly selected

when the local department's procedures require CARES eligibility to be finalized by someone other than the case manager. This occurs when the local department requires pre-issuance reviews and finalization of eligibility in CARES by the supervisor or other specialized staff. In these situations the CARES report of randomly selected cases can not be used as it identifies a random sample of the reviewer's rather than the case manager's transactions.

- How supervisors who review a case action completed by one worker will handle errors and deficiencies identified that were created by a different worker. A recommended procedure would be to have the reviewing supervisor generate a second 102 and count it as part of the second three (3) reviews for the other worker.

- How TCA-POC cases will be selected for review when:

    - The FIA staff initiate the POC applications but do not determine POC eligibility or
    - The TCA-POC case manager does not determine the TCA eligibility.

  In these situations the CARES random report can not be used to select the Priority 1 cases for review. CCA recommends the use of the CCAMIS Priority 1 Report in these instances.

- How the local department will track, monitor and address deficiencies. Local departments may choose to have BCI report deficiency data as reported on 102s and 102Ps.

- What performance standard the local department has established for probationary employees.

- The second three (3) reviews per worker may be adjusted monthly by the local department based on vacancies, absences or vacations of reviewing staff by 10% for each full day of unavailability.

- Local departments may request time-limited exemptions to the case reading sample size due to extenuating circumstances. Written requests are to be directed to Charles Henry, Director of the Office of Administrative Services and Continuous Improvement at DHR for FIA and Barbara L.Tayman, Director of the Office of Program Development for CCA. FIA and CCA will jointly review and respond to the local department request.

- Supervisory accountability is provided for in the CPRS process via the second level

CPRS reviews performed by local departments, BCI and CCA. The results of those reviews completed by BCI or CCA will be provided to the local departments.

- When the error rate for a first level CPRS review for an individual case manager exceeds the established standard for three (3) consecutive months, then the supervisor of that worker will develop a Performance Improvement Plan that will focus additional attention or target additional reviews toward that worker.

SELECTION CRITERIA

- CARES will provide a random list of 20 (twenty) cases from the prior month's transaction activity report by case manager ID reflecting actions completed by each case manager during the prior month. This will be sent to each local department by the 5th working day of the month. This report will be valid to use for selecting case records for review for up to forty-five (45) days from the run date. Cases are to be selected from the list for each case manager in the order presented on the list. If it is necessary to skip one of the cases, then document the reason on the list before proceeding to the next case. District offices are to retain the transaction activity report from which the cases were selected for a period of three (3) years for conducting second level reviews on the selected cases and for audit purposes.

- CCAMIS Priority 2 and 3 reports are to be used to randomly select POC cases. These reports will be valid to use for selecting case records for review for up to forty-five (45) days from the run date. District offices are to retain the CCAMIS report from which the cases were selected for a period of three (3) years for conducting second level reviews on the selected cases and for audit purposes.

- All associated assistance units handled by the same case manager for each head of household selected are to be included in the case review. Assistance units include Cash Assistance, Food Stamps, Medical Assistance and Purchase of Care.

- **High Risk Cases (Error Prone) -** Earned income, unearned income, household composition, and cases with previous work history are cases that have been identified by Quality Control as exhibiting a high potential for error. Resources is a high error prone element for Long Term Care (LTC) cases. For a POC policy area in which there is a large number of errors or deficiencies, additional reviews should be conducted.

  If high numbers of errors or deficiencies are found for a case manager or policy area, supervisors/managers should develop a Performance Improvement Plan that will focus additional attention or target additional reviews to that case manager or policy area. Local departments are encouraged to use the performance standards on page eleven (11) to determine deficiency performance standards.

CASE REVIEW PROCESS

Best Practice

A holistic approach to reviewing case records is recommended. The reviewer should look at the case record in its entirety, considering all associated programs and all parts of the case record handled by the case manager as pieces of a whole. The different parts of the case record should fit together like parts of a puzzle. Information in one part of the case record should be consistent with information found in other parts of the case record. A recommended plan for performing this type of case review includes:

- Review the case record narrative first to get the "big picture" before beginning to look at the details of the case record.

- Review the hard copy of the case record next to ensure appropriate documents and verifications are present to support the eligibility decision. Hard copies of CCAMIS or CARES screens used to verify customer's POC eligibility must be filed in the POC case record.

- Review the CARES screens last to ensure that data has been accurately entered so that benefits/payments and eligibility decisions are appropriately authorized.

- Review the CCAMIS screens last to ensure that data has been accurately entered so that benefits/payments and eligibility decisions are appropriately authorized. Hard copies of CCAMIS screens must be filed in the POC case record.

- Refer to the Comprehensive Program Review System Guidelines (chart attached) for specific guidance while navigating through the computer system portion of the review.

Outcome-based Reviews

The new CPRS plan features an outcome-based case record review process. An outcome-based review focuses on the end result of the eligibility determination process. This means that the determination of what is an error will not be based on the individual elements or procedures reviewed during the case review process. Instead, an error will be defined in terms of the accuracy of the eligibility decision or the benefit/payment authorization. Specifically:

- An **error** will be cited when the supervisory review identifies an action that must be taken in order to correct a prior or existing payment/benefit or eligibility status error.

An **error** will also be cited on pre-issuance reviews when the supervisory review identifies an action that must be taken to prevent a payment/benefit or eligibility status error that would have occurred had a correction not been made. Errors are defined as:

- Underpayments
- Overpayments
- Incorrect MA Spenddowns (Amount or effective date)
- Incorrect eligibility status for individuals
- Incorrect eligibility status for assistance units

- A **deficiency** will be cited when the supervisory review identifies an action that must be taken to correct the case, but the action did not result in an adjustment to a completed or scheduled benefit/payment amount or eligibility status.

- A **correct** determination will be made when no action is required to correct either an error or a deficiency.

PROCEDURES AND FORMS

- Review the cases selected on the sample report for all pertinent factors of eligibility and required procedures in all applicable programs. For the present time, local plans will continue to review the target element as outlined in the local plan. (See Local Plans on page 11 for additional information.) Identify each factor needing correction.

- Record results of the review for all programs except POC on form 102 by entering cause codes for any factors identified as contributing to errors or deficiencies. Use the 102P to record results of reviews for POC. Describe errors or deficiencies in detail in the Action Needed section and check Correction Needed. **On the 102 and 102P enter cause codes for errors and deficiencies. Circle the cause codes for errors only.** (See above for definitions of errors and deficiencies.)

- If no correction is needed, check Correction Not Needed. Local departments with local plans will complete the review on the local CPRS form for the target element(s).

Routing the CPRS Form (102, 102P)

Local departments may develop and implement their own flow for the CPRS form 102 or 102P as long as it is documented in the SOP and instructions are provided to staff. **The 102P is a new form that is specific to POC.** Below are suggestions for reviews needing correction and correct reviews:

- **White, yellow and pink** - Attach to the case file and return to the worker for correction. Return cases needing correction to the appropriate worker. Allow a maximum of twenty-one (21) calendar days from the date of the review for completion. Local departments with local forms continue the case record return as indicated in your local plan.

- **Gold** - File this copy in the **CORRECTION FILE** maintained in the unit or a central control in the local office. Keep the forms in this pending file in a review date order until corrected.
- The worker corrects the finding; signs and dates the correction in the space provided and returns the case with all three copies of the 102 or 102P for re-review.

For reviews not needing correction, or corrected reviews:

- Re-review the action taken to correct the case. Once corrected, initial and date the three copies in the correction block and:

  If keeping the correction file, pull the gold copy from the error correction file and throw it away. File the White copy into a "Corrected During the Month" file to be held until the end of the month for reporting purposes.

- If the correction file is kept centrally, forward the case with the white copy attached to the central control person who will pull the case, and throw away the gold copy.

- **Yellow** - File yellow copy by individual worker. Use this to complete the monthly CPRS report form (DHR/IMA 103C) and to monitor workers' performance.

- **Pink** - File in the case record.

Any case record not corrected within 21 days is considered overdue. These cases are at risk of being selected for QC reviews with the potential of costly errors being discovered. The number of overdue error cases must be recorded on the monthly report. Compliance with this requirement will be monitored through the PEP process and second level reviews completed by BCI.

Filing System

Worker Files

The reviewer keeps a folder of each worker. Place the **yellow** copy of the 102, 102P for each case reviewed. At the end of the month, the reviewer tabulates the

forms to show how many reviews were completed and the number of errors identified for each worker. After the monthly report is completed, the forms are kept in a back-up file to be used for monitoring worker performance, training, and evaluation purposes.

Error Correction Files

This file tracks error correction activities using the **gold** and **white** 102, 102P forms. At the local department's option, the reviewer, a unit clerk, or a central control file may keep the file.

When a case is returned for correction, file the **gold** copy in due date order in the error correction file. As each case is corrected, pull the gold 102, 102P and throw it away. Put the white copy in a separate file labeled "Corrected During the Month." These forms are used at the end of the month to complete the Error Correction section of the Reviewer's Worksheet (103C) form and subsequently the CPRS Monthly Report (103D).

Monitoring File

In multi-office jurisdictions, each district office is required to submit a report (103D) with the corrected error reviews and the Reviewer's Worksheet (103C attached). Local departments with one office are required to submit one report for their office with the corrected error reviews attached. Reports are due by the 10th of the month following the report month to the Bureau of Continuous Improvement. Reports include the Reviewer's Worksheet (103C), the CPRS Monthly Report (103D) and corrected error reviews (102, 102P). Retain random selection documentation for three (3) years for audit purposes.

MANAGEMENT MONITORING

Local Departments of Social Services will ensure that CPRS is an effective method of identifying and correcting errors and not just a requirement to read a required number of cases each month. The above reporting system provides information that enables managers to ensure that CPRS not only corrects but also prevents errors.

- Management is responsible for holding staff accountable for meeting CPRS case reading standards. These include the case reading sample size and established performance standard requirements (see page 11). Staff who fail to meet these performance standards are to have a Performance Improvement Plan developed to improve their performance.

- BCI/CCA will notify local departments when any of its district offices are failing to

meet the district office case reading sample size or quality performance standard requirements. When a local department receives notification that these standards have not been met, the local department will establish a corrective action plan or target additional case reviews to error prone cases or staff as appropriate. Local departments are expected to monitor these standards and provide feedback to appropriate staff.

- BCI will perform second-level CPRS reviews for all FIA programs. CCA will perform second level reviews for POC. These reviews will give management the means to determine the accuracy of first level reviews and identify issues that require procedural clarification or training. Failure to achieve established standards in second level CPRS reviews will result in a Corrective Action Plan for that supervisor to resolve the performance issues.

- Second Level Review Exceptions-- Second level CPRS reviews will be conducted by BCI and CCA on a rotating schedule in all district offices to validate the accuracy of supervisory reviews. Local departments will receive a report of the second-level findings within thirty (30) days from the completion of the second-level review. Local departments may file exceptions to the findings within thirty (30) days from the date the local department is notified. If an exception is not filed within thirty (30) days, the review findings will become final without further notice. Exceptions are to be in writing from the Director of the respective local department to Charles Henry, Director of the Office of Administrative Services and Continuous Improvement at DHR for FIA programs. POC exceptions are to be in writing from the Director of the respective local department to Barbara L.Tayman, Director of the Office of Program Development, Child Care Administration. A decision regarding the exception request will be provided within 30 days.

  Bureau of Continuous Improvement staff who complete second level reviews will be held to the same performance standard as established for local department staff.

- By using CPRS reports, management can monitor and evaluate the effectiveness of providing clarification or training.

- Local management will establish a procedure to ensure that error cases are corrected within the 21-day timeframe, to help prevent costly QC errors. Monitoring demonstrates commitment by management to ensure that all levels of staff understand the importance of CPRS as a strategy for increasing payment accuracy. Compliance with this requirement will be monitored through the PEP process and second level reviews completed by BCI.

PERFORMANCE STANDARDS

Staff are expected to achieve a standard percentage payment accuracy rate as measured by the CPRS. The case accuracy rate is determined by dividing the number of CPRS cases with errors by the total number of CPRS cases reviewed and deducting this number from one hundred (100). The established quality performance standards for PEP evaluations are as follows:

Accuracy Rate	PEP Standard
95-100	O
89-94	E
81-88	M
75-80	N
74-0	U

LOCAL PLANS

Local jurisdictions that have an approved local plan will be contacted by FIA to schedule a joint meeting with FIA and CCA to negotiate a mutually agreed upon CPRS plan. Action Transmittal 98-14 remains in effect until further notice for local plans.

PURCHASE OF CHILD CARE (POC) GUIDELINES

1. Each local department is to ensure that a representative random selection of Non-TCA POC cases is included in the case reading sample size. Non-TCA cases can be accessed from the CCAMIS Priority 2 and Priority 3 Reports.

2. Local departments with local plans approved by CCA for POC should follow the guidelines in Action Transmittal 98-14.

3. The 102P is to be used to review, track and report all POC case errors and deficiencies.

INQUIRIES

Please direct questions to Deborah McWilliams at (410) 767-7080 or Pamela Rich at (410) 767-7974. Purchase of Care questions are to be directed to Pamela Evans at (410) 767-7845 or Dion Sutton at (410) 767-1498.

ATTACHMENTS

cc: FIA Management Staff
Constituent Services
OIM Help Desk
CIS Testing Facility

COMPREHENSIVE PROGRAM REVIEW SYSTEM

ASE NAME / Client ID#	CATEGORY	AU NUMBER	A.R or IC	AU/HH SIZE	BENEFIT AMOUNT	LDSS/Office
						Case Manager
If Application, DAF						Reviewer
If Redet, Redet Due Mo____						Date of Review

MVA _____
Wage Screen _____
MMIS _____
Child Support _____
New Hires _____

AU Member	Age	AU Member	Age

REVIEW FINDINGS:

☐ CASE CORRECT
☐ **CORRECTION REQUIRED**
DUE DATE ___/___/___

Benefits After Correction
Cash $ ____ FS $____
MA $ ___ MA AU Change? Y N

☐ ERROR FOUND (Circle Cause Code)
☐ DEFICIENCIES ONLY

ENTER CAUSE CODE BELOW IF CORRECTION NEEDED
1. Policy Incorrect 2. Info Disregarded 3. Incorrect on CARES
4. No Verification 5. Other

Corrected by_____Dt_____
Review Approved by_____Dt_____

Screen	REVIEW FOR:	TCA	FS	MA	TEHMA	OTHER	ACTION NEEDED
	1. Narration / Past Management						
ADDR	2. Address / Resid/ Arep						
STAT	3. AU Comp / MFU						
	4. SSN / Age						
M1	5. Living Arr / Deprl / Pregnancy						
	6. CIT/ 379 / Student/ Med Incap						
DEM2	7. PPI: Health Exams						
TPL1	8. Medical Insurance						
ALAS	9. Alien / Student / PPI School						
FSME	10. Medical Bills						
INST	11. LTC: 206 N						
APID	12. Child Support						
AST1,2	13. Assets/ Vehicles						
ERN 1,2	14.Earnings/ Wage Screen						
CARE	15. Dependent Care						
UNEM	16. PWE						
UNIC	17. Unearned Income						
WORK	18. Work Requirements/ FSET						
SHEL	19. Shelter Costs / Sub Housing						
	20. Exp FS / SOP / Delay Fault						
MISC	21. Case Assignment Overide						
–FI	22. Proration / Cert / HH/ Ben						
–FI	23. Expenses Exceed Income						
–FI							
	24. Retro MA/ Spenddown/ 216						
	25. Case Record Format						
	26. 9707 / EDD Signed and Dated						
	27. BEG						
	28.						

Worker Response (Use other side if needed):

HOW TO COMPLETE THE 102 FORM

Identifying Information

Case Name and Client ID No. - Enter case name and client identification number.

Category and AU Number - Enter category and the assistance unit number of case selected for review. Enter all additional programs and assistance unit numbers for which you are completing a review.

Application, Redetermination/Recertification/Interim Change - Enter A, R, or IC as appropriate for the review. Enter Add-A-Program as 'A' but Add-A-Person as 'IC'.

AU/HH Size - Enter the number of individuals included in the assistance unit or household.

Benefit Amount - Enter the amount of cash benefits or FS allotment as appropriate.

LDSS/Office, Worker, Reviewer, Date of Review - Enter local department and district office, enter the appropriate information indicating the name or number of the worker completing the action, enter the Reviewer's name and enter the date of the case record review.

Application/Redetermination - If reviewing an application, enter the date the application was filed. If reviewing a redetermination/reconsideration, enter the redetermination/reconsideration due month.

MVA, Wage Screen, MMIS, Child Support - Enter a check mark that the case contains the required Motor Vehicle, MMIS, Wage/UI screens and Child Support screens per program policy. Enter a check mark to indicate that the New Hires Match alert was reviewed if applicable.

AU Members and Age (Optional) - Use this area to list AU members and age if this is helpful in the review process.

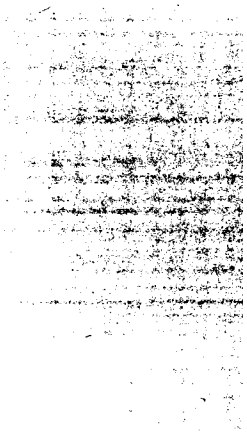
Cause Code: - Cause codes are provided to assist in identifying the cause of the error or deficiency. Use one of these codes for the elements reviewed for which a correction is needed. When a correction is returned that caused a benefit or eligibility adjustment, circle the cause code for the errors only. Example: (1), (2) etc. The following is the description for each code:

1 - Policy Incorrect - Policy has been incorrectly applied.
2 - Information Disregarded - Failure to take action on information reported by the customer or known by the agency.
3 - Incorrect on CARES - Information has been incorrectly entered on CARES (fields, income amounts, frequencies, codes etc.)
4 - No Verification - Failure to verify required information.
5 - Other - Causes which do not fall under any of the specific causes listed above.

REVIEW FINDINGS - Enter a check mark in the block for NO CORRECTION NEEDED only for reviews for which no error or deficiency was found. Enter a check mark in the block for CORRECTION REQUIRED for reviews for which an error or deficiency is found. If CORRECTION REQUIRED is checked, the box for ERROR FOUND or DEFICIENCIES ONLY should be checked after corrections are made and it is determined if the correction caused a change in the benefit amount or eligibility status. Note: An error is any factor identified as contributing to a payment/benefit error or incorrect eligibility status. Factors that do not contribute a payment/benefit error or incorrect eligibility status are deficiencies. **Refer to page 6 and 7 of this Action Transmittal for further information regarding errors/deficiencies.**

REVIEW ITEMS - For each item reviewed in which a correction is needed, enter an ERROR CAUSE CODE 1-5 as indicated on the form. Follow the current program policy and procedural requirements when identifying an area for correction. Before beginning a review of the screens, it is suggested that the Notice History be reviewed first.

Worker Response - The staff person completing the correction has the option to write a response describing the action taken. The back of the white original may be used if addition space is needed.



COMPREHENSIVE PROGRAM REVIEW FORM - POC

DIRECTIONS: FOLLOW THE DIRECTIONS ON THE BACK OF THIS FORM TO COMPLETE THE 102P. USE THE SAME WORKFLOW, ROUTING, AND FILING PROCEDURES USED FOR THE FIA 102.

CASE NAME	CUSTOMER ID #	CCAMIS #	LDSS/OFFICE
SUBSIDY	HH SIZE	PRIORITY CODE	CASE MANAGER
APPL.DATE	REDET DATE	INTERIM CHANGE DATE	REVIEWER/ DATE

ENTER CAUSE CODE BELOW IF CORRECTION IS NEEDED:

1. POLICY INCORRECT
2. INFORMATION DISREGARDED
3. INCORRECT ON CCAMIS
4. NO VERIFICATION
5. OTHER

REVIEW FINDINGS:

☐ CASE CORRECT
☐ CORRECTION REQUIRED
DUE DATE ___/___/___
Subsidy After Correction_____
☐ ERROR FOUND (Circle Cause Code)
☐ DEFICIENCIES ONLY
Corrected by_____Date_____
Review Approved by _____Date_____

REVIEW ITEMS:	CAUSE CODE	ACTION NEEDED CASE MANAGER RESPONSE
1. Medical Disability	_____	
2. Application/Signed & Dated (Technical Factor)	_____	
3. Application denied/No Verification	_____	
4. Application decision/Verification	_____	
5. Application/Eligibility Notice	_____	
6. Redetermination/Timely	_____	
7. Priority Code/Documentation	_____	
8. Benefits/Subsidy/Copayment (Technical Factor)	_____	
9. Income	_____	
10. Adverse Action/Customer	_____	
11. Adverse Action/Provider	_____	
12. Voucher Expiration/Customer Notice	_____	
13. Activity/Documentation (Technical Factor)	_____	
14. Informal Provider Registry/Payment Valid (Technical Factor)	_____	
15. Other_____	_____	
16. Other_____	_____	

DHR/CCA 102P (10/99) WHITE-ERROR CORRECTION COPY

HOW TO COMPLETE THE 102P FORM

Case Name, Customer Identification, CCAMIS Number, LDSS/Office- Enter case name, the customer's identification number assigned by CIS, the case number assigned by CCAMIS, and local department and district office name.

Subsidy, HH Size, Priority Code, Case Manager- Enter the subsidy level as determined by CCAMIS, the number of individuals included in the POC unit household, the priority code assigned by CCAMIS for the case, and the name of or number of the local staff completing the action.

Application/ Redetermination / Interim Change and Date/ Reviewer- Enter the word "application", "redetermination" or "interim change" and the date the action was completed by the case manager. Enter the reviewer's name and enter the date of the case record review.

Cause Code - Cause codes are provided to assist in identifying the cause of the error or deficiency. Use one of these codes for the elements reviewed for which a correction is needed. When a correction is returned that caused a change in the subsidy level, household size, or the customer's eligibility, circle the cause code. When circled the caused code is identified as an error. (Example 1, 2, etc.) The following is the description of each:

1- **Policy Incorrect**-Policy has been incorrectly applied.
2- **Information disregarded**-Failure to take action on information reported by the customer.
3- **Incorrect in CCAMIS**- Information has been incorrectly entered on CCAMIS (income, HH, priority code etc). When CCAMIS screens (milestones, activity log, 8004) are not in the case file as required this should be cited.
4- **No verification**-Failure to verify required information
5- **Other**-Causes which do not fall under any of the specific cases listed above.

POC Technical Factors- When a case is missing the documentation to support meeting a program technical factor, enter cause code four (4) no verification beside the specified technical factor. A case that fails a technical factor is automatically cited as an error. The cause code should be circled.

Review Finding-Enter a check mark in the block for **NO CORRECTIONS NEEDED** only for reviews for which no error or deficiency was found. Enter a check mark in the block for **CORRECTION REQUIRED** for reviews for which an error or deficiency is found. For POC an error is any factor identified as contributing to a payment error, incorrect eligibility status, a change in household size or a case's failure to satisfy a POC technical factor. IF **CORRECTION REQUIRED** is checked, the box for **ERROR FOUND** or **DEFICIENCIES ONLY** should be checked after corrections are made and it is determined whether the correction caused a change in the subsidy level, or housed size, or eligibility status. A case failing a POC technical factor is cited as an error.

Review Items-For each item reviewed for which a correction is needed, enter an ERROR CASE CODE 1-5 as indicated on the form. Follow the current program policy and procedure requirements when identifying an area for correction. Before beginning a review of the case file it is suggested that the case file narrative be reviewed.

Action Needed/ Case Manager Response- The reviewer should enter specific instructions for correcting the case as appropriate. The staff person completing the correction has the option to write a response describing the action taken. The back of the white original may be used if additional space is need.

COMPREHENSIVE PROGRAM REVIEW
LDSS / OFFICE REPORT

LDSS/CENTER: _____ PREPARED BY: _____ PHONE NO: _____ DATE: _____

REVIEW MONTH: _____ APPROVED BY: _____ PHONE NO: _____ DATE: _____

A. REVIEWS COMPLETED

REVIEWERS	Program Quota	Days absent	Adjusted Quota	PROGRAMS						POC		ERROR CASES
				CASH	FS	MA	TEMHA	OTHER	TOTAL	TCA	NON-TCA	
1.												
2.												
3.												
4.												
5.												
6.												
7.												
8.												
9.												
10.												
11.												
12.												
TOTAL												

B. ERROR CORRECTION

REVIEW STATUS		
CORRECTED	PENDING	
	0 - 21	21 +

Completing the DHR/IMA103-D

The purpose of this form is to provide a to provide a summary of the review activity completed during the month for each supervisor. This form contains data that can be used to monitor and evaluate the performance of individual supervisors.

Identifying Information

Enter the following information:

- County or Baltimore City District
- Month - The month and year for the reviews
- Prepared By ,Phone No and Date - Completed by the person completing the report
- Approved by, Phone No and Date - Completed by management staff approving report

A. Routing the Monthly Report (103D)

1. Following approval by the Local Director, Office Manager or designee distribute as follows:

- original to IMA
- file copy (for audit purpose)

Note: In multiple office jurdictions send only one report to IMA.

2. Enter the quota of case reviews.

3. Enter the number of days each supervisor was absent during the month in which the reviews were completed. This information can be taken from the 103C.

4. Using each supervisor's completed Worksheet (103C), transfer the information from the last (total) line in section a to the line beside that supervisor's name on the 103D. Be sure to enter the numbers in the correct program block.

5. Add down the number of program reviews and enter the total in the appropriate column in the last line of Section A.

6. Add down the number of Programs reviewed and enter the total in the appropriate column in the last line of Section A.

Section B - Error Correction Activity

1. Supervisors maintaining their own Error Correction Files:

   a. For each worker add the number of error cases corrected from the error correction file.

   b. Count the number of cases pending correction for each worker (0-21 days) or overdue (21+).

2. For Correction Files maintained centrally by a clerk:

   a. From the file "Corrected During the Month" pull the corrected white originals the 102s for the month. Separate supervisory unit. Count and enter the number corrected for each supervisor's unit in the column "Corrected."

   b. From the "Pending Correction File" count the number of cases pending correction as either within limits (not due by end of report month) or overdue (due before end of report month) and enter figures in the appropriate column for within limits (0-21) or overdue (21+).

   c. Count the number of cases pending correction from the Potential Error Log (104) for each supervisory unit.

COMPREHENSIVE [illegible]AM REVIEW SYSTEM

REVIEW[illegible]RKSHEET

CENTER _____ REVIEWER _____ PHONE _____

REVIEW MONTH _____ PREPARED BY _____ DATE _____

A. REVIEWS COMPLETED

B. ERROR CORRECTION

WORKERS	PROGRAMS							M/I CASES	TOTAL ERROR $	REVIEW		
	CASH (AFDC)	FOOD STAMPS	MED ASSIST	TITLE IV-A	OTHER	TOTAL						
1.												
2.												
3.												
4.												
5.												
6.												
7.												
8.												
9.												
10												
11												
12.												
TOTAL												

B. UNIT QUOTA _____ DAYS ABSENT (IF APPLICABLE) _____ ADJUSTED QUOTA _____

Completing the CPR Monthly Worksheet (DHR/IMA 103C)

The purpose of this form is to provide a summary of the review activity completed during the month for each worker. This form contains data that can be used to monitor and evaluate the performance of individual workers.

Information for Section A is taken from the yellow copies of the CPR review sheets (102) that are filed in the Worker Files by individual worker.

Information for Section B is taken from the Error Correction File.

Identifying Information

Enter the following information:

- County or Baltimore City District
- Month - The month and year for the reviews
- Reviewer's Name
- Prepared By - Name of the person completing the report
- Date - Date report completed

Section A - Number of Reviews Completed During the Month

For your own identification purposes, enter each worker's name or initials in the left hand column.

1. Pull the yellow 102's from the current month's worker's file. Count the forms by program: AFDC (including AFDC-UP) GPA-PW, Food Stamps, NPA Medical Assistance and TEMHA. If the review includes more than one program, count one program at a time. Go back and recount for each program. Total the program across.
2. Count the number of review sheets that require a correction. Enter that number for error folder.
3. Continue for each worker.
4. Add down the number of programs reviewed and place the total in the appropriate column in the last line of Section A.
5. Add down the number of reviews requiring correction and enter the total in the appropriate column in the last line of Section A.

Section B

This section is completed by the reviewer or unit/central control clerk

1. From the file "Corrected During the Month", pull the corrected white originals of the 102s for the month. Separate by worker. Count and enter the number corrected for each worker in the column "Corrected."
2. From the "Pending Correction File" count the number of cases pending correction as either within limits (not due by end of report month) or or overdue (due before end of report month) and enter figures in the appropriate column for within limits (0-21) or over due (21+).

COMPREHENSIVE PROGRAM REVIEW SYSTEM

CORRECTION LOG

LDSS/OFFICE ______________ SUPERVISOR ______________

H/H NAME	H/H NUMBER	TYPE CORRECTION NEEDED	WORKER	DUE DATE	DATE COMPLETED

R/IMA 104 (Rev 3/96)

Date Page Begun ______

Completing the Correction Log (DHR/IMA 104)

The Correction Log (DHR/IMA 104) is designed for the local departments where error correction is controlled centrally. The use of the form is optional.

This form is used to notify supervisors when outstanding error cases are becoming overdue. It is filled out by the control clerk responsible for maintaining the centralized Error Correction File. A separate Potential Error Log is kept for each supervisory unit. Complete the following information for each form.

- Supervisor - enter the supervisor's name
- County Office or Baltimore City District
- Date Photocopied - see Routing the 104 below.

For each white copy of the 102 you receive, do the following:

1. Locate the Potential Error Log for the supervisory unit. Identify Information: enter the head of household name and number, worker's name from the information on the top of the 102.
2. Review Date - enter the review date from the bottom left of the 102 (beside the supervisor's name).
3. Correction - enter the first item checked as an error cause code entered identifying and item to be corrected.
4. Due Date - enter the date the correction is due as shown on the 102.
5. Date Corrected - when you receive notice (green on record) that a case has been corrected. enter the "Case Correct" date found on the 102.

Routing the 104

At the end of each week the control clerk makes two copies of any sheets listing cases that have not been corrected by the worker. Enter the date photocopies on the line at the upper left of the log sheet. The clerk then forwards one copy of the log to the appropriate first line supervisor and one copy to the Assistant Director or Assistant District Manager.

Mandatory Filing System

Eligibility Worker Files

For every case reviewed, the reviewer keeps a copy of the 102 (yellow) in a folder by individual worker. There is only one folder per worker.

At the end of the month, the reviewer tabulates the forms to show how many reviews were completed and the number of error cases identified for each worker.

After the monthly report is completed, the forms are kept in a back up (monitoring) file to be used for monitoring worker performance, training or evaluation purposes.

Error Correction File

This file tracks all correction activities using the white 102's. At the local department's option, the file is kept by the reviewer, a unit clerk or in a centralized control file.

Whenever a case record is returned for correction, the original (white) of the 102 is filed in due date order in the error correction file. As each case is corrected, the white 102 is pulled from the error correction file and refiled in a separate file labeled "Corrected During Month." These forms are used at the end of the month to complete the Error Correction section of the Reviewer's Worksheet form (103C) and subsequently the CPR Monthly Report (103D).

Monitoring File

In multi-office counties and Baltimore City, only one report is required for each LDSS. Where there are multiple offices, follow the instructions of your local department in order to compile a LDSS report.

White 102 forms may be disposed of after the report is completed. The pink copies are to be retained for one year and a copy of the 103C & 103D reports held for 3 years for auditing purposes.

COMPREHENSIVE PROGRAM REVIEW SYSTEM GUIDELINES

(CPRS)

SCREEN	ITEM	FOCUS	WHAT TO DO
DDR	NARRATION NOTES	Is each page of the narrative dated? Does it identify the worker and DO? Does it provide a complete and concise summary of the action taken? Does it identify the customer by name and ID number on each narrative page? Does it explain verification codes entered as other? Does it address **Others** living in the home listed on the Application/Living With Form but not included in the AU? Does it address areas outside of CARES, such as Work Activity/WOMIS? Has the worker added free-form text to notices, especially worker-entered denials and closings?	Review Narrative for proper documentation of case action.
	PAST MANAGEMENT	At application, has the change that caused the applicant to apply for benefits been documented?	Does Narrative give explanation of past management when applying for cash benefits or managing with excessive expenses?
	ADDRESS RESIDENCY	Is address where the customer lives within the project area? Is this a "New Address?" Is there a separate mailing address?	Compare residential and mailing addresses against verifications or form(s) completed / submitted by customer that shows address (CARES), 491, Rent form, etc.
	AUTHORIZED REP.	Has an authorized Rep. been designated to access EBT benefits, etc., especially the spouse in a two-parent unit?	If Authorized Rep. make sure Rep. is not listed in the mailing address. Go to AREP screen to review codes for who gets benefits and who gets notices (customer or rep. or a combination). Review data and compare to record.
	OTHER	Has the primary language been determined for Notices, etc? Check Previous Addresses in last 2 years.	Review Primary Language and check PREV screen for previous address.

CREEN	ITEM	FOCUS	WHAT TO DO
TAT	AU/HH COMPOSITON	Have all mandatory members been included and all sanctioned, disqualified or ineligible individuals been coded correctly? Were MA units constructed into the most beneficial coverage groups?	Check AU composition constructed at application/redet. Check Relationship and Financial Responsibility codes against verifications in case. If **"OTHER"** is used for Relationship, check Narration for documentation. Check MA coverage group for NPA/MA as worker can change this field. If a closing, check the status reason. **NOTE: Penalty Information will also appear on STAT screen. A separate STAT will appear for each program (TCA, MA, FS).**
	MANDATORY FILING UNIT	**TCA:** Has a child age 19 that is still attending school and expected to graduate in the calendar year been included in the TCA Unit? Is there a child 18 yrs. old still in school? **FS:** Are **children** under the age of 22 included in the FS unit? Are **parents** of child 18 – 21 included in FS **unit?** Has a CSB child for TCA been correctly Included in FS AU? Are Deemers identified (i.e., stepparent)?	Check Relationship and Financial Responsibility Codes. Check verifications in record. Review School Form (604). Review Living Arrangement Verification form, Check for relationship between tenant and landlord. Check to see if there is a report of newborn and that newborn has been included. Check Relationship and Financial Responsibility codes.

SCREEN	ITEM	FOCUS	WHAT TO DO
DEM1	VOTER REGISTRATION	Has each HH member 16 years or older, present during an interview for either address change, appl/redet been offered an opportunity to register to vote?	Review case record for DHR-784, compare against "PRES@INT" and " VOTER-REG" fields for correct coding.
	CSB NOTIFICATION	Has notification date been added to HH DEM1 screen? Has child been added to AU coded as CSB or CSB exempt?	Child only case does not require CSB Notification Date. Review DEM1 "Place of birth, Hospital" field for child's coding when added to AU.
		Has customer filed for child support?	➢ Review APID screen coding in the Assign Rights & IV-D Coop fields. ➢ Check BENL screen for benefit ISSN Amt.
		Is the CSB portion of the grant paid separately to a third party? Were benefits paid timely for both the CSB or CSBE child?	Check CAFI to determine if there is earned/unearned income counted towards TCA benefits. Review VEND screen for CSB payment amount.
		If there is unearned or earned income for any AU member that reduces the TCA benefits, has a calculation been done outside of CARES to determine the correct benefit payment to the REP Payee for the CSB child?	**Check to make sure the CSB vendor payment is an Incremental Portion of the total grant.** **Review FIA AT 97-78 :** **FOR A COMPLETE OVERVIEW ON HOW TO CALCULATE CSB WHEN THERE IS UNEARNED OR EARNED INCOME FOR ANY TCA AU MEMBER.**
	SSN/AGE	Has SSN or application for SSN been verified for each member? Has date of birth been verified for critical age factors such as age of majority, MCHP/PWC groups, etc?	Review SSN, DOB and Verification codes against verifications in case. If NEWBORN, is DHR/IMA 20 in case correct? Is alert for follow-up of SSN for Newborn pending?
	LIVING ARRANGEMENTS	If living with others, is there verification in record that the others purchase and prepare food separately, unless parent and child under 22.	Check rent verification form to see who all is listed and relationship to head of household. Review Living Arrangement and Verification codes. Check record for verification of living with for school age children.
		If ABD, QMB, SLMB and food is included in rent or free room and board, is in-kind income (1/3 MNIL standard added to UINC)?	Review UINC screen for Source Type, Valid Value (IK), Amount and Frequency Code.

SCREEN	ITEM	FOCUS	WHAT TO DO
DEM1	DEPRIVATION FACTOR	Is there a Deprivation Factor for at least one child in FAC unit? Although there is no longer a Deprivation requirement for TCA, CARES still require that codes be entered for this screen.	Review DEM1 "Deprivation" and "Verification" codes for each child against case EDD/forms completed by customer.
	PREGNANCY	Has pregnancy (and EDC) been verified?	Review pregnancy verification codes against case, if **Other** is used, check Narrative. Was an Alert created for follow-up?
DEM2	CITIZENSHIP	Has citizenship been declared for all members? If illegal alien and medical emergency exist, has approval been requested/received from SRT?	Review citizenship and verification codes against verifications in case. If other is used as a code, check Narrative for explanation. If coded as (Non-Citizen), focus attention to **ALAS** field coding and Attachment A. (Immigration Coding Requirement Chart).
	STUDENT	Does any NPA/FS member age 18-50 attending post secondary school meet the definition of an eligible student (i.e., has a dependent child under 12 or works at least 20 hours per week or is in work-study?	Review age and student status code against verifications in case. If Other is used for verification check Narrative. If **PT, HT, OR FT** is entered in "student status" field review ALAS screen for correct coding. **Note: "Student Status" field is coded (FS) for Former Student for anyone who ever attended school but currently not attending.**
	MEDICAL INCAPACITATION	Is any member claiming a disability and has the disability been verified? Has the time period on the medical expired? Does the medical appear altered? If FMA or potential FMA has medical been submitted to SRT, is decision returned and if so, is customer eligible? For anyone in the AU determined disabled by SRT, is the Disability Approval Source code that gives Uncapped Shelter correct?	Check the disability and verification codes against medical verification and SRT material in record. **Review "Disability Approval Source" code.** **Note: A customer who has a disability but is not receiving SSA, SSI, Railroad Retirement, or VA benefits (determined by VA to be 100% disabled)must be active MA and coded MS in the disability source field.**
	IPV	Is there a HH member receiving SS, VA, RR, SSI (even if child)? Has a member committed an Intentional Program Violation (IPV)?	Review "Disability Approval Source" code. Review this screen for IPV code and compare to case record.

SCREEN	ITEM	FOCUS	WHAT TO DO
DEM2	**PPI: HEALTH**	Customer must provide proof of health examinations once every year for children from birth to 6 years.	Review Pre-School codes against verifications in case record. See ALAS screens for more entries on PPI. A child under 7, subject to Pre-school health, must be coded **PT** for student status to prevent system closure of the child.
		Was an AU member eligible for Annual Health Bonus coded correctly?	Check verifications in record against DEM2 **"Medical Entitlement"** codes.
TPL1	**MEDICAL INSURANCE**	Does customer or AP have Health Insurance?	From DEM2 hit PF22 to access TPL1. If Customer or AP has 3rd party coverage, make sure the correct information was entered.
ALAS	**ALIEN**	If non-Citizen, has SAVE procedures been followed?	If Non-Citizen, compare Citizenship and Verification codes to verifications, SAVE material and sponsor information (if applicable) in case record. Check to make sure all ineligible members are coded **"ND 202"** on STAT screen.
		Is the Non-Citizen eligible for any state program (i.e., TCA or FS)?	Compare DEM 2 "Citizenship" code and ALAS "INS STATUS" code against IMMIGRATION CODING REQUIREMENT CHART.
	STUDENT	Has all information been entered on the eligible student for FS?	Screen appears if Student Indicator is marked **PT, HT**, or **FT** on DEM2 screen. If eligible student for FS, check education level, highest-grade completed, school name, graduation date, dep.care respon. and verification code entered against verifications in record.
	PPI: SCHOOL	Customer must verify once every year that school age children (7 in calendar year through 18 years, or under age 19 and expected to graduate in the calendar year he turns age19) are attending school at least 80% of the time.	Check verifications in record against code entered in **"Good Standing"** field. For child eligible for benefits based on graduating in the calendar year he turns age 19, check screen **"Graduation Date"** field for month and year of the child's 19th birthday.
FSME	**MEDICAL BILLS**	Is any FS member age 60+ or disabled and therefore entitled to special deductions for medical expenses? Has gross medical expense been listed on FSME? CARES will deduct $35 from Gross medical expense and calculate the deduction allowed.	If DOB on DEM1 results in age 60 or older or Disability code on DEM2 shows Disabled per Federal Guidelines, the FSME will appear for that individual. Review for entry of medical expenses against documents in case, If no expenses entered, check Narrative for explanation.

SCREEN	ITEM	FOCUS	WHAT TO DO
IST	LTC: 206N	If married, has spouse's income been correctly counted for Long Term Care? Have requirements been met and 206N completed?	Review institutional information, Provider ID, Level of Care Spousal/Family Allowance, etc. and compare to documents in case.
PID	CHILD SUPPORT	Has absent Parent (AP) been identified for the proper children? A series of AP screens (APID, APAD, APDE, APEM, and APCO) will appear for each AP identified. Have Support Rights been assigned? Is non-cooperation and/or good cause indicated? Has all case records information been entered? Was available information on IVD (CAS1/CAS2) screens used to complete **CARES** child support screens? If the absent parent is (unknown), is there an explanation in narration?	Check that AP name is correct and complete as compared to case documents to ensure known data has been entered. Review Legal Relationship code for association with proper child (ren). If court order information is entered, check to see that proper children are associated with this particular C/O. Check 9707 for support rights for all children. Check APID screen "Cooperation" code. An **"A"** in this field indicates caretaker failed to keep an appointment or is otherwise non-**cooperative** and **a #956 Alert** was generated. **"B"** indicates that the caretaker failed to show up for a CSE appointment and a **#957 Alert** was generated to the case manager. If non-cooperation is indicated, has the payee been sanctioned or filed good-cause via 909A?
		Has TCA AU closed because of Excess Child Support? If receiving NPA/FS, has the child support income been entered on the UINC screen?	Check IVD (PAY1/Pay 2) screens; ensure correct amount of support payment is entered on the UINC screen.
ST1, 2	ASSETS	Have all assets been recorded on CARES in the correct asset type? Have cash values for life insurance been included? Are burial contracts recorded? Even though the Asset may not count towards a program, it must still be entered on CARES.	Review AST1 for any assets listed and compare Liquid Asset Type and verification codes against verifications in case. Check to ensure asset was attributed to correct individual. Check life insurance (cash value) and burial contract information. **NOTE: Asset Type is important as it can determine how each program treats the asset.**
	VEHICLES	Has MVA been checked for vehicles for all adults and correct Blue Book value determined?	CHECK AST2 to ensure that all vehicles have been recorded and usage code is correct for each program. Check Value against Blue Book. Any other Real Property is entered on this screen.
		Has the TCA closed and Household will remain eligible for NPA/FS? Was the coding changed to comply with NPA/FS regulations?	Check to ensure the correct code for vehicle is entered.

SCREEN	ITEM	FOCUS	WHAT TO DO
AST1, 2	OTHER	Are there any other assets or have assets been transferred?	AST3 is used to record any assets not previously listed. Transfer of assets appears on "TRAN" Screen. Check any data that appear on these screens.
ERN1, 2	EARNINGS	If earnings are indicated, have gross amounts been entered with correct begin and end dates? Has anyone voluntarily quit a job? Were cents retained for hourly and daily amts. Until weekly amt. Is calculated. *Cents are dropped for income received weekly or less frequently. Is anyone self-employed (i.e., providing childcare, collecting roomer/boarder income)?	On ERN1, check begin and end dates for each job and check employer's name and address. If voluntary quit, check code against documents in case. Check ERN1 for code **"SE"** **NOTE: Effective 12/98 CARES correctly calculates GROSS SELF-EMPLOYMENT EARNINGS coded "SE".** On ERN2, check earnings entered against verification in case record. Check frequency pay received against frequency entered in "Freq" field. Make sure the right frequency code "AC" is used for semi-monthly and monthly earnings. **NOTE: CARES will correctly calculate earnings using the actual income and correct frequency code with respect to policy specific to each program.**
	NEW HIRE ALERTS (990 ALERTS)	Are there outstanding 990 Alerts? Were alerts completed using the correct disposition code?	PF23 from "ADDR" screen or "STAT" screen to check status of alert.
	WAGE SCREENING	Is there current WS completed for each individual 16-17 not in school and 18 and older? Has earning on MABS for last 2 quarters been verified? Are there unreported wages? Has employment status been verified? Has an Overpayment Form (737) been completed for unreported earnings?	Check MABS screens for information on wages and compare to case documents. Check date on printout for currency (obtained within 60 days of when case is submitted to Edit). Check case record for a 737 form completed for the Overpayment.

SCREEN	ITEM	FOCUS	WHAT TO DO
:ARE	DEPENDENT CARE	Are expenses verified?	Check Case Record for Verification. Check that childcare expense is listed for proper children in the correct amount. Check for the provider name.
		Were the actual amounts as **paid** or **billed (including cents)** entered in the "Amt1, AMT2", etc. fields? Is the actual frequency code entered in the "FREQ" field? For child care expenses paid or billed monthly, was the actual amount entered in the "AMT" field and coded "AC" in the "FREQ" field?	Review Verifications and compare to amounts entered in the "AMT" fields and check to ensure that the "FREQ" field is correctly coded. Actual amounts and Actual Frequency codes are entered (i.e., "AMT 1, AMT2, etc. with "FREQ" coded WE or if Biweekly coded BW). CARES will calculate amounts correctly with respect to the policy specific to each program.
		Are there two or more providers for one child over 2 years old? * When a child has more than one child care provider, CARES does not recognize the situation and cannot cap the deduction at the allowable maximum amount.	Check the **CARE screen to be sure a "Y" is not** entered for more providers. Check to make sure, there is only one provider's name and the entire amount paid to both providers is entered in the "AMT1" field.
INC	UNEARNED INCOME	Are all sources and amounts such as SSA, SSI, UIB, Pensions, Phantom Income, etc. considered? Has unearned income been entered for correct household member? Has the claim # including **alpha letter been listed for SSA/RSDI/SSI?**	Check for person receiving, type of income, amounts, frequency codes and verification codes against documents from source in case. Do not accept checks, as this may be net rather than gross income. Use SVES, Award Letter, SDX, MABS II or IEVS. If customer has pending benefits, review bottom of screen for block checked for potential income. This will generate an **Alert** to follow up on claim.
		If customer has applied for benefits, was the pending information listed to generate a 745 ALERT?	Check "APPL TYPE AND "STAT/DATE" fields to ensure follow-up of potential benefits. NOTE: Source of income is particularly Important as each type is identified separately for each program
		Is unearned income entered using correct amounts and frequencies?	Actual amounts and Actual Frequency codes are entered (i.e., "AMT 1, AMT 2 etc. with the "FREQ code WE or if Biweekly code BW). **Cents are not included when entering unearned income.**

SCREEN	ITEM	FOCUS	WHAT TO DO
WORK	**WORK REQUIREMENTS**	Are individuals properly screened and referred for work requirements? Have sanctions been appropriately applied if non-cooperative?	Was an allowed exemption verified? (TCA) Review Assessment/ Independence Plan in case record. Check "WORK" screen PI Status code. Review WO-MIS printouts in case record. Compare Activity Code on WO-MIS printout against CARES "WORK" screen PI Status code. If sanction check HH Size to ensure individual is not included or full family sanction (TCA).
	24-Month Work Requirement	There are no exemptions to the 24-month work requirements. Customers affected by the 24-month work requirement must be enrolled and participating in a **Vendor Program** or in a **STATE Defined Work Activity.** If determined customer is not meeting the 24-month work requirements, was there follow-up with conciliation and sanctioning?	Review Assessment/Independence Plan in case record. Check CARES "WORK" screen PI Status code. Review WO-MIS printouts in case record. Compare Activity Code on WO-MIS printout against CARES "WORK" screen PI Status code. **FULL FAMILY SANCTION FOR FAILURE TO MEET WORK REQUIREMENT:** ➢ Check **WORK** screen for PI status "MN". ➢ Check **AF STAT** screen for sanctioning code. ➢ Check **DEM1** screen for non-compliant individual. Check the **"Birth City"** field for correct code that records the number of sanctions incurred. ➢ Check **MA "STAT"** screen for MA F05 coverage. Make sure the MA Certification End Date match the Food Stamp End date (Fast Path to MAFI/FSFI) to check cert. end dates.
		16-17 year olds and Minor Teen Parents not enrolled in school, a remedial education, or an alternative school which leads to a GED or a diploma must be referred to work or receive an individual sanction if referred and refused to cooperate.	**INDIVIDUAL SANCTIONING:** ➢ Check **WORK** screen for PI status "MP". ➢ Check **UINC** screen for code "OA" (Other countable CASH or MA). Check the amount entered (the difference in the amount of the grant for the HH size with the customer and without.). Check **DEM1** screen for non-compliant individual. Check the **"Birth City"** field for correct code that records the number of sanctions incurred by the individual.

SCREEN	ITEM	FOCUS	WHAT TO DO
WORK	FSET	Are mandatory individuals referred to FSET? Has good cause procedures been followed before sanctioning? Has sanctioning been applied if Non-cooperative?	If a Personal Exemption was granted, check against case record for documentation. Check FS Registration status. Check sanction code and HH size.
SHEL	SHELTER COST	Are shelter cost and billing for utilities correctly determined?	Check amounts and verification codes against documents in case. Check Utility Standard indicators based on case situation.
		If responsible for mortgage payment, is there verification of monthly cost, are taxes or home insurance included in mortgage payment or the responsibility of HH to pay separate from mortgage?	Check for verification of mortgage amount and tax bill. Ensure amount for mortgage payment and for taxes verified as HH responsibility are correct and entered in correct "EXPENSE TYPE" field,
		If responsible for 2nd mortgage, ground rent, were cost entered in the correct expense field?	Ensure that correct type of expense is entered in the correct "EXPENSE TYPE" field.
	HOUSING TYPE	Has subsidized housing been verified at application, after a change of address or once per year at redet? (TCA only).	Check for verification of housing type. Look for inconsistencies in address and type of housing. NOTE: This does not apply to non legally responsible relatives who are not In the AU.
		Review SHELL Screen carefully.	**UTILITY STANDARD CODING HAS PROVED TO BE ERROR PRONE.** ➢ Utility amounts are not entered if HH receives utility standard. ➢ $20 Flat Phone Rate Allowed (HH billed for phone and no other utilities) ➢ SUA allowed (HH billed for Heating/cooling), Enter UTL Y, HEAT in Rent ? N. ➢ LUA allowed (HH billed for electricity not Heat) Enter UTL STD Y, Heat in Rent ? Y. ➢ HH shares Utilities (Enter number HHs sharing. ➢ HH shares Rent (Divide offline by # of HHs sharing)

SCREEN	ITEM	FOCUS	WHAT TO DO
MISC	EXPEDITED F/S	Is HH eligible for Expedited Food Stamps and if so were they issued within **7** calendar days after the date of application?	Check Expedited Discovery date against Issuance Date.
	SOP	Did case meet Standard of Processing for timeliness of application compliance?	Check Date Application Filed against Issuance Date.
	DELAY FAULT CODE	For FS, if benefits were delayed beyond **7** or **28** day processing time, was delay fault determined correctly?	Check Delay Reason if Applicable. Failure to enter reason will cause system to assign Agency fault. **NOTE: If non-compliance is identified, an error is cited but the worker will not be able to correct the case.**
ELIG			Review "ELIG" screen for NON-FINANCIAL results, especially individual status reason for correct AU. If penalty is indicated, check type and date. If a child under 7 has been coded NO for student status at redet the system will close the child with a 231 code. To remove the closure, change DEM2 student status from **NO** to **PT.**
	CASE ASSIGNMENT OVERRIDE	Is case assigned to a worker other than the worker of alphabet?	Check auto reassign override indicator if applicable.
__ FI	APPL. MONTH	Have benefits been correctly confirmed for application month, especially 14-day delay for TCA?	Check screen for application month benefits.
__ FI	CERT. PERIOD	Have correct certification periods been assigned?	Review certification periods for correct assignment.
__ FI	HOUSEHOLD	Is AU/HH size correct? Are MA coverage groups correct?	Check AU/HH and MA coverage groups against expected results. Check for Deemed Income for stepparents, parents of minor children, alien sponsors, excluded aliens and ineligible HH member.
	BENEFITS	Are results of financial calculation correct? Was the correct notice sent? For MA, has a notice been sent for each consideration period?	Check benefit level for ongoing benefits.

	ITEM	FOCUS	WHAT TO DO
	EXPENSES VS INCOME (DEFICIT BUDGET)	Are customer expenses in excess of income? Has action been taken to clarify how customer manages?	Check shelter costs against income. If cost is excessive, check Narrative for explanation. At application, check for 745 Alert to follow-up.
	RETRO MA	Has customer applied for MA coverage for any of the 3 months prior to application month? Has eligibility been correctly tested?	Check screening form completed at application for request for RETRO period? Review ELIG and MAFI screens for decision against proofs of income in case. Review Narrative for proper documentation.
	SPEND DOWN/216	Have MA applicants with over scale income been tested for SPENDDOWN? If yes, have requirements been followed? Is case preserved or has 216 been correctly completed and forwarded?	Check income entered on ERN1, 2 and UINC screens against case for verifications of income. Check SDME (option W) from AMEN. Review medical expenses. Option W=SPEND DOWN Expense Inquiry.
	CASE RECORD FORMAT	Is the case record in the proper format with correct documents filed in appropriate sections? Should worker make a Retired Folder?	Review case materials.
	9707/EDD SIGNED	Has customer signed and dated the screening form, 9707, EDD and any other document that requires a signature?	Review case for properly signed documents.
	BEG	Are there any outstanding BEG Alerts that have not been acted on?	From Welcome to MD Screen, check Alerts for Outstanding BEGs and go to Option R (Benefit Error Group).
	ALERTS	Are there any pending/outstanding Alerts that have not been acted on?	PF23 from "ADDR" screen or "STAT" screen to check status of ALERTS.

TCA CUSTOMERS THAT CAN BE MOVED FROM FEDERAL FUNDED TO STATE FUNDED TCA

5 GROUPS MEETING ELIGIBILITY	CUSTOMER GROUPS	FOCUS	CARES CODING FOR CUSTOMER GROUPS
IMMIGRANTS	• Families with at least one member is not a qualified alien (qualified aliens are not eligible for federal TCA)	Ensure the case manager has correctly identified families that meet eligibility for State funded TCA versus Federal funded TCA. Check that families subject to time limits and work requirements are coded correct on CARES.	**IMMIGRANTS** Families with legal immigrant adults and children (admitted to the country after August 22, 1996) who are not eligible under federal law and meet all other TCA eligibility requirements. On the DEM2 screen enter L in the Citizen field: 1. On the ALAS screen enter the **MM YY** in the Entry date field (the date of entry in the **U.S. must be equal to or greater than 9/96).** 2. This AU <u>will not</u> have an immigration and Naturalization status of **AA, AS** or **RF** INS status or alien country code **AA** or **CU** – Country of Origin on this screen.
NON-PARENT CARETAKER RELATIVES	• Families that include a non-parent caretaker relative		
STUDENTS AGE 19	• Families with a child who is a full-time student and expected to graduate and turn 19 before graduating (the month the child turns 19 through the month of graduation).		
FAMILY VIOLENCE	• Families that include a victim of domestic violence		
DISABLED ADULTS/CHILDREN	• Families that include adult parents or children that are disabled (have a medical that indicates a 12-month disability or expected to result in death.)	Ensure that families subject to time limits can be identified for accurate tracking needed for state/federal reporting requirements.	**NON-PARENT CARETAKER RELATIVES** Families with children included in the AU cared for by a non-parent relative who is included in the AU and has no dependent children of his/her own. This AU is identified by the household composition of children whose relationship to the Head of household: 1. On the STAT screen REL field is grand/great child **GC**, niece/nephew **NN**, first cousin **FC**, sibling **SI, half sibling HS,** or step sibling **SS**.

			CARES CODING FOR CUSTOMER GROUPS
ROUPS MEETING LIGIBILITY FOR TATE FUNDED TCA			**STUDENTS AGE 19** Families with a child who is a full time student and turns 19 before graduating (the month the child turns 19 through month of graduation): 1. On the STAT screen REL field is **CH, CP, CC, SC, GC, NN, FC, SI, HS, or SS.** **FAMILY VIOLENCE** Families where an adult or child is a victim of family violence and is actively receiving as part of a service plan to overcome barriers to independence caused by family violence. 1. On the DEM2 screen the **DMVIOL** field is coded **Y.** **DISABLED ADULT/CHILDREN** Disabled TCA parents and/or children who present a medical with a 12 month or more disability (or a series of medical reports that total 12 months or more) must sign a 340 Interim Payment Reimbursement Authorization Form and be referred to and cooperate with DEAP. 1. On the DEM2 screen **HO, HP, OR,PA, RR, RS, VA,** or **VZ** is entered in the Approval Source field. 2. The date the 340 was signed is entered in the **IAR** date field. The begin and End dates are the dates indicated on the disability verification form. 3. On the UINC screen: • **DE** in the **APPL Type** field • **P** in the STAT field (update STAT field as changes occur). • The date the customer was referred to DEAP in the **Date** field.

TECHNICAL FACTORS - FOOD STAMPS

Note: These are technical factors for eligibility for this program that will be cited as an error if not present during the CPRS review.

FOOD STAMP PROGRAM	WHAT TO DO
Social Security Numbers - Individuals who refuse or fail without good cause to provide a social security number (SSN) or to apply for one are ineligible to participate as a member of the household.	Verification of SSNs is not required for households, which are categorically eligible, based on TCA or SSI payments. However, an SSN may be verified for a member of a categorically eligible household when the number is needed to do an IEVS check and the SSN is not in the case file or it appears incorrect. For other households, including those households which are categorically eligible based on TEHMA payments, verification of the SSN must be obtained for each household member. If the SSN is not verified, the case is cited in error.
Application/EDD - Application forms must be signed and dated by the customer prior to payment of benefits.	Review Application/EDD form for signature and date.

COMPREHENSIVE PROGRAM REVIEW SYSTEM GUIDELINES-POC
(CPRS)

SCREEN	ITEM	FOCUS	WHAT TO DO
CHILD RECORD	MEDICAL DISABILITY	If a payment adjustment to a provider was approved for a child with a disability, is there documentation of compliance with the definition of "child with a disability"?	Check for documentation from a qualified physician, psychologist, or licensed social worker that verifies the child has a disability limiting self-care as appropriate to the child's age.
MILE STONES	APPLICATION	Was the most recent application, dated and signed by the applicant? **(Technical Factor)**	Check for a DHR/CCA 354 or DHR/CCA 8004 application form which includes the fraud statement, that is signed and dated by the applicant.
		Was the decision made for denial of service within thirty days from the date of receipt of the application form?	Check the case file for a DHR/CCA 354 or the DHR/ CCA 8004 or CCAMIS milestones indicating the date the application was received and the date of case denial. Check case file for a Service-1 (CIS) form which indicates both an Application Date and Denial Code. Check case file for denial notice dated no more than 30 days after the Application Date.
		Was the decision made for acceptance of service within thirty days from the date of receipt of all requested verifications?	Check the case file for a DHR/CCA 354 or the DHR/ CCA 8004 or CCAMIS milestones indicating the date The application was received and the date of case acceptance. Check the case file for CCAMIS letters or other locally produced letters requesting verification. Check the file for the listed verifications with date stamp or a case manager's log entry indicating the date verifications were received. Check case file for a Service-1 (CIS) form which indicates both an Application Date and an Acceptance Date. The Acceptance Date is no more than 30 days after

SCREEN	ITEM	FOCUS	WHAT TO DO
MILE STONES	APPLICATION (Continued)	Was the decision made for acceptance of service within thirty days from the date of receipt of all requested verifications?	the date the last verification is received. Check the file for a voucher with an effective date on or after the date the last verification was received. If the voucher's effective date is before the date the last verification was received, then the case is not in compliance and an overpayment has occurred.
		Was customer notified of eligibility within thirty days from the date of receipt of all requested verifications?	Check the case file for a DHR/CCA 354 or the DHR/ CCA 8004 or CCAMIS milestones indicating the date the application was received and the date of case was denied. Check case file for a Service-1 (CIS) form which indicates both an Application Date and Denial Code. Check the case file for a CCAMIS voucher cover letter (POC 16 or 51) or a locally produced letter notifying the customer of their approval/eligibility for service.
	REDETERMINATION	Was the most recent redetermination completed on time?	Check case file for a DHR/CCA 354 or DHR/CCA 8004 signed and dated by customer no later than 12 months from the original application or the previous redetermination. A Services-2 form reflecting the redetermination was completed no later than 12 months from the original application or the previous redetermination must be present for the redetermination to be considered timely. If customer was no longer eligible for POC during the sample month and the case was closed after the end of the sample month in which the redetermination was due then, the item is not in compliance. If the redetermination of the case due in the sample month was not completed prior to the review then, the item is not in compliance.

SCREEN	ITEM	FOCUS	WHAT TO DO
MILE STONES	PRIORITY CODE	Is there documentation in the case record to support the indicated priority code?	Check the case file for a DHR/CCA 354, DHR/CCA 8004, a CCAMIS case profile or case milestones screen which indicates the priority code. **For Priority 1 customers-** Check the case file for proof that the customers is receiving or has applied for TCA. If the customer has applied for TCA the application must still be pending for Priority 1 status to be granted. Check the case file for proof that the customer is working (pay stubs or statement from employer) or participating in an approved activity (statement from FIP case managers or a program approved by FIA). When an employment verification form letter is used to verify employment check the form for a date stamp from the employer. In the absence of a date stamp check the file for documentation that the case manager contacted the employer and verified the information on the form. For customers in an approved activity, check the file for documentation of participation in public school, training, work experience, job search, work activity, community service or other activity included in the customers personal responsibility plan. If the customer is in school or a training activity, a schedule which includes start and end dates must be in the case file. If the customer is working, pay stubs or other verification of work activity must be in the case file.

SCREEN	ITEM	FOCUS	WHAT TO DO
MILE STONES	PRIORITY CODE (Continued)	Is there documentation in the case record to support the indicated priority code?	**For Priority 2 customers-** Check the case file for proof that the customer is working and: (1) received TCA for at least 3 of the prior 6 months and (2) lost TCA benefits due to an increase hours or earnings from employment or loss to income disregards. Cares screens or a termination letter can be used to verify this information. Check the closing code or closing reasons/citation to assure TCA benefits were lost as specified above. Both the loss of TCA and the reason for losing TCA must be documented in the file for the case to be compliant. **Priority 3 customers-** Check the case file for a DHR/ CCA 354 or DHR/CCA 8004 which indicates the gross family income. The family must meet the income requirement. Check the application form for customer's activity (work, school or training program including undergraduate school). If the customer is in school or a training activity, a schedule which includes start and end dates must be in the case record. If the customer is working, pay stubs or other verification of work activity must be in the case record. **All Priority Codes-** Check the case file for a DHR/CCA 354 or DHR/CCA 8004 which indicates the gross family income. The family must meet POC income requirement for the family size.

SCREEN	ITEM	FOCUS	WHAT TO DO
VOUCHER	BENEFITS	Is there indication in the case record of the subsidy and the copayment to be paid for each child? **(Technical factor)**	Check the case file for a DHR CCAMIS generated voucher or a manual voucher (DHR/CCA 411F or DHR/CCA 411I). For the voucher to be valid it must be signed and dated by the customer and the provider and returned to the agency with 60 days of the date of authorization listed on the voucher. An unsigned copy of a voucher is acceptable only if the 60 days period has not elapsed. If there is no voucher in the case file or only an unsigned copy is the case file when the 60-day period has elapsed, then the case is non-compliant.
INCOME WORK SHEET	INCOME	Does the case record contain documentation of the family income which was the basis for the subsidy and co-payment level?	For TCA, a CIS clearance or benefits letter must be in the case file. When unearned income is received (SSI, UIB, VA) or Social Security a benefit award letter must be in the case file. If a CARES screen can verify the unearned income it may be substituted for a benefit award letter. When a customer is currently receiving a benefit, the documentation of income must verify the amount of funds received in the month the action is being taken. For working customers, copies of recent and consecutive payroll receipts representing 4 weeks of pay must be included in the case file. When a letter from an employer is used to verify pay it must be on company letterhead. If an employment form is used it must contain a date stamp or the case file log must indicate that the case manager verified the information. Letters from employers and employment forms must verify gross pay, dates of pay, amount paid hourly and the number of hours worked per week.

SCREEN	ITEM	FOCUS	WHAT TO DO
INCOME WORK SHEET	INCOME (Continued)	Does the case record contain documentation of the family income which was the basis for the subsidy and co-payment level?	For newly employed or recently terminated customer's the letter or form must also verify the first day of work and first date of pay or the last day of work and pay. Check for the DHR/CCA 354 or the DHR/CCA 8004 application form indicating the gross family income. Check for a copy of the Deed Wage History Screen for the most current application or redetermination for non-TCA customers.
ACTIVITY LOG	ADVERSE ACTION	If the service is terminated, was customer given a timely and correctly written notice of adverse action?	Check for a Notice of Adverse Action or a Terminiation letter written at least 8 calendar days before the action. Check that the notice contains the action to be taken, the reason for the action, the regulation supporting the action, and an explanation of the right to a fair hearing and the method for obtaining it. When the customer's case is being closed, check for a copy of the notice to the provider indicating termination of service, dated at least 8 calendars days prior to termination date of case.
		If the service was terminated, was the provider given timely a timely written notice?	When payment to a provider is being denied, check the case file to determine if payment to the provider is stopped: (1) based on documentation of risk to the health or safety of a child in that placement, or (2) to an informal provider based on a child abuse or neglect case review. If so then, check for a Notice of Adverse Action written at least 8 calendar days before the action. Check that the notice contains the action to be taken, the reason for the action, the regulation supporting the action, and an explanation of the right to a fair hearing and the method for obtaining it.

SCREEN	ITEM	FOCUS	WHAT TO DO
ACTIVITY LOG	VOUCHER EXPIRATION	Did the customer receive 30 days notice that the voucher was about to expire?	Check the file for a written notice to the customer that is dated 30 days prior to the expiration of the current voucher.
CASE PROGRAM ACTIVITY	CUSTOMER ACTIVITY	Does the case file contain documentation of the customer's activity? **(Technical Factor)**	Check the case file for documentation of the customer's activity and schedule. The schedule must include the days and hours of the activity. For working customers four consecutive weeks of pay stubs and the customer's declaration on the application is sufficient. The pay stubs must be the most recent stubs received by the customer.
INFORMAL PROVIDER REGISTRY	INFORMAL CARE	Does the case record contain documentation that the informal provider was eligible for payment? **(Technical Factor)**	Check the case record for a: 1. DHR/CCA 1714 completed and signed by the provider and customer. Check the 1714 to assure that the provider is caring for no more than six children. The six children include no more than two children under the age of two and the provider's children under the age of six, 2. DHR/CCA 1420 signed by the provider and any Adult regularly present in the home when the child is in care, 3. CIS Services clearance or a POC evaluation form (DHR/CCA 1716) completed by the local Services Unit or designated staff. The form must indicate that the provider is recommended for the provision of child care for the provider to be eligible for payment, and 4. A copy of the informal provider registry screen. The informal provider registry screen and the information on the informal child care forms listed above must match. All of the required documentation must be present for the case to be compliant.

TECHNICAL FACTORS – POC

Note: These are technical factors for eligibility for these programs that will be cited as an error if not present during the CPRS review.

1. POC Application Form – The DHR/CCA 354 or 8004 must be in the case file. The application must contain an original signature of the potential customer.

2. POC Voucher – A valid CCAMIS generated voucher or manual voucher (DHR/CCA 411F or DHR/CCA 411I) must be in the case file. For the voucher to be valid it must be signed and dated by the customer and the provider and returned to the agency within 60 days of the date of authorization listed on the voucher. For vouchers issued prior to September 1, 1999 the voucher must have been returned to the local department as specified above within 30 days of the date of authorization listed on the voucher.

3. Proof of Acceptable Activity – Documentation of the customer's activity must be in the case file. It must include the customer's Activity, days scheduled and hours worked. For working customers 4 consecutive weeks of pay stubs and the customer's declaration on the application form is sufficient.

4. For Customers Using Informal Care: Informal Care Provider Eligibility Documentation – The following items must be in the case file:

   a. DHR/CCA 1714 completed and signed by the provider and customer. Check the 1714 to assure that the provider is caring for no more than six children. Of these children no more than two children under the age of two including the provider's children under the age of six,

   b. DHR/CCA 1420 signed by the provider and any adult regularly present in the home when the child is in care,

   c. CIS Services clearance or a POC evaluation form (DHR/CCA 1716) completed by the local Services unit or designated staff and recommending the provider for the provision of child care must be case file, and

   d. A copy of the informal provider registry screen must be in the case file. The informal provider registry screen and the informal child care forms listed above must match.

All of the required documentation must be present for the case to be compliant.