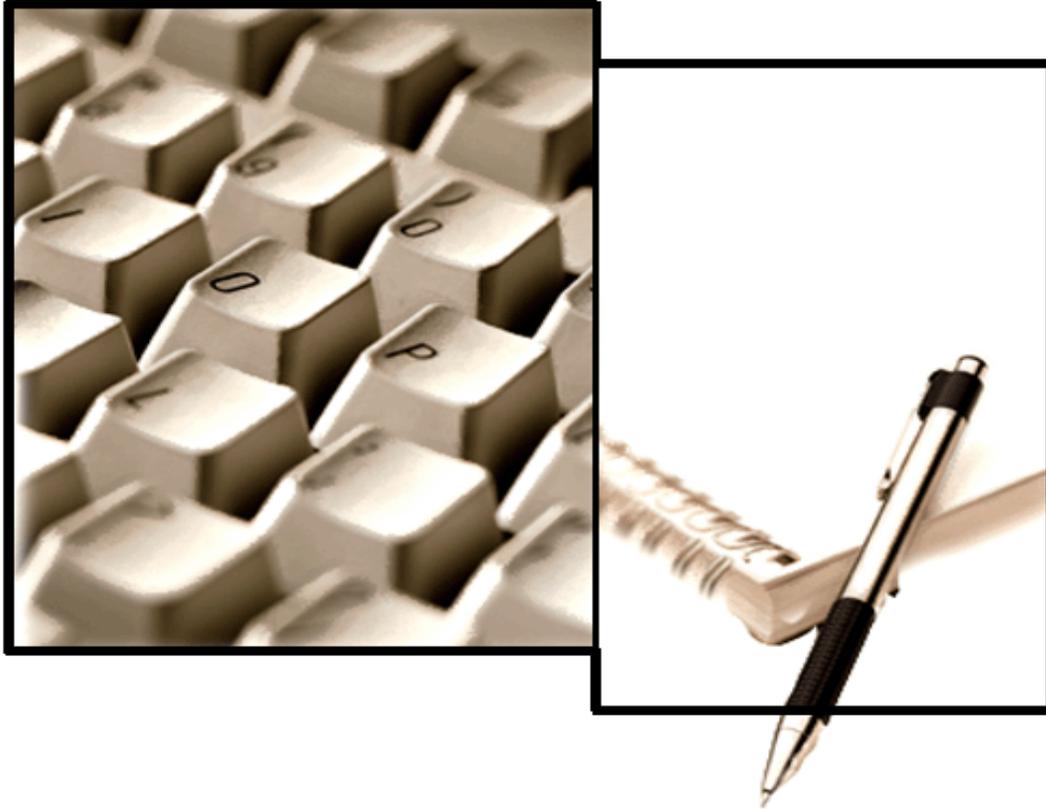


Title II Claims Specialist Basic Training Curriculum



Unit 5 Modules 31 – 37 Appeals, Title II PE & Other Subjects Student

SOCIAL SECURITY ADMINISTRATION,
Office of Human Resources, Office of Learning
SSA PUB. No 25-1290

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LESSON PLAN

Chapter Objectives

At the completion of this chapter, the students will be able to:

1. Recognize when to abate an application and how to process abatements.
2. Recognize when to withdraw an application and how to process withdrawals.

Length of Chapter

4 hours

Local Supply

SSA-521

BACKGROUND AND RATIONALE

Introduction

In previous chapters, you learned how to develop and adjudicate a claim as an allowance or disallowance.

In this chapter, we will discuss two additional methods of disposing of applications. These methods are used when you have determined no entitlement exists and no benefits are payable: Abatement and Withdrawals.

OBJECTIVE 1:

Recognize When to Abate an Application and How to Process Abatements

Abatement

[GN 01010.475](#)

Abatement is a method of disposing of an application without making a determination about the claimant's entitlement. There are no appeal rights for abatement because there has been no initial determination.

Conditions for Abatement

[GN 01010.475](#), [EM-15045 SEN REV](#), [EM-17016 SEN REV](#)

Prepare an abatement only in these situations:

- An individual filing an application on a claimant's behalf is not a "proper applicant." See [GN 00204.003](#) for information about the proper applicant.
- The non-disabled claimant or disabled child dies in or before the first month of entitlement to benefits, and there is no entitlement to HI/SMI.
- Anomalous claims in which the 'ANOML' issue code is present on the Development Worksheet (DW01/DW02) and the NH:
 - does not contact the agency within 15-calendar days after we send the Field Office Call/Come in Request (SSA-2708).
 - denies filing the pending claim.

- A DIB or DWB claimant dies during the waiting period, there is no possibility of an earlier onset date, there is no existing prior DIB or freeze, which ended within five years of the current onset month, and there is no entitlement to HI/SMI.

If the claimant is entitled to HI/SMI in the month of death, an award is appropriate.

NOTE: Third parties can establish a protective filing date for another person by submitting a written statement indicating a clear intent to file an application for benefits. See [GN 00204.010-.013](#) for more information. A claim established by an improper applicant must be abated if the person claiming benefits, or a proper applicant for that person, does not subsequently attest to or sign the application.

Processing Abatements

[GN 01010.475](#), [SM 00380.040](#), [EM-17016 SEN REV](#)

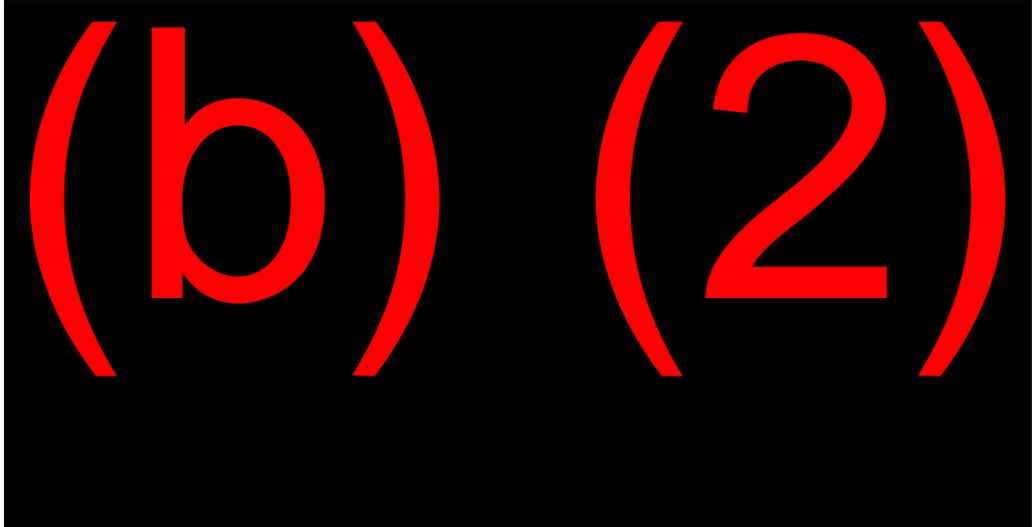
Clearance Process

Abatements are processed through EC. An abatement will not establish or update an existing MBR.

When a claim is abated, take the following action to process:

- Enter #2 (Update) and #6 (Claims Clearance) on the MCS Main Menu.
- On the Claims Clearance Menu (CMEN), select option #5 (BECF).
- Enter the abatement code on the BECF screen in the Disallowance Reason. The only allowable codes are:
 - **67** – improper applicant,
 - **68** – claimant died in or before first month of entitlement and is not entitled to HI or SMI,
 - **96** – Disability - death in the waiting period.

- Complete any other optional clearance screens as needed.
- Review the pre-adjudicative EC along with the application screens and proofs.
- On the MCS Main Menu, select #2 (Update) and #23 (Decision Input) and complete the DECI screen with DEC STAT Code of 07 (With/Abate).



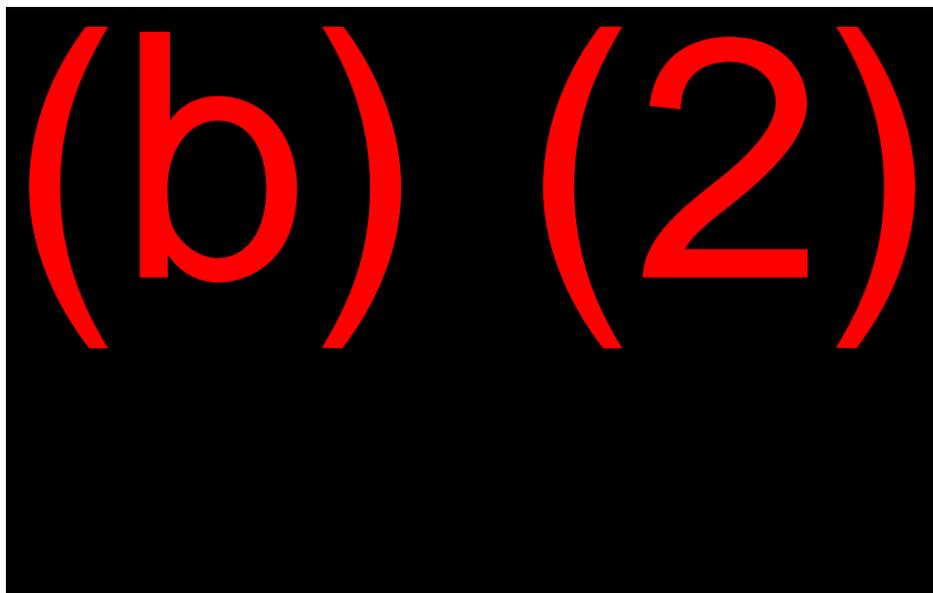
With the DECI screen completed, you will process the abated claim through EC in the normal manner.

- Complete the adjudicative request to process the claim in EC. (Enter #2 (Update) and #21 (Earnings Comp Request) on the MCS Main Menu.
- On the MREQ screen, show “ADJUDICATIVE REQUEST: Y.” Indicate “PROCESS ALL CLAIMANTS: Y.”
- On the MCR1 screen, enter option #7 (Approve) in the Case Display field to access the DAPP Screen.
- On the DAPP screen, show “PERMIT CLAIM PROCESSING: Y” to process the withdrawal.
- After entering the DAPP screen, you will return to the MCS Main Menu with the message “FINAL TRIGGER SUCCESSFUL.”

MCS sends an automatic notice of the abatement action telling the applicant:

- A determination based on the application has not been made;
- The reason for not making the determination; and
- To call or visit the field office if there are any questions.

NOTE: Suppress the abatement notice for anomalous claims. On the Notice 3 (NOT3) screen, enter “Y” (YES) in the SUPPRESS field to stop the generation of the MCS abatement notice. See below:



OBJECTIVE 2:

Recognize When to Withdraw an Application and How to Process Withdrawals

Withdrawal

[GN 00206.000ff](#)

A withdrawal is a voluntary act in which an individual forfeits all rights to a specific application. A subsequent application may not cover the same retroactive period as the initial application. Benefits could be lost when an application is withdrawn.

The processing of a withdrawal is not considered an adjudicative action. This is because the claimant makes the decision to withdraw an application and it is not a "decision made by the Administration," like an allowance or disallowance.

An approved withdrawal request DOES NOT preserve appeal rights.

RIB-only Withdrawals

[GN 00206.001](#), [GN 00206.014](#)

Policy regarding withdrawal of **RIB Only** applications changed 12/08/10. The current policy changes include:

- A time limit to withdraw a RIB application (12 months after MOE).
- One RIB application withdrawal per lifetime.

NOTE: The one (1) RIB application withdrawal per lifetime refers to post-adjudicative withdrawal requests regardless of the reason.

Pre-Adjudicated Claims Withdrawal Requests

[GN 00206.011](#)

The FO has jurisdiction of withdrawal requests received on pre-adjudicated claims for RIB. The claimant's request to withdraw must be in writing, preferably on form [SSA-521](#). There are several steps to take on these requests:

1. Annotate the SSA-521 following the instructions in [GN 00206.011](#).
2. If the claimant meets all of the requirements in [GN 00206.005 A](#), then approve the request.
3. Code the BECF screen with the appropriate withdrawal code.
4. Complete the DECI screen with the appropriate status code.
5. Adjudicate the claim through EC. The system will send the appropriate notice.
6. Store the SSA-521 in NDRed.

Post-Adjudicative Claims Withdrawal Requests

[GN 00206.014](#)

The PSC has jurisdiction of withdrawal requests received after adjudication. If you receive a withdrawal request, then take the following actions:

1. Review the SSA-521 to ensure it states what the claimant is withdrawing (i.e., RIB-only or RIB and HI coverage) and the reason for the withdrawal.
2. Print the fax cover sheet using Paperless Barcode application under TOEL "CLAIM WITHDR" and include the message: "WITHDRAW – Claim Withdrawal {Post-adjudicative}."
3. Fax the withdrawal request and any associated documentation to the PSC paperless system and NDRed.

4. Add a special message to the MBR: "WITHDR REC MM/DD/YYYY forwarded to PSC# on MM/DD/YYYY."
5. Suspend the claimant's monthly benefit via POS, per [SM 03020.270](#).

Do NOT take a new claim for a new date of entitlement until after the claimant receives formal withdraw determination.

If the claimant insists on filing a new claim prior to the WD approval, the FO must process the claim as a duplicate application. Follow instructions for duplicate applications in [GN 00204.028](#).

PSC Action on Withdrawal Request

Once the PSC receives the withdrawal request, their action will depend on if the request was made within 12 months of the current date of entitlement (DOEC).

The 12 months are counted beginning with the first month after the DOEC and ends with the 12th month.

EXAMPLE: If the DOEC is 12/2018, then the 12 months begin 01/2019 and end the last day of 12/2019 (12/31/2019).

If the request is made within 12 months of the DOEC, then the withdrawal request is processed like all other withdrawals. See [GN 00206.014](#).

If the request is made more than 12 months from the DOEC, then the request for withdrawal will be denied. The technician in the PSC will annotate the Special Message field of the MBR and send the appropriate denial notice.

Conditions for Withdrawal

[GN 00206.005](#)

Withdrawal Prior to Adjudication

A claimant or proper applicant can withdraw an application prior to final adjudication if all the following conditions are met:

- A written request for withdrawal is filed by the proper applicant specifically stating what is being withdrawn and why;
- The claimant is alive at the time the request is filed; and
- The request is filed on or before the date of final adjudication.

NOTE: A request for withdrawal made prior to final adjudication is the **responsibility of the FO**. All individuals whose entitlement will be affected by the withdrawal must receive a written notification. The withdrawal will be processed through MCS. Annotate the Report of Contact (RPOC) screen in MCS describing the request for withdrawal and include the date the NH signed the request. ([GN 00206.011](#))

Withdrawal After Adjudication

If a request for withdrawal is filed after adjudication, the following conditions must also be met:

- Any other beneficiary (or proper person acting on their behalf) whose entitlement will be nullified by the request must consent in writing to the withdrawal ([GN 00206.005A](#)), and
- The beneficiary wishing to withdraw a claim must repay all monthly benefits received (and any amount paid for hospital and medical services where applicable). Repayment may be in the form of restitution or adjustment against the first check under a new claim. Under no circumstances can repayment be made via monthly installments against benefits which will be payable in future months. ([GN 00206.014](#))

NOTE: A request for withdrawal made after final adjudication is the **responsibility of the PC**. Fax the SSA-521 or written request, along with any supporting documentation, to the appropriate PC using the Paperless Barcoding Application. If other claimants are involved, obtain necessary consent statements and fax these along with the withdrawal request using the Paperless Barcode application. The PC will approve or disallow the withdrawal and issue all appropriate notices.

If the withdrawal request is approved, the claimant will have no appeal rights. If the request for withdrawal is disallowed, a reconsideration paragraph will be included in the notice. ([GN 00206.014](#))

Withdrawal after the NH's Death

If the NH is deceased, the widow(er) can withdraw a NH's application for **reduced** RIB only. This most commonly occurs when the RIB/LIM is involved. A written request or SSA-521 must be received before the benefit is certified for payment to the Treasury Department. If the payment has already been certified to Treasury, certification must have occurred after the NH's death. See [GN 00206.005B](#) for more information.

Medicare Involved

[GN 00206.020](#)

If Medicare is involved, the beneficiary can choose to withdraw the application for:

- RSI monthly benefits only; or
- RSI monthly benefits and hospital insurance (HI). A beneficiary who receives monthly RSI benefits cannot withdraw HI coverage only; or
- Medicare only claim; or
- RSI cash benefits and supplemental medical insurance (SMI). The beneficiary must submit a separate [CMS-1763](#) to cancel SMI coverage and, if the beneficiary was entitled to premium HI, this request will also end the HI coverage.

NOTE: An individual withdrawing a claim based on disability (DIB, CDB, DWB, or ESRD) will lose any entitlement to Medicare. [SM 03040.500B](#)

Withdrawal Documentation

[GN 00206.005](#)

SSA-521

A withdrawal does not become effective until it is approved by SSA. Any written request for withdrawal signed by the claimant or proper applicant represents an acceptable request; the SSA-521 is the preferred form.

Conditional Withdrawal**[GN 00206.055](#)****DIB Involved**

A claimant may be eligible for more than one T2 benefit. When a claimant has to wait for the outcome of one claim, but requests to receive the other while waiting, he or she has the option to withdraw the lower benefit once the determination is made on the other, higher benefit. For example, withdrawing a RIB claim while filing a DIB claim. A statement should be included on the withdrawal: "I wish to withdraw my retirement application only if it is finally determined I am entitled to a DIB beginning no later than (date)."

Note: The withdrawal will not be immediately processed. The FO will set a 9-month diary for the PC to contact DDS regarding the disability decision.

DIB Not Involved

If the claimant bases the withdrawal upon the outcome of some future event, other than approval of a claim for DIB, the withdrawal will be processed right away. In this situation, it is the claimant's responsibility to notify SSA if the conditions of the withdrawal request are not realized.

Withdrawal Processing

Clearance Process

[GN 00206.011](#), [SM 00380.040](#)

When a claim is withdrawn prior to adjudication, the withdrawal can be processed through EC. When the claim processes, the proper notices will be generated.

Take the following action when a claim is withdrawn:

- Enter #2 (Update) and #6 (Claims Clearance) on the MCS Main Menu.
- On the Claims Clearance Menu (CMEN), select option #5 (BECF).
- Enter the withdrawal code on the BECF screen in the Disallowance Reason. The only allowable codes are:
 - **Withdrawal - RSI**
 - 200 - Claimant will continue to work (Unconditional Withdrawal)
 - 201 - Other (Unconditional Withdrawal)
 - 202 - Conditional Withdrawal
 - **Withdrawal - Disability**
 - 203 - Claimant will continue to work (Unconditional Withdrawal)
 - 204 - Other (Unconditional Withdrawal)
 - 205 - Conditional Withdrawal
 - **Withdrawal- MQGE/ESRD**
 - 206 - Unconditional
 - 207 - Conditional

- Complete any other optional clearance screens as needed.
- Review the pre-adjudicative EC along with the application screens and proofs.
- On the MCS Main Menu, select #2 (Update) and #23 (Decision Input) and complete the DECI screen with a DEC STAT Code of 07 (With/Abate).
- On the MCS Main Menu, select #2 (Update) and #21 (Earnings Comp Request).
- On the MREQ screen, show “ADJUDICATIVE REQUEST: Y.” Indicate “PROCESS ALL CLAIMANTS: Y.”
- On the MCR1 screen, enter option #7 (Approve) in the Case Display field to access the DAPP Screen.
- On the DAPP screen, show “PERMIT CLAIM PROCESSING: Y” to process the withdrawal.
- After entering the DAPP screen, you will return to the MCS Main Menu with the message “FINAL TRIGGER SUCCESSFUL.”

Request Received After Case Transferred to DDS

[GN 00206.120, DI 23015.001](#)

The FO has jurisdiction to approve a withdrawal request for a DIB claim and release a notice to the claimant when we have not made a determination. When the FO receives a request for withdrawal of a case that has already been transferred to DDS, the FO will:

- ensure all conditions in [GN 00206.005](#) are met;
- process the withdrawal per [GN 00206.011](#);
- make a decision to approve or deny the request; and
- if approved, notify DDS vis Update-After-Transfer.

DDS will:

- process the withdrawal request as outlined in [DI 23015.001](#); and

- close the case in EDCS using the “No Determination” process. Follow the steps in [DI 81020.127](#) for electronic instructions or [DI 32005.020](#) for paper instructions.

If the DDS receives a withdrawal request directly from the claimant, they will determine whether the request is for withdrawal or a desire “not to pursue” the claim. If the claimant wants to withdraw then the DDS will follow the procedure in [DI 23015.001B.2](#).

NOTE: Approval of a withdrawal request will not provide appeal rights whereas a disallowance preserves the claimant’s appeal rights. It may be preferable to process a disallowance rather than a withdrawal request. [DI 23015.001](#)

Request Received After Adjudication

[GN 00206.014](#)

When a request to withdraw a claim is received after adjudication, the request will be sent to the appropriate PC for processing. Set a tickle as a follow up for PC action.

Per [GN 00206.105](#), if the adjudicated claim was **disallowed**, inform the claimant that a disallowance decision has no future disadvantages and provides appeals rights. If the claimant insists on withdrawing the claim after the disallowance:

- obtain a signed statement stating that he or she understands:
 - The disallowance decision preserves his or her appeal rights, as a withdrawal does not.
 - The subsequent application (if any) may not cover the same retroactive period as the disallowed claim.
- Forward the signed statement with the WD request to the appropriate PC.

MBR

Withdrawal information is posted to the MBR in the W/D SUSP line and W/D TERM line of the MBR.

NOTE: Refer to [Exhibit 1](#) for an excerpt of an MBR with a withdrawal coded on the W/D TERM line.

Cancellation of Withdrawals

[GN 00206.017](#)

A withdrawal may be cancelled within 60 days after the date of the notice approving the withdrawal. Cancellation of the withdrawal reinstates all applications withdrawn or nullified by the original withdrawal.

Cancellation of a withdrawal request must:

- Be in writing;
- Be signed by the claimant or proper applicant;
- Give a reason for the cancellation; and

State the claimant wants a determination on their eligibility and entitlement for the original filed application.

To Withdraw or Not to Withdraw

Reminders

Raise the issue of withdrawal only if it is to the claimant's advantage. In some situations, a disallowance would be preferable because a disallowance preserves the right to reconsideration, hearing, and further appeals. A withdrawal does not.

Do not conclude a claimant is actually requesting their claim be withdrawn in the technical sense because they use such words as "withdraw" or "cancel." Claimants may use these words because they do not know the terminology to use in expressing they do not wish to pursue their claims.

When the claim involves one or more entitled persons age 65 or older, withdrawal by the NH does not nullify the auxiliary's HI entitlement even if the monthly benefit is lost.

The withdrawal for monthly benefits does not terminate supplemental medical insurance (SMI). SMI terminates with the end of the month after

the month in which the request for "withdrawal" is filed. A separate CMS-1763 is used for this purpose.

EXHIBIT 1: MASTER BENEFICIARY RECORD (MBR)

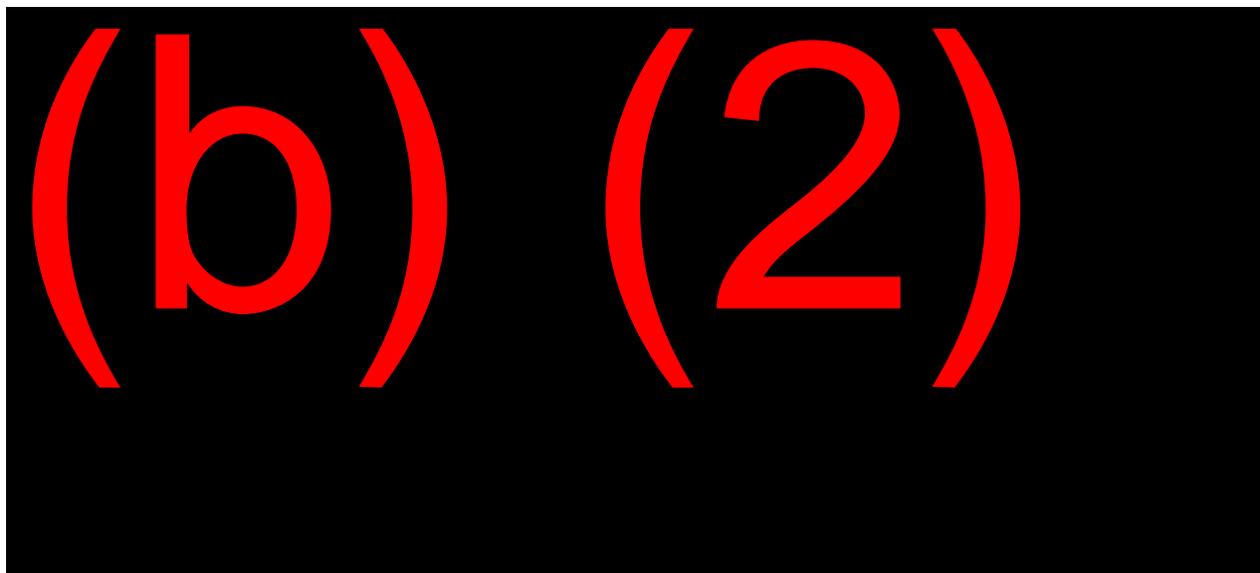


EXHIBIT 2: ABATEMENT AND WITHDRAWAL CODES TO BE SHOWN ON BECF SCREEN

SM 00380.040

ABATEMENTS	67	Improper Applicant
	68	Claimant died in or before the first month of entitlement and is not entitled to HI or SMI.
ABATEMENT-DISABILITY	96	Death during the waiting period (Refer to GN 01010.475B)
WITHDRAWAL – RSI	200	Claimant will continue to work (Unconditional Withdrawal)
	201	Other (Unconditional Withdrawal)
	202	Conditional Withdrawal
WITHDRAWAL – DISABILITY	203	Claimant will continue to work (Unconditional Withdrawal)
	204	Other (Unconditional Withdrawal)
	205	Conditional Withdrawal
WITHDRAWAL – MQGE/ESRD	206	Unconditional
	207	Conditional

OFF-AIR ACTIVITIES

1. Locate POMS sections [GN 01010.475](#) and [GN 00206.001ff](#) and study each section. These POMS references will be used in the exercises, which follow.
2. Locate and review form SSA-521 in UniForms.
3. Refer to [Exhibit 2](#) in this chapter for a listing of Withdrawal Codes that can be used on the BECF screen.

The list of Disallowance, Withdrawal and Abatement codes can also be located on the (b) (2)(b) (2)(b) (2):

- First, go to the [Program Information](#) section and click on [RSI Desk Guide \(OQP\)](#);
 - Then, from the table of contents select [Code Book](#) and click on [Disallowance Abatement and Withdrawal Codes](#).
4. Check with your mentor to see if there are any cases in your field office to be processed as a Withdrawal or Abatement. If so, process the claim to completion with the assistance of your mentor or the CS/CTE to whom the claim had originally been assigned.

EXERCISE #1

OBJECTIVE 1: Recognize when to abate an application and how to process abatements.

Read each of the following questions. After analyzing each situation, determine the correct decision or response for each particular situation.

1. Delores applies for DIB on January 6 alleging a traumatic onset that occurred in the prior year on December 15. Her husband contacts you on February 10 and reports Delores died the previous week. What type of decision will you make on this claim?
2. Alfred became eligible for HI and SMI this month. Unfortunately, Alfred died suddenly within the same due to a vehicle accident. If Alfred had an application for benefits (including Medicare) pending with SSA at the time of his death, would the application be processed as an award, a denial or in some other fashion?
3. Antoinetta applies for RIB alleging she has attained age 62. After extensive POA development, the evidence conclusively establishes her age as 60. What type of decision will you make on this claim?
4. The NH, who filed his own RIB claim, died prior to the first month of entitlement and there is no entitlement to HI or SMI. What processing action will you take in this situation?

EXERCISE #2

OBJECTIVE 2: Recognize when to withdraw an application and how to process withdrawals.

Determine what action or response would be appropriate in each of the following situations.

1. Roberto has been receiving retirement benefits since his 63rd birthday (about 6 months ago). He comes into the DO and asks you if he may cancel his application. After a discussion, you determine Roberto wants to withdraw his application. Is it too late to process a withdrawal?
2. Kyle withdrew his application for retirement benefits because he decided not to retire as he had planned. On January 12 he received a notice stating his withdrawal had been approved. On February 20 he returns to the DO and asks to cancel his withdrawal. What do you tell him?
3. Giancarlo filed for reduced retirement benefits in February. His wife filed concurrently for spouse's benefits. She has never worked. After receiving several checks, Giancarlo contacts the DO and states he wants to withdraw his claim. He says he would rather wait until he reaches his full retirement age and receive an unreduced benefit. You obtain an SSA-521 from him. When his wife is contacted, she states she does not agree to have her entitlement nullified. She has her own income and she doesn't want to give up the checks until he is FRA. An SSA-795 is obtained with details about her objection. The next day, Giancarlo calls to ask when his withdrawal will be approved. What do you tell him?
4. Ford filed a disability application on December 3, the day he was injured at the automotive production plant where he had been employed for 16 years. He comes back into the office on February 10, while his claim is pending at DDS and tells you he started a part-time job on February 2. You determine his earnings are below the SGA limit, but he wishes to withdraw his application. He states he realizes his earnings are not substantial and he may still receive disability benefits if his claim is approved, but he insists he wants to withdraw his claim. After explaining the effects of a withdrawal, what should you do?

5. Michael is withdrawing his RIB claim because he will continue to work. The request is received prior to adjudication. You have obtained the SSA-521 and documented the RPOC screen in MCS. What processing action will you take in this situation?

EXERCISE ANSWERS

Exercise #1

1. Abatement. She died before her initial month of entitlement ([GN 01010.475](#)).
REMEMBER: For non-traumatic onset cases, a possible earlier onset should be considered.
2. Alfred's application would be processed as an award with a termination effective with the MOE because of death. This allows HI/SMI coverage up to the date of death. ([GN 01010.475B.2](#)).
3. Process Antoinetta's claim as a disallowance. This will provide appeal rights. ([GN 01010.400](#), [GN 01010.410](#)).
4. Process the claim as an abatement using the following steps:
 - Enter abatement code 068 in Disallowance Reason field of BECF screen.
 - Enter DEC STAT code of 07 WITH/ABATE on the DECI screen.
 - Trigger via EC.

Exercise #2

1. No, it's not too late. There is a 12-month time limit from MOE for withdrawing a RIB application and only one withdrawal per lifetime is allowed. ([GN 00206.001](#))
2. A withdrawal may be cancelled within 60 days after the date of the notice. Kyle's request is made less than 60 days after the date of the notice and can be honored. ([GN 00206.017](#))
3. Explain all parties involved must agree to the withdrawal before it can be approved. His request will be denied by the PC. ([GN 00206.005](#))
4. Obtain an SSA-521 or signed statement from the claimant detailing the reasons for the withdrawal. Ensure all withdrawal conditions are met. Process and approve the withdrawal per [GN 00206.011](#). Send an Update-After Transfer alert to DDS to take appropriate action. ([GN 00206.120](#)) ([DI 23015.001B.1](#))

5. Process the withdrawal using the following steps:

- Enter withdrawal code 200 in the Disallowance Reason field on the BECF screen.
- Enter DEC STAT code of 07 on the DECI screen.
- Trigger via EC.
- Claim will be cleared and the notice will be generated.

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LESSON PLAN

Chapter Objectives

At the completion of this chapter, the students will be able to:

1. Identify the different levels of appeal, the timeframes appropriate to each and the procedures for handling appeal requests.
2. Identify the MCS screens and forms used to process a reconsideration; understand the roles of the field office (FO), Disability Determination Services (DDS), and Processing Service Center (PSC) in processing a reconsideration.
3. Identify the MCS screens and forms used to process a hearing; understand the roles of the field office (FO), Office of Hearings Operations (OHO), and Processing Service Center (PSC) in processing a hearing.
4. Determine how to process an Appeals Council case.
5. Determine how to process special appeal situations.
6. Determine who represents the claimant and the forms needed to process the appeal when there is representation.
7. Process appeals using the Appeals Program.

Length of Chapter

12 hours

Local Supply

Reconsideration:

SSA-561
SSA-820/821/823
SSA-3441

Hearing:

HA-501
HA-3441
SSA-4608

Appeals Council Review:

HA-520

Representation:

SSA-1694
SSA-1695
SSA-1696
SSA-1699
SSA-3288

BACKGROUND AND RATIONALE

Introduction

It is inevitable; SSA will make determinations that will not satisfy some individuals. Under the Social Security Act and within the regulations of SSA, a person who is dissatisfied with a decision may seek satisfaction through an administrative appeals process and civil litigation. You must understand the appeals process in order to process appeal actions properly. It is your responsibility to explain the appeals process and help claimants pursue their appeal rights.

The purpose of this lesson is to teach you about the appeals process.

OBJECTIVE 1:

**Identify the different levels of appeal,
the timeframes appropriate to each,
and the procedures for handling
appeal requests.**

Overview of Appeals

[GN 03102.100](#); [GN 03103.010](#); [GN 03104.100](#)

Levels of Appeal

There are four levels of appeal. Normally, they must be pursued in the order shown here. See Objective 2 for exceptions (Prototype Cases).

TYPE OF APPEAL	DEFINITION
Reconsideration GN 03102.000ff	The first step in the administrative appeals process. It is an independent, thorough re-examination of an initial determination.
Hearing GN 03103.000ff	The second step in the administrative appeals process. It is an informal proceeding before an Administrative Law Judge where the appellant may appear personally and/or be represented. He/she may present evidence, witnesses and oral or written arguments.
Appeals Council (AC) Review GN 03104.000ff	The third step in the administrative appeals process. It is a review of the hearing decision and may be initiated by either the appellant or the AC on its own motion.
Civil Suit GN 03106.005	When the appellant has exhausted the three levels of administrative appeal, he/she may file a civil action in Federal District Court.

Timeframes

Timeframes for Filing

[GN 03101.010](#)

The appeal period is generally 60 days from the day after the individual receives the notice of determination or decision. We presume the individual receives the notice 5 days after the date on the notification unless the individual can show us he/she did not receive it within the 5 days.

NOTE: The 5 days allowed for receipt of a mailed notice of the determination or decision does not apply when the claimant receives the notice by hand.

EXAMPLE:

Elaine's DIB denial notice was dated February 15th. On March 21st, she inquired about filing an appeal of the determination. She appealed within the 60-day appeal period, so we accept the request and forward it to the appropriate component for processing.

Good Cause for Late Filing

[GN 03101.020](#)

A NH may file a request for appeal more than 60 days after the receipt of a determination notice. When this occurs, the appeal is considered only if "good cause" for late filing is found to exist. [GN 03101.020 B](#) In most cases, the component responsible for making the reconsideration determination (FO or PSC) will make the good cause determination. In hearings cases, an Administrative Law Judge (ALJ) will decide whether to grant an extension for filing the hearing request. [GN 03103.010 C.7](#)

If the claimant is in the field office at the time of filing their hearing request, then we will obtain the good cause statement and forward it to OHO or the AC for a determination. If they file their request by mail, fax, email or the internet then we will forward it to the appropriate component and obtain a good cause statement only at OHO's or the AC's request. If the claimant

files a request for reconsideration after their appeal period, we will develop for good cause immediately.

EXAMPLE:

John's reconsideration DIB denial notice was dated June 25th. On September 13th, *he came into the field office* and inquired about filing an appeal of this determination. John stated he had a death in his family the prior week and was unable to file his appeal timely. Complete the request for hearing and document his reason for late filing. The ALJ will determine whether John meets the requirements for good cause. [GN 03101.020 D.2](#)

EXAMPLE:

John's reconsideration DIB denial notice was dated June 25th. On September 13th, you receive his appeal *by mail*. Complete the *request for hearing*, but do not develop for good cause. The ALJ will determine whether good cause development is needed and will contact the FO if a good cause statement is required. [GN 03101.020 D.2](#)

EXAMPLE:

John is filing a reconsideration on his DIB denial notice dated June 25th. On September 13th, the *reconsideration was received by mail*. Send a letter informing the claimant that unless he submits the evidence within 10 business days; or contacts the FO to explain the delay; a determination will be made based on the available evidence. [GN 03101.020 D.1](#) and [GN 03102.300 B.2.a](#)

See [GN 03101.020 C](#) for additional examples of good cause.

Initial Determinations

[GN 03101.070](#)

What Is an Initial Determination?

Initial determinations are those subject to administrative and judicial review. They apply to both entitlement and post-entitlement issues.

An initial determination is any determination affecting:

- Entitlement and Termination
- Amount of benefit
- Overpayment and underpayment
- Representative Payee
- Disability provisions
- Other initial determinations such as revision of an earnings record.

What Is Not an Initial Determination?

[GN 03101.080](#)

There are actions that are not initial determinations and consequently are not subject to appeal. Some examples are:

- Suspension of benefits pending investigation of entitlement
- Denial of a request to be made representative payee
- Rate of withholding from claimant's monthly benefit to recover an overpayment.

Request for Explanation vs. Request for Appeal

Some claimants want to appeal, while others do not know what action they intend to take. Be alert to the fact the claimant may disagree with a determination and just want an explanation. Do not treat a request for an explanation as a request for an appeal right away.

Conducting a Denial Explanation Interview

[GN 03101.120](#)

During the interview, ask the individual requesting the appeal why he/she believes the determination is incorrect. In DIB cases, you should familiarize yourself with the claim so you can provide the claimant with a complete explanation of the denial. In addition to the claim file, in eView or on paper, review the claimant's notice, MBR, MCS Claim, and EC screens.

Review the following with the claimant:

- Any specific issue(s) the claimant disagrees with;
- The determination on his/her claim;
- Explain the right to appeal, the time limits, and the right to representation. Use pamphlets that you can give to the claimant, as guides.
- Explain that if he/she appeals, SSA can review all issues even those decided favorably.
- Assist the claimant in filing an appeal, if that is his/her decision. Determine whether there is additional evidence or information that relates to the issue(s) in controversy.

Who May Request an Appeal

The claimant, his or her appointed representative or representative payee, or other third party on behalf of the claimant can file a request for appeal. You must always give a copy of the appeal request to the claimant as notification that SSA received the appeal.

What Constitutes an Appeal

An appeal is a request for further review under the administrative review process of an initial determination or decision.

You'll find:

- A claimant's disagreement with a determination or decision by SSA must be in writing. An appeal request can be either formal (made on prescribed forms) or informal (not made on prescribed forms).
- Informal requests for appeals can be implied. A writing for appeal purposes may be a letter, facsimile, or submission of additional evidence which clearly implies disagreement with the initial determination.
- Neither a wet signature nor signature proxy is required for appeal requests for any issue, at any level, or for Title II and/or Title XVI

appeals. However, signature requirements for forms relating to an appeal request (e.g., SSA-1696) have not been eliminated.

- Oral inquiries are not protective filings. Therefore, an SSA representative cannot protect an individual's filing date for an appeal based on an oral request. **An appeal request is not considered valid/filed until SSA receives it in a written format.**
- SSA will accept faxed appeal requests.

NOTE: The Overpayment module covers the overpayment appeals process, which differs from other appeals processes.

Appeal Requests by Phone, In Person, Or In Writing

[GN 03102.200](#)

Handling Telephone Requests for Appeal

If a claimant requests a hearing by phone, provide correct information based on the situation and mail the appropriate appeal forms. You should also:

- Suggest the claimant come to the office or send a written request as soon as possible if the time limit for requesting an appeal will expire within 10 days;
- Request the claimant return the forms upon receipt; or
- Provide the claimant with the internet address and information for filing an iAppeal if they meet the criteria as discussed later in this objective.

Once SSA receives the appeal forms, update the system.

NOTE: You may also document the appeal form with the field office code and date of call in the upper right hand corner of the form. This does not serve as a protective filing, but may be a factor in determining good cause.

In-Person or Paper Appeal Request Received in FO

A claimant may file an appeal in-person at the FO without completing a written request. Complete the appeal screens in MCS and provide a printed copy of the request to the claimant. The paper copy does not need signature or attestation as long as the claimant agrees all information shown on the printed output is correct.

If the claimant disagrees with any information on the output, correct the SSA record to document the disagreement and correct the appeal information before final processing. Following this process satisfies the regulation requiring written requests for appeals.

You will receipt and process paper requests for appeal received in the mail, or brought to the FO based on procedures discussed in the following objectives. An FO interview is not mandatory.

Documenting Receipt of an Appeal Request

The FO will acknowledge receipt of all appeal requests by handing or mailing the MCS generated appeal to the claimant. If MCS is not used to process the appeal, return a copy of the paper appeal form to the claimant.

Internet Appeal Requests (iAppeals)

[GN 03101.125](#); [GN 03101.127](#)

Introduction

More and more people are choosing to do business using the internet. For this reason, Social Security provides a secure way to appeal a disability and non-Medical decision online. Claimants who are appealing the medical and non-medical decisions on both Title II and Title XVI disability claims can complete and submit the following appeal forms online:

- i561 (Request for Reconsideration)
- i501 (Request for Hearing by Administrative Law Judge)

- i520 (Request for Review of Hearing Decision/Order)

The SSA website that allows claimants to access the appropriate appeal form online is:

www.socialsecurity.gov/disability/appeal

Requirements to Use iAppeals – Medical Decisions:

[GN 03101.125 B](#)

An iAppeal for a medical decision can be filed by a claimant, his/her authorized representative, or other third party. To start an iAppeal, the claimant whose decision is being appealed must meet all of these requirements:

- the claimant filed a claim for disability benefits;
- the claimant received a Notice of Disapproved Claim or Notice of Reconsideration concerning his or her claim for disability benefits;
- the claimant disagrees with the initial or reconsideration determination;
- the technician used the Electronic Disability Collect System (EDCS) to process the claimant's claim for disability benefits; and
- the claimant is not barred from using the Social Security Administration's (SSA) Internet Services due to blocked access or special indicator codes on the Numident.

Requirements to Use iAppeals – Non-Medical Decisions:

[GN 03101.127 B](#)

- the claimant received an initial determination notice or Notice of Reconsideration concerning the non-medical issue;
- the claimant disagrees with the initial or reconsideration determination;

- the claimant is not barred from using the Social Security Administration's (SSA) Internet Services due to blocked access or special indicator codes on the Numident.

Process to Establish an iAppeal – Medical Decisions:

[GN 03101.125 D](#)

Once the identification information is entered by the user, the iAppeals system determines the appeal level and issues the user a reentry number. iAppeals will present the user with either the form i561 (Request for Reconsideration) / i501 (Request for Hearing by Administrative Law Judge) / i520 (Request for Review of Hearing Decision/Order). The user can then complete and submit the appeal forms in the same session or use the reentry number to complete and submit the appeal forms in a later session(s). Nevertheless, all of the appeal forms must be submitted at one time in order to file the appeal request. If the user does not complete *and* submit the appeal forms within 90 days of the date that iAppeals issues the reentry number, he/she will need to restart the process.

Once the forms are completed, iAppeals provides the opportunity to review, update, and print the information provided on the appeal forms. Before submitting the appeal forms, adult claimant IU's may electronically sign the Form SSA-827 (Authorization to Disclose Information to SSA) and attach evidence files. Users cannot use iAppeals to make any other updates once he or she submits the appeal forms to us. The appellant may submit any updates by mail, telephone or in person.

Process to Establish an iAppeal – Non-medical Decisions:

Once the identification information is entered, the iAppeals system will verify the user has the Notice. The user needs the notice to complete the appeal request because it details the SSA Program Title, appeal issue, and the appeal level (reconsideration or hearing). The user can then move forward by completing and submitting the i561 / i501 / i520 appeal request. The user can use the attachment utility to attach and submit evidence or other documents along with the appeal request.

iAppeals Non-Medical provides the opportunity to review, update, and print the information provided on the appeal form. Once all forms are submitted, the user cannot use iAppeals Non-Medical to make any

updates. Other updates can be submitted by mail, telephone, fax, or in-person.

Field Office (FO) Process: iAppeals (T2 Medical Decisions)

FOs must:

- Use Internet workload management information (iWMI) listings to identify pending cases and assign them.
- Import the iAppeal into MCS within 5 business days of the submit date that appears on the WMI listing by opening an appeal event or using the Banana Appeals Program (discussed in [Objective 7](#)).
- Review the information on the imported screens and contact the claimant to resolve any discrepancies.
- Use MCS to document the development of the appeal. Mail a copy of the iAppeal to the claimant after uploading to the online retrieval system (ORS).

Field Office (FO) Process: iAppeals (T2 Non-Medical Decisions)

Non-medical appeal requests do not propagate to the mainframe or the Modernized Claims System appeal screens. Therefore, CSs manually key information from these appeal requests into the appropriate system and process the appeal requests and evidence, if any, per the instructions in [GN 03102.200](#) (request for reconsideration) or [GN 03103.010](#) (request for hearing).

You view and Access the Non-Medical iAppeal in the Non-Medical iAppeals Tracking System on the IMAIN Menu. Your manager will assign these out using this system. The system allows you search by SSN or Field Office Code on the Search for a Case Screen.

Use the case information on the Case Details Screen to process the appeal request. If the claimant has attached documents, select "View Attached Files," to "View," "Print," and process the documents along with the appeal request. Indicate where the documents are stored and select save in Attached Files Screen. If needed, you may change the document's name. If you do, remember to "Save."

Complete the Case Details Screen by indicating the system used to process the appeal request, “Save” and then “Mark as Complete.”

OBJECTIVE 2:

Identify the MCS screens and forms used to process a reconsideration; understand the roles of the field office (FO), Disability Determination Services (DDS), and Processing Service Center (PSC) in processing a reconsideration.

Reconsideration

[GN 03102.000ff](#); [DI 12005.001](#)

Definition

[GN 03102.100](#)

Reconsideration is:

- The first step in the appeals process for initial determinations – in a Prototype State, different rules apply for initial medical determinations;
- An independent re-examination of the initial determination by someone who did not take part in the original determination

EXAMPLE: A disability claim goes back to DDS for a reconsideration. Another examiner who did not make the initial decision will make the decision on the case.

- An opportunity to consider any additional evidence;
- An opportunity for SSA to review a determination an individual finds unsatisfactory.

Prototype States

[DI 12015.100](#)

Ten states are involved in the Disability Redesign Prototype. In these states, initial medical determinations do not have a reconsideration step in the appeals process. So, if the claim processes under the Disability Redesign Prototype:

- A hearing is the first level of appeal for the initial medical determination, and
- Reconsideration is the first level of appeal for all non-medical issues (e.g. RSI, SGA denial, benefit amount, insured status, etc.).

The states participating in the Disability Redesign Prototype are:

Alabama, Alaska, Colorado, Louisiana, Michigan, Missouri, New Hampshire, New York, Pennsylvania, and select field offices in the following areas in California (LA Metro, Inland, Sierra West, and South Coast).

Jurisdiction

[GN 03102.175](#)

The FO has jurisdiction of the following reconsideration determinations:

Initial Claims

- DIB insured status denials
- Res Judicata denials
- Initial SGA denials

Post Entitlement

- Work CDR determinations
- Representative payee issues
- Medicare State Buy-In issues

- IRMAA appeals
- Administrative sanctions

DDS has jurisdiction of reconsiderations of DDS medical determinations.

The PSC has jurisdiction of all other reconsideration decisions.

Dismissing a Reconsideration Request

[GN 03102.200 B](#)

Dismissal of a request for reconsideration is the rejection of or refusal to accept the request. The purpose is to make the prior action the final determination. A dismissal is not subject to appeal.

A request for reconsideration may be dismissed for a number of reasons. Grounds for dismissal include, but are not limited to, requests:

- Not based on an initial determination
- Filed by improper requestor
- Filed prematurely
- Filed late and good cause for late filing cannot be found

Using MCS to Establish the Reconsideration Request

MCS Claims

A formal request for reconsideration on an MCS claim is recorded on the MCS appeal screens. If a paper form is received, transcribe the information verbatim from the written form into the MCS appeal screens.

The appeals path is accessed from the MCS Main Menu by selecting #1 (Establish) and function #9 (Appeals). MCS then displays the Appeal Establishment (NAPP) screen.

MCS Exclusions

Some reconsideration requests are MCS exclusions and cannot be recorded or processed through MCS. For these cases, use the Form SSA-561-U2 as a formal request for reconsideration.

NAPP Screen

[MS 03510.002](#)

Completion of NAPP Screen



MCS propagates the NH Name and SSN, CL Name and SSN, File Date, Decision, and Adjudication Date.

- Appeal File Level: Enter a "1" to establish reconsideration. Once you enter this screen, you cannot change the type of appeal or delete it. If you established the wrong level of appeal, you can man-clear the claim to your own field office code, then go back in and establish the correct level.
- Select: Enter an "X" next to the name of the CL who is requesting the appeal. When updating or querying the appeal later, type the "X" next to the name of the CL whose record you wish to update or query.

RCN1 Screen

[MS 03510.003](#)

Reconsideration request information is recorded on two screens:

- Reconsideration Request 1 (RCN1), and
- Reconsideration Request 2 (RCN2)

Questions on these screens are about the claimant (CL), the appellant and the CL's representative.

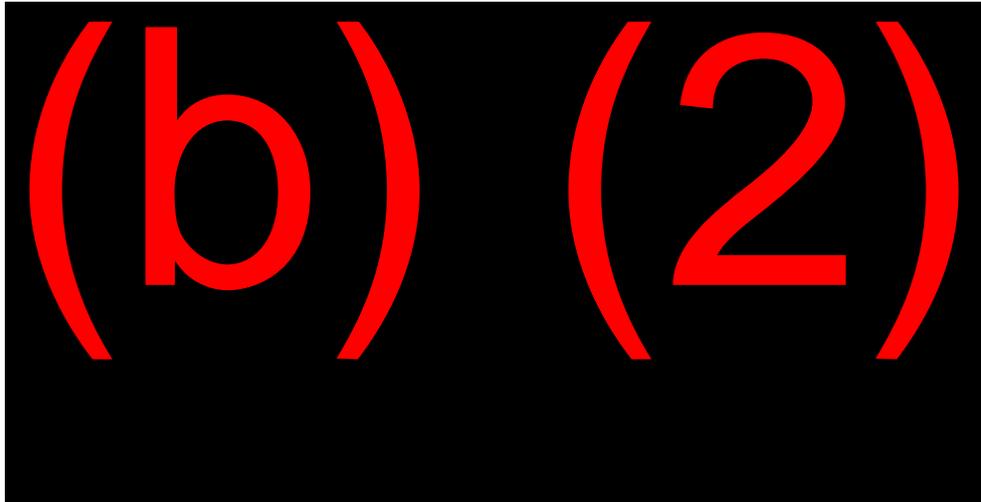
Define Appellant

An appellant is the person making the appeal and may be:

- the CL, or
- a representative of the CL, or
- anyone filing on behalf of the CL. [MS 03510.001](#); [GN 03102.375](#)

Claimants have the right to attorney representation or any other qualified person of their choice.

Completion of RCN1 Screen



- Appellant: Type the appellant's name if he/she is neither the CL nor the CL's authorized representative.
- Address, City, State, ZIP, Phone: Enter the mailing address and phone number of the appellant.
- Country, Consul Code: If the appellant's address is not in the U.S., complete these fields.
- BIC: Enter the CL's BIC on this NH's SSN.
- Spouse SSN: If a concurrent SSI appeal is filed and a spouse is on the record, enter spouse's SSN.
- Explanation Provided: Type "Y" if you have explained to the appellant the reason for the initial denial; "N" if you did not. Be careful not to violate the Privacy Act when discussing a claim with an appellant who is not the CL.
- Recon Requested: At this point in the interview, does the appellant still want to request reconsideration? If yes, type "Y." If no, type "N" and then type NONE in the Reason Requested field.
- Appeal Claim Type: Select the number corresponding to the type of appeal that has been filed.
 - Other: If #8 (Other) was chosen as the type, explain here.
- Issue: Describe the issue the appellant is protesting (example: disability benefits denied).

- **Reason Requested:** Explain why the appellant believes the prior determination is incorrect. Type the explanation in first person because it will print for claimant's signature. Type up to 284 characters, ending the explanation with a period. If you receive a paper form, input the reason verbatim from the form.

EXAMPLE: I BELIEVE MY HEART CONDITION MEETS THE DISABILITY REQUIREMENTS OF THE LAW.

If the appeal was initiated via the internet, the reason requested that was entered on the internet screens will propagate here.

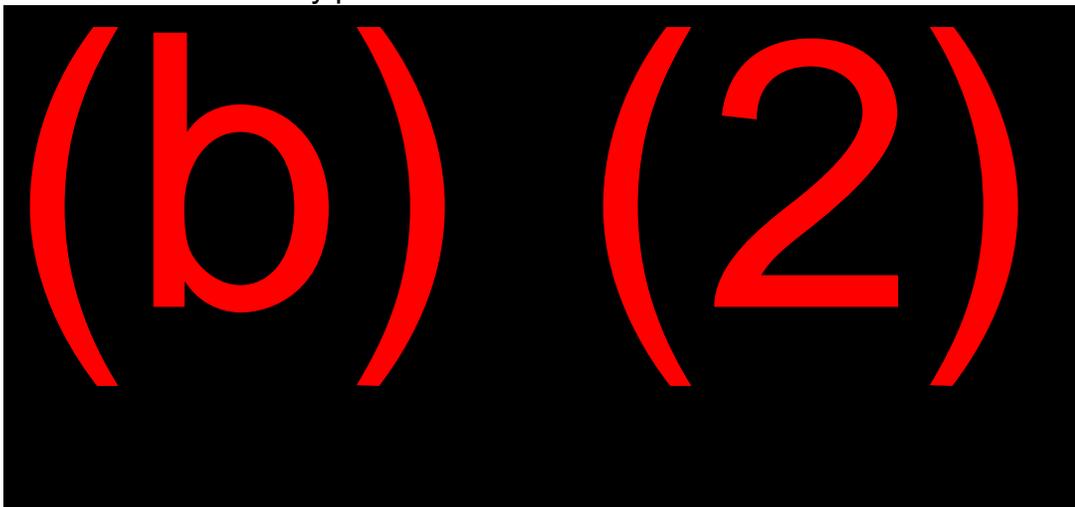
- **Additional Evidence:** Does the appellant have any other evidence to submit now (Y or N) or in the future (F)?

RCN2 Screen

[MS 03510.004](#)

Completion of RCN2

MCS automatically presents the RCN2 screen next.



- **SSI Appeal:** For a concurrent SSI appeal, indicate if the appellant has requested (1) a case review or (2) an informal conference. Option (3) formal conference is not a valid choice. Answering this

question does not initiate an SSI appeal. The SSI appeal is a separate process completed in MSSICS.

- Is interpreter needed and specify language: Answer only if the claimant requested an SSI informal conference.
- Represented: Yes or no
- Legal referral list: If no to above, give the appellant a list of legal referral and service organizations and indicate "Y." [GN 03910.030](#)
- Attorney Name, Address and Phone: Document information about the attorney/representative, if any.
- Filed By: Type "1" for any appellant other than the representative, or "2" if filed by the representative.
- Date Filed: Type the filing date of the recon.
- Determination Date Being Appealed: Type the date of the notice containing the determination being appealed.
- Timely Request: Is the request filed timely? If yes, type "Y" and go to Date Screen Begun field.
- If No: If the NH does not file the reconsideration request timely, indicate whether the CL is the source of the information and provide an explanation for the late request
- Date Screen Begun: Enter the date you began to complete the screen. Use MMDDYY format.

Processing Considerations

DW01

On the MCS Main Menu, select #2 (Update) and function #5 (Claims Development). The submenu screen CLSU is for your selection of the segment containing the appeal. Select the Recon claim and enter. The DW01 for the appeal is the next screen to appear.

Signature Proxy does not apply to appeals. However, the ATTEST issue automatically propagates on the DW01. You must "X" out the ATTEST issue for appeals.

PRST

Complete the PRST screen, which propagates into your path after the Development Worksheet screens. To ensure the storage of the completed reconsideration request to ORS, it is critical to print and store appeals processed in MCS, even if another signed request is in file.

Electronic Claim vs. Claim with a Paper Folder

[DI 81010.150](#)

If the appeal is for an electronic claim, a copy of the MCS appeal request will store to ORS. Once the request is stored to ORS, no further action is required. Next, shred any paper request. Assume the record accurately stored in ORS if the MCS printout is accurate. If you cannot create the ORS record of the MCS appeal, the FO will fax the SSA-561, or similar written request, into the electronic processing system.

For appeals filed for claims with a paper folder, or if a paper folder must be created to process the appeal because of an EDCS exclusion, the FO will place a copy of the paper appeal in the paper folder. While the paper copy of the appeal will usually be the SSA-561, it could be a printout of the MCS appeal, if the case is loaded into MCS (e.g., an EDCS exclusion).

Update Application Screens

Once the appeals screens have been completed and printed, any changes or additional information may be recorded to the actual claims path by selecting #2 (Update) and function #4 (Claim Update/Inquiry), from the MCS Main Menu. Any changes may result in:

- Additional application screen being added to the path;
- Inter-screen edits; or
- Application amendments

To re-enter the appeals path, select #2 and function #9 from the MCS Main Menu. You will be able to update the RCN1 and RCN2 screens as appropriate.

Establish Reconsideration When All Segments are Archived

[MS 03502.002](#)

Once an MCS claim archives, an appeal cannot be loaded to the system. This is true even if the initial claim is subsequently un-archived. However, you can load another initial application. Manually clear (MANCLR) the claim to your own office code, and then load the appeal to get around this limitation. Do the same to load hearings on archived claims. There is a workflow on (b) (2)(b) (2)(b) (2)(b) (2)(b) (2) in the (b) (2)(b) (2)(b) (2)(b) (2) entitled "Establish an Appeal on an Archived Claim" to help you with these cases.

Form SSA-561-U2 Request for Reconsideration

[GN 03102.225](#)

The SSA-561 is the prescribed paper form for requesting reconsideration of a prior determination. Complete the form as follows:

- **Social Security Claim Number:** Claim number (not SSN) must show.
- **Claim For:** Specify type of claim (e.g., retirement) and/or action (e.g., waiver of recovery).
- **Reason for disagreement and additional evidence:** Enter the claimant's specific reasons for the disagreement. If the claimant has additional evidence, provide a description of what is available. If the individual refuses to provide any of the information called for on the form, note this on an RPOC.
- **Other Instructions:** Until revised, the SSA-561 will continue to have a signature block. However, signatures are no longer required for appeal requests.

Upon receipt of an SSA-561, establish the reconsideration in MCS and load the information onto the reconsideration screens as described earlier in this objective.

Internet i561

The i561 (Request for Reconsideration) can be completed online and transmitted electronically to SSA.

While the i561 is completed online, the user receives step-by-step guidance on how to complete the appeal request form. iAppeals also allows multi-session use of the i561 and other appeal forms like the i3441. Nevertheless, the appellant must complete all fields required by the i561 and the i3441 before the system will allow submission. Keep in mind all appeals must be submitted within 90 days of the date the iAppeals issued the reentry number.

iAppeals has a document attachment utility. This feature offers an opportunity to submit other forms and documents via the Internet (e.g., SSA-1696 or medical records).

Reconsideration of Initial Disability Denials

[DI 81010.150](#)

In disability denial reconsiderations, the following forms are also used.

FORM	USE
SSA-3441/i3441	Provides updated medical information for the DDS and eliminates duplication of information obtained in the initial interview
SSA-3367	Provides observations made by the interviewer and non-medical factors that DDS must consider
SSA-827	Medical release forms (or regional equivalent) so the DDS may obtain new medical evidence, if necessary. (This form must be in the file.)
SSA-820/SSA-821/SSA-823	Provides up-to-date work activity information, where applicable

Internet Disability Report Appeal (i3441)

[DI 81007.050](#)

Individuals and their representatives should be encouraged to complete the i3441 on the SSA website. iAppeals automatically presents the proper appeal request by checking EDCS. This system then presents the i561 or i501, followed by i3441, the e827(if applicable) and the document attachment utility. After all questions are answered the last screen in the path as a single "Submit Appeal" button.

iAppeals submits all the completed forms and attachments to SSA as one package. After importing the appeals, data from the Internet propagates into EDCS when the case is opened.

Query the WMI Internet listings (discussed in the module on Workload Management) or obtain the i3441 query using the Shared Process menu for the claimant's contact information.

Processing a Reconsideration on a Medical Denial - EDCS

[DI 81010.150](#)

Key the 3441 disability report data into EDCS. This is required unless one of the EDCS exclusions or limitations in [DI 81010.030](#) applies to the case adjudicated at the lower level.

You must establish a reconsideration request in MCS before you can create an EDCS appeal case. For CDB or DWB cases that did not require an MCS application at the initial level (conversion cases), you can only create an EDCS appeal if EDCS was used for the associated initial filing.

Creating a Reconsideration Appeal Case in EDCS

Once you open the reconsideration in MCS, open the EDCS application by selecting the EDCS icon on your desktop. The Disability Case

Selection page will open. On this page, enter the claimant's SSN in the Client SSN box and select the search button. EDCS performs a SSN search. If an EDCS case already exists, the search results will display all previous EDCS cases for the SSN. Select the appropriate radio button to indicate the case you want to create the appeal for and click on the Create Case button.

If no existing EDCS cases match your search, the Select Case Level dialog box displays and you will be asked to select the adjudicative level at which you want the case to be established. Select the Reconsideration radio button and the Create Case button at the bottom of the dialog box. The Confirm Case Creation dialog box will appear. To confirm you wish to establish a case for this person, select the Create Case button.

NOTE: If you are establishing an MCS Exclusion, then select the MCS Exclusion check box.

Whether or not a prior case exists, from the point of selecting the Create Case button, you will complete the screens in much the same manner as you would the SSA-3368 on an initial claim.

Once you complete the screens for the SSA-3441 and the SSA-3367 on EDCS, transfer the case to the appropriate DDS. This process is identical to transferring an initial disability case on EDCS. It is important to remember this step, because if skipped, the DDS will not be able to read the information and use EDCS properly.

Copying Data from Linked Prior Level Cases

A big advantage of linking cases is the ability to copy data from a prior level case. The following types of data can be copied:

- Sources
- Contacts
- Medications
- Tests
- Other names

If information is available from a prior level for the user to copy, EDCS will display the toggle link "Show information from prior level(s)." To copy an

item from a previous level, select the desired item in the “available for copy” box. Please note that all fields for the item selected may not copy into your current case. Information that may have changed, such as last and next visit dates, reasons for visits, and treatments will be blank after data is copied and must be completed by the interviewer.

EXAMPLE: When the claimant filed his initial level case, he had seen Dr. Smith who prescribed the medication Albuterol. The initial disability claim was denied and the claimant filed a request for reconsideration. He continues to take the Albuterol but has not been back to see Dr. Smith. If you link the reconsideration and initial level cases together, you can associate the reconsideration level medication Albuterol with the initial level Dr. Smith source.

Routing a Reconsideration to DDS

[DI 12005.005](#)

Handle assembly and routing of disability reconsideration cases in the same manner as initial claims.

In disability cases, folder preparation and routing depends on whether the case is a CEF (certified electronic folder) or a non-CEF.

- CEF reconsideration case handling is explained in [DI 81010.020](#).
- Non-CEF reconsideration case handling when EDCS can be used is explained in [DI 81001.020](#).

Non-CEF cases that are EDCS exclusion cases require preparation of a modular disability folder (MDF). The MDF is explained in [DI 70005.005](#). The MDF houses forms and information not completed and captured electronically through another system (e.g., MCS and/or MSSICS).

When a medical decision is the issue of an appeal, the case transfer the case to DDS. Take the following steps:

- Annotate the DW01 for the medical decision with a DDSDEC issue and DDS office code (example: S80) in remarks.
- Reconsiderations can be processed as non-medical completion input in the same manner as an initial disability claim.
- Transfer EDCS to DDS

Be sure to fax any pertinent information into the EF.

Processing a Reconsideration Request of an Initial Denial Based on Non-Medical Issues

[DI 12005.010](#); [DI 12005.020](#); [DI 81010.145](#); [DI 81010.110](#)

Reconsideration requests for disability claims denied for some non-medical reasons are the jurisdiction of the field office. Examples include SGA denials, denials due to lack of insured status, denials due to lack of information, and Failure to Cooperate (FTC)/Whereabouts Unknown cases. The person who made the original determination cannot make the reconsideration evaluation.

Take the following steps if you receive a reconsideration request on an initial denial based on non-medical issues:

- Review the recon request and any documents submitted.
- Make a determination to reverse or affirm the prior decision.
- Record the determination on the appropriate form or screen, e.g., SSA-823, and store it in the official folder.
- If a form does not provide a place for a determination, or if a specific form is not needed:
 - Use the RPOC screen or MCS
 - For non-MCS cases, document the determination on an SSA-553 (Special Determination).

Non-Medical Denial is Reversed

If the review of the non-medical denial decision is reversed:

- Do not establish a reconsideration segment on MCS, per [DI 81010.145 B](#)

- Send the notice in DPS titled “Reversal of Nonmedical Denial” to the claimant. This notice lets them know we will resume processing their initial application.
- Complete a technical reactivation of the initial determination.

EDCS provides the field office with the capability to reactivate most records for cases closed as FO Determination or No Determinations. This is called “Technical Reactivation” and allows the FO to update and transfer these EDCS cases to DDS for an initial medical determination. [DI 81010.110](#)

EDCS technical reactivations apply as follows:

- Only permissible for initial-level claims;
- The case must be the most recent case in EDCS;
- The case must have been closed with an “FO Determination” or “No Determination”;
- If one title of a concurrent claim is transferred to DDS and an FO Determination is made on the other title, the FO determination cannot be reactivated through EDCS;
- There must not have been a medical determination for any claim in the case. If the TXVI portion of a concurrent claim went to DDS for a medical decision and is still pending, notify DDS you need to reactivate the TII portion of the claim. Wait for an alert on the EDCS Actions Page stating the case returned to the FO or wait five days, whichever comes first, before reactivating the claim;
- There must be at least one closed mainframe claim for the reactivated EDCS case;
- MCS exclusion claims cannot be reactivated.

For each technically denied EDCS claim reactivated, the FO must establish a new MCS claim. To do this, the CS must:

- Re-establish the denied initial disability claim on MCS (in other words, put the initial claim back on MCS – copy the screens from the prior claim and enter the new claim with the same information – updating any changes like address) – this creates a new segment on MCS.

- On the DW01, use the original application/protective filing date before sending the claim to DDS.
- Enter the FDC of “C” on the DECI screen (C indicates reopening).
- Update appropriate medical/non-medical forms.
- Resolve any questionable issues that could preclude eligibility.
- Route the case to the appropriate decision-making component. Identify (using EDCS remarks – or if paper, the routing slip) cases that were denied for failure to cooperate (“Prior Denial – Failure to Cooperate”) or whereabouts unknown (“Prior Denial – Whereabouts Unknown”) as appropriate.

To reactivate the case in EDCS:

- Verify the case meets the criteria listed above.
- Select the “Reactivate Claim(s)” button on the Disability Case Selection screen.
- Complete the “Reactivate Claim(s)” screen and select the appropriate claim type. This will generate a pop-up box where the CS will either cancel the reactivation request or select “OK.” A message will confirm the case was successfully reactivated.

After EDCS reactivation:

- All action needed to process the initial claim can be taken, including re-propagation and Update-After-Transfer (UAT).
- All disability reports and data existing in the case at the time of the FO closure are available and can be edited as needed.
- Update all reports and add any new ones, and prepare the case for transfer to the DDS.

Non-Medical Denial is Affirmed

If the CS reviewing the appeal on the non-medical issue affirms the prior decision:

- Load the Reconsideration appeal on MCS.

- Document the new determination on the appropriate forms (as listed above).
- Use MCS, whenever possible, to release the appropriate notice. In situations where the system cannot generate the appropriate notice, use DPS. See [NL 00701.390](#) or [NL 00705.110](#) for examples of manual Title II reconsideration notices.

Prototype States

These instructions apply for technical denials processed in “Prototype” states as well as non-Prototype states. Because the claimant has not yet received a disability determination, the appeal of a technical denial cannot be treated as a disability hearing request under Prototype instructions.

Requesting the Folder

Requesting the Folder

When the FO or DDS will be making the reconsideration determination, associate the reconsideration material with the claims folder. If a prior paper folder exists and the folder is not in the FO, locate and request the folder via PCACS (#26 from PCOM Main Menu). You can also use the **(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)**. Post the folder request to the DW01 screen by typing the issue FOLDER with a request date and a tickle date. When the file is received, post this to the DW01 screen and associate the reconsideration request with the folder.

Routing the Reconsideration (PSC Jurisdiction)

[GN 03102.175](#); [GN03102.300](#); [GN 03102.500](#)

If a reconsideration request is established in MCS but is PSC jurisdiction, transfer the MCS Appeal control to PSC as follows:

- Select function #7 (Claims Movement) from the MCS Main Menu and complete the Claim Movement/WMS Clearance (CMWM) screen.
- Store development in EVID, eDIB claim filing record or NDRED. [GN 00301.328](#)
- Fax the MCS reconsideration request to the PSC using the Paperless Barcoding Application and the Non-Disability Repository or the eDIB record. Select the barcode “RECON RQST – Reconsideration Request – Not O/P.” Also, any related development not recorded on the EVID screen should be placed in NDRED or eView. [GN 00301.328](#)

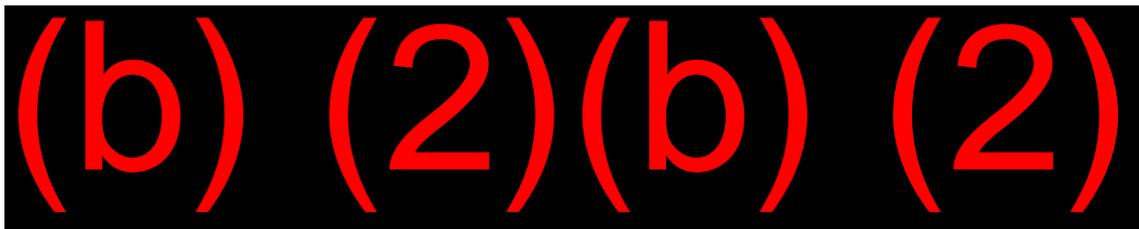
If a reconsideration request is not established in MCS, i.e. post entitlement reconsiderations, process as follows:

- Record the request on an MDW (Modernized Development Worksheet) or in the DMS (Debt Management System) remarks as appropriate.
- Fax any supporting documentation into NDRED or eView.

Completion of CMWM Screen

In order to transfer control in MCS of the PSC jurisdiction Appeal, use the Case Movement option from the MCS Main Menu. Select #2 (Update) and function #7 (Case Movement). The system may present the Claim Summary (CLSU) screen, from which you can select the segment (if applicable) containing the recon request.

On the Case Movement (MOVE) screen, select function #1 (Claim Movement/WMS Clearance).



The next screen you will see is the CMWM screen, which displays all the records in the segment, propagating NH name and SSN, appeal level,

current location, CL name and SSN and application type. Complete only two fields to transfer WMS control to the PC:

- Select Function: Type a "2" to transfer an appeal record to a PC.
- Transfer To: Type the code for the PC to which you want to transfer the record (e.g., PC2).



DISP Screen

[MS 03510.007](#)

Purpose of DISP Screen

The completed Appeal Disposition (DISP) screen records reconsideration and hearing decisions. It is also used if the appeal is unproductive (an "N" is entered on the RCN1 screen in the Recon Requested (Y/N) field) to close out an unproductive lead or dismiss a request.

The DISP screen is displayed when you enter #2 (Update) or #3 (Query) and function #9 (Appeals) on the MCS Main Menu. Enter through the reconsideration screens and the DISP screen will be final screen in the path. However, the DISP screen will display only after a RCN2 screen transmits.

NOTE: You will not complete the Appeal Disposition (DISP) screen for a reconsideration request on which you have entered a non-medical completion. MCS locks all screens when you transmit a non-medical completion.

Completion of DISP Screen



- Disposition: Type a number to show the appeal decision or to show an unproductive appeal (#7 – Abandon).
- Disposition Date: For any actual decision, type the date the FO, DDS, or PC issued the appeal decision. For an unproductive appeal, type "7" in Disposition and the date the screen is completed. Entering the screen at that point locks the segment and clears all WMI controls.
- Effectuation Date: Type the date the FO, PC or DDS effectuated the appeal decision.
- ALJ and ALJ HO: These fields record hearing decisions and are not used for recon decisions.

Auxiliaries

An appeal by the NH protects all auxiliaries on the record. However, when the NH appeals and MCS application(s) exists for auxiliaries at the same level as the NH's denied claim, MCS will generate appeals screens for the NH and each protected auxiliary, placing them all together in the same segment. In this situation, complete the appeals screens for the NH but not the auxiliaries.

When a reconsideration decision posts to the DISP screen for the NH, the DISP screens for the auxiliaries are not completed.

EC Processing and the MBR

EC Processing

Process reconsideration decisions through EC in the same manner as an initial claim.

MBR Segment

Appeals post to the BEN DENY and DIB data lines of the MBR. See [Exhibit 2](#) for a MBR example.

DIB Line

[SM 00510.200](#)

The LOD field on the DIB line of the MBR shows the level of denial. The denial codes are:

1 –Initial, **2** - Recon, **3** - Hearing, **4** - Appeals Council **5** - Court Action,
6 – Initial DSI, **7** – FedRO Review, **8** – Hearing DSI, **9** – DRB DSI,
A – Court DSI

NOTE: Codes 6-9 and A apply to decisions made under the Disability Service Initiative (DSI), a pilot program in the Boston Region only. DSI is no longer in effect, but you may still see these codes on some records.

OBJECTIVE 3:

Identify the MCS screens and forms used to process a hearing; understand the roles of the field office (FO), Office of Hearings Operations (OHO), and Processing Service Center (PSC) in processing a hearing.

Hearing**[GN 03103.000ff](#)****Definition**

A hearing is:

- the level of appeal for those individuals who disagree with a reconsideration determination,
- held before an Administrative Law Judge (ALJ) in the Office Hearings Operations (OHO), and
- is an informal proceeding where the claimant may present evidence, witnesses, and oral or written arguments.

A claimant may appear personally, through video teleconference, acquire representation, or may waive the oral hearing opportunity and request the ALJ render a decision on the evidence in file. If the claimant wishes to waive their right to appear, obtain a HA-4608. Refer to **[GN 03103.030](#)** for instructions on completing the HA-4608.

If the appellant chooses to attend the hearing, he/she may be reimbursed for travel expenses if the distance is more than 75 miles one way. This reimbursement also applies to any representative and/or witness(es). **[GN 03103.060](#)**

MCS Process

The procedures used to process an MCS hearing request are somewhat similar to those used in processing reconsiderations. MCS screens are completed within the appropriate segment (paper forms are sometimes necessary).

MCS Exclusions

[GN 03103.020](#)

Not all requests for a hearing can be recorded on MCS. The HA-501-U5 is the prescribed form to use when completing a hearing request that must be processed by paper.

NAPP Screen

[MS 03510.002](#)

Establish Hearing Request

In addition to being used to establish a reconsideration, the NAPP screen is used to establish a hearing level appeal.



Complete a hearing request as follows:

- Appeal File Level: Complete this field with a "2" for a hearing request.

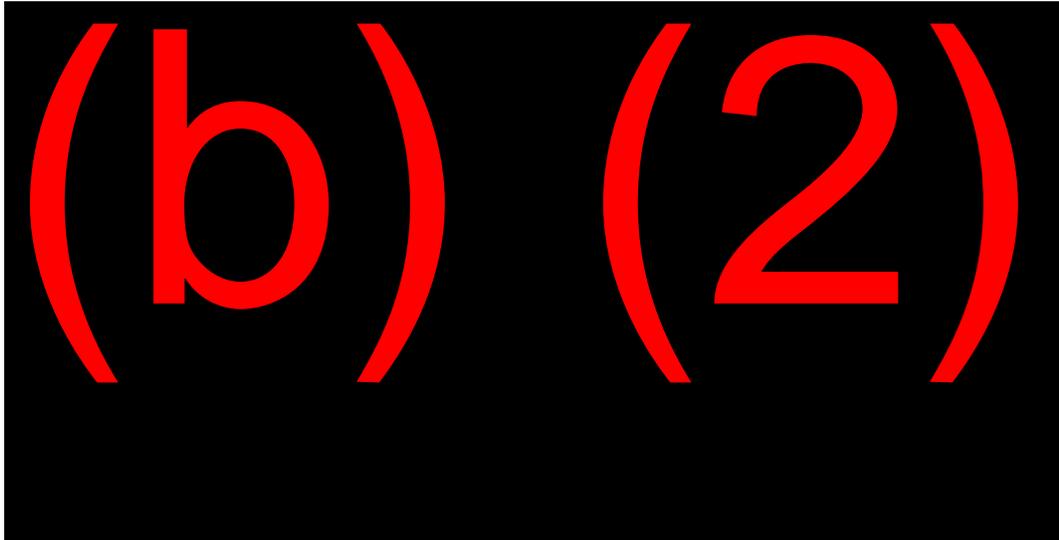
- Select: As with the recon, type an "X" beside the name of the applicant filing the appeal. For a NH and protected auxiliaries listed in the segment, type the "X" beside only the NH's name.

HNG1 Screen

[MS 03510.005](#)

Completion of HNG1 Screen

Record information about the appellant on the Hearing Request 1 screen.



- Appellant (If Other Than Claimant Or Representative): Type the name of the appellant, if appropriate.
- Address, Including Country And Consul Code: Enter the mailing address and phone number for the appellant.
- Foreign Postal Zone: Type the foreign zone of the country the appellant receives mail.
- BIC: This is the CL's BIC on the NH's SSN.
- Spouse SSN: For an appeal on a concurrent SSI claim and a spouse is on the record, enter the spouse's SSN.

- Appeal Claim Type: Enter the number to show the type of claim under appeal.
 - Other: If type 8 was chosen above, explain here.
- Hearing Requested (Y/N): At this point in the interview, does the appellant still want to request a hearing? If so, type "Y" and complete the screen. If no, type "N" here and type "NONE" in Reason Hearing Requested field.
- Reason Hearing Requested: Explain why the appellant believes the prior decision is incorrect and end with a period. If a paper form is received, the reason input should be verbatim from the form.
- Additional Evidence: Indicate if the appellant has additional evidence to submit now (Y or N) or in the future (F).

NOTE: If the evidence is not available at the interview, request that it be submitted within 10 days. Do not hold the appeal for additional evidence. The hearing should be released within five business days to the appropriate OHO. When the additional evidence is received, forward the evidence to OHO or fax into the electronic folder. [GN 03103.080](#)

HNG2 Screen

[MS 03510.006](#)

Completion of HNG2 Screen

Use the Hearing Request 2 screen to record more information about the CL, the appellant and the representative.



- Request Oral Hearing: Indicate appellant's choice.
- Reason Hearing Waived: If oral hearing not requested, explain the reason here. Be sure to obtain a HA-4608 (Waiver of Right to Oral Hearing).
- Represented: Indicate if the CL has a representative.
- If No, Legal Referral List: Enter "Y" if the CL has no representative, and give the appellant a list of legal referral and service organizations.
- Attorney/Rep Name: Type name of representative, if any.
- If yes, Attorney: Is the representative an attorney?
- Attorney/Rep Address Through Consul Code: Type the mailing address of the representative.
- Foreign Postal Zone: Type the foreign postal zone of the country where the representative receives mail.
- Filed by and Date: Indicate which person filed the hearing request and on what date.
- Deter Date Being Appealed and Timely Request: Type the notice date of the decision under appeal and indicate whether the hearing request is filed timely.

- If No and Explanation: Document the reason for an untimely appeal and which individual provided the explanation.
- Interpreter: Type “Y” or “N” to show if the CL needs an interpreter. If Yes, enter the language in the “If Yes, Specify Language” field.

As with a recon, you do not need to complete the appeal screens for a protected auxiliary.

MCS/EC Considerations

DW01 Issues

Complete the DW01 with pertinent issues and establish a tickle for a hearing decision. The DW01 documents issues related to an authorized representative (as discussed in [Objective 6](#)).

With the signature proxy functionality in MCS, attestation will continue to display as an issue on the DW01 screen for Title II appeals. Until the system is corrected, complete the ATTEST issue on the DW01 by entering “XXXXXX” in the RECEIVED date.

Print Hearing Request

Complete the PRST screen. To ensure the storage of the completed hearing request to ORS, it is critical to print and store appeals processed in MCS, even if another signed request is in file.

Forward the request to the hearing office within five business days of the date it is filed.

Electronic Claim vs. Claim with a Paper Folder

If the appeal is for an electronic claim, a copy of the MCS appeal request will store to ORS. Once the request is stored to ORS, no further action is required except to shred the paper request. Assume the request accurately stored in ORS if the MCS printout is accurate. If creation of the

appeal request in ORS is impossible, fax the HA-501, or similar written request, into the electronic processing system.

For appeals of claims with a paper folder, or when a paper folder must be created to process the appeal because of an EDCS exclusion, the FO will place a copy of the paper appeal in the paper folder. While the paper copy of the appeal will usually be the HA-501, it could be a printout of the MCS appeal, if the case is loaded into MCS (e.g., an EDCS exclusion).

Update Application Screens

If the appellant reports any changes, you will update the application screens in the segment containing the hearing request.

Non-medical Completion

Hearings cases are excluded from the non-medical completion input.

HA-501-U5

[GN 03103.020](#)

The HA-501-U5 is the prescribed paper form to request a hearing. Completion of the form is self-explanatory, but you should review the form and note the following:

- If the space provided regarding the reason for the appeal is not sufficient, use an SSA-795 attached to the HA-501.
- If the claimant submits additional evidence at the time of filing the hearing request write, "evidence attached" in the evidence block. If the claimant wishes to submit evidence but it is not available at the time of the request, enter a brief description of the pending evidence. Request the claimant submit the evidence within 10 days.
- Provide the appellant(s) with an explanation of the right to appear at the hearing. If the appellant waives that right, check the appropriate block of the HA-501 and complete an HA-4608, Waiver of Right to Oral Hearing.

- In all cases where the representative signs the HA-501, indicate whether the representative is an attorney. If the person appointed is not an attorney, the claimant and the representative must sign the SSA-1696 (or an equivalent statement). Although the regulations do not require an attorney representative sign the SSA-1696 (or an equivalent statement), SSA strongly encourages the practice.
- If the request for hearing is not filed timely (within 60 days after the previous determination notice), attach the claimant's explanation for the delay. [GN 03103.010 C.7](#)
- The type of claim should be shown as "other" for either a request for hearing by a DIB auxiliary (or representative) or for non-claims situations (e.g., revision of an earnings record).
- If the appellant will bring an interpreter to the hearing, prepare an SSA-5002 (Report of Contact) outlining the person's qualifications as an interpreter. Fax the SSA-5002 into the CEF or attach this to the Hearing Office copy of the hearing request.
- If the ALJ must arrange for an interpreter, be sure to indicate the language involved (see bottom of HA-501-U5).

Disability Issues

[DI 12010.000ff](#); [GN 03103.010](#)

Hearings on Disability Issues

When a claimant requests a hearing on an issue involving disability, obtain the following forms.

FORM	USE
SSA-3441/i3441	Provides updated medical information for the DDS and eliminates duplication of information obtained in the initial interview.
SSA-827	Medical release forms (or regional equivalent).

FORM	USE
SSA-820/SSA-821/ SSA-823	Provides up-to-date work activity information, where applicable.

SSA-827

Only one SSA-827 is required for appeals sent to OHO. The completed SSA-827 must show the claimant's name, SSN, address, signature and date. Fax the front and back of the SSA-827 into the electronic folder, verify the image is in eView, and destroy the original.

When the claimant files a request for hearing but fails to provide the SSA-827 do not delay transferring the case to OHO. A follow-up with the claimant or his/her representative to obtain an SSA-827 is not required. If you receive an SSA-827 after the case has been transferred, fax the front and back of the form to the electronic folder, verify the image is in eView, and destroy the original.

NOTE: When you receive a signed, dated SSA-827 and have a paper folder, file the SSA-827 in the file. Do not delay in forwarding the paper folder to OHO. Follow the same procedure as you do for the EF.

EDCS

Like the reconsideration, you must key the SSA-3441 for a hearing into EDCS, if no limitation exists. The same exclusions to using EDCS on reconsiderations also apply to processing hearings. For cases requiring an MCS application at the initial level, establish a hearing request in MCS before you can create the case in EDCS. For CDB or DWB cases that did not require a MCS application at the initial level, you can create an EDCS appeal only if EDCS was used for the associated initial claim.

Establishing a hearing in EDCS uses the same process as establishing a reconsideration, except you will select "hearing" on the adjudicative level.

The EDCS screens must be transferred when they are completed. However, instead of transferring the case to the servicing DDS, you will send the case to the proper OHO for processing.

Transfer the Hearing Request to OHO

Transfer the case in MCS and EDCS on the same day. To transfer a case to OHO you must:

- Select all the claims to transfer on the EDCS Transfer screen;
- Verify the correct EDCS destination is shown. The EDCS destination can be over keyed if necessary;
- Select “OK” on the EDCS Transfer screen to transfer the case

Complete and enter the CMWM screen to document the case movement in MCS. [MS 03520.003](#)

- From the MCS Main Menu select #2-Update and #7-Case Movement
- On the MOVE screen enter a #1 – Claim Movement/WMS Clearance. Press enter.
- On the CMWM screen enter #2 – Transfer and enter the office code of the OHO office with jurisdiction. Press enter.

Verify the case transferred successfully from the MCS Main Menu:

- Select #3-Update #24 Case Query.
- On the WMSR select #2-History Query and #3-Both
- Review the WMMH screen - Juris Movement History.

NOTE: If the appeal is loaded via the Appeal “Banana” Program (discussed in [Objective 7](#)), the program performs the case movement action.

Routing Paper Folders

If the paper folder is in the field office, associate the hearing material with the folder and forward the folder to OHO via a SSA-636.

If the folder is in another office or PSC:

- Request the folder.

- Forward a copy of the hearing request with any related material and documentation of folder request to OHO,
- Post the folder request to the DW01 screen with the issue FOLDER. Complete a request date, a tickle date and a REMARK indicating which office is sending the folder.
- When receiving a paper file, receipt in the FOLDER issue on the DW01 and forward the folder to OHO using the SSA-636 as a cover sheet.

If the hearing request is filed in a FO other than the servicing FO, the office taking the request should ascertain the folder location, and request the folder be sent to the servicing FO. Then, forward the hearing request with a copy of the folder request to the hearing office, and forward all related material to the servicing FO for association with the folder when it arrives.

A folder request for OHO should receive top priority and expedited. If no response within 15 calendar days, send a second request. If, after an additional 10 days, you do not receive a satisfactory response, transfer jurisdiction of the claim to the Special Process Unit, Regional Commissioner's Office.

Non-Medical Hearings

[GN 03103.080](#)

In an effort to improve the quality of the non-medical hearings sent to OHO for processing, the agency developed a document that must be completed before a case is sent to OHO: the Electronic Non-Disability Summary Sheet (eNDSS).

Cases involving non-medical hearings include any appeals for issues not related to a claimant's impairment, i.e. overpayments, SSI income, WC/PDB computations, etc. Although non-medical, exclude the three following issues from the eNDSS process:

- Substantial Gainful Activity (SGA). [DI 12005.010 C](#)

- Work Issue Continuing Disability Review (Work CDR) if the claimant disputes earnings or work activity. This does not include hearing requests for overpayments that occur due to a Work CDR. [DI 13010.145](#)
- Res Judicata appeals on a previously determined claim for disability benefits [DI 27516.001 C](#)
- Benefit Offset National Demonstration (BOND) Overpayments

DO NOT transfer a case to the PC, or complete an eNDSS, if the issue under appeal is one of the above issues or a medical appeal per [GN 03103.130](#). Instead, the FO must review the folder for case documentation, ensure all documents are in the folder, obtain any missing documents, and transfer the case to OHO.

Title II

For Title II non-medical hearing cases, refer to [GN 03103.130](#) and [GN 03103.080](#) which provide step-by-step instructions for handling and routing Title II only cases from the FO to the PC and from the PC to OHO.

Title XVI and Concurrent

For Title XVI and common issue concurrent cases, the FO is responsible for reviewing the folder and ensuring all necessary paperwork and documentation are included in the folder before sending the case to OHO. [SI 04030.030](#)

CPMS

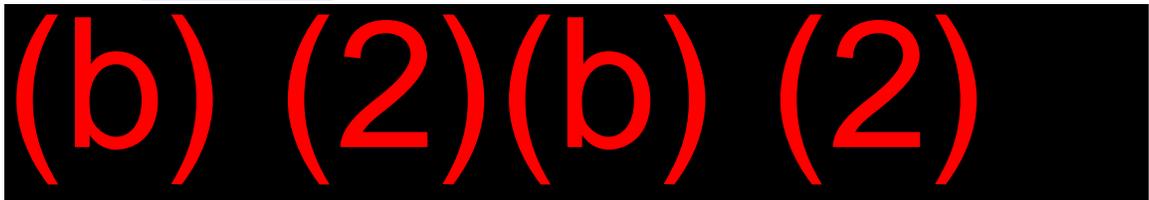
CPMS

[DI 80550.001](#)

The Case Processing and Management System (CPMS) is the appeals processing system used by OHO. CPMS is available to non-OHO components to query current information about specific hearings-level cases. CPMS is a web-based system that can be accessed SSA-wide, including the DDS, to obtain the most current information on hearing cases. You can access CPMS through the “Big Red I” icon on your desktop or the following URL: [\(b\) \(2\)\(b\) \(2\)\(b\) \(2\)\(b\) \(2\)\(b\) \(2\)\(b\) \(2\)](#).



- Select the “Find a Case” link. The SSN Search page will appear.
[DI 80550.020](#)



- Enter the SSN and select the “Search” button. A summary of all cases meeting the search criteria displays with “Query” access only. Only OHO can edit or add information to the CPMS program.
- If you cannot find any matches based on the SSN search, the case does not establish on CPMS.

Effectuation of ALJ Decision

Effectuation

[GN 03103.240](#); [GN 03103.140](#)

When the ALJ renders a decision, the claimant and his/her representative receive a copy of that decision, and a copy goes into the case folder.

When the ALJ makes a decision **favorable** to the claimant, the case is sent to ODO or the PSC for processing. Receipt in the OHO issue on the DW01. Unless auxiliary applications are needed, FO action is complete.

When the ALJ makes an **unfavorable** decision or dismisses the hearing, a copy of the decision (but not the folder) is sent to the FO for processing.

The folder is sent to the Social Security Administration National Records Center (SSANRC).

Unfavorable ALJ Decisions

To effectuate an unfavorable decision:

- Receipt the hearing back into the field office. (2/07 in MCS)
- Receipt the tickle of the OHO issue on the DW01.
- Enter the decision on the DISP screen (02/09) and #1 Unfavorable Denial and the dates
- Enter any applicable optional clearance screen coding, including Denial Basis field on DIDL screen. Find the denial code used on the Recon or initial claim, and put this denial code on the DIDL.
- Code the DECI screen.
- Process the decision through EC. Process non-MCS hearing requests through MACADE.

ALJ Dismissal

[GN 03103.220](#)

When the ALJ dismisses a hearing request, he/she does not decide the merits of the case. Reasons for dismissal may include:

- A party requests dismissal.
- All parties abandon the hearing. This occurs often when the individual fails to appear for the scheduled hearing and there is no good cause established for the failure to appear.
- Res Judicata applies.
- There is no right to a hearing, e.g. if the individual has not yet received a reconsideration determination.

- The request for hearing is not filed timely and good cause is not shown.
- The claimant dies and there is no spouse, surviving child, etc., who would be adversely affected if the hearing is not held.

To effectuate a dismissal:

- Receipt the hearing back into the field office. (2/07 in MCS)
- Record the dismissal on the DISP screen with a code 4.
- Close out any issues on the DW01.
- MANCLR the hearing to your own field office code.

Unproductive Hearing Requests

As with MCS recon requests, there will be times you establish a hearing request, but the appellant decides not to pursue the appeal. The segment containing the unproductive hearing request is locked when you enter the DISP screen with a code 7 (Abandon) in the Disposition field. FO management must clear a protected auxiliary in the segment. [MS 03510.007](#)

Informal Remand

[DI 27520.001](#); [DI 27520.005](#); [DI 81010.141](#); [DI 12010.025](#)

Definition

Informal remand is a procedure developed to provide a pre-hearing case review for those hearing cases in which there is a strong likelihood of reversal of the previous DDS determination.

Pre-Hearing Review

When a claimant requests a hearing, the FO will review the folder, including the previous determination. Based on the review, an informal remand may be appropriate in the following situations:

- The claimant submits new evidence with the request for hearing showing his/her condition has deteriorated to the point that the DDS can reverse their previous denial to an allowance without additional development;
- New evidence reveals a significant new impairment of which DDS was not aware;
- There was a cessation determination because the recipient had failed to cooperate by providing evidence necessary for a continuing disability decision but is now submitting that evidence.
- There is no indication the claimant engaged in Substantial Gainful Activity after the Alleged Date of Onset.

The FO will send the case to the DDS that made the previous determination, rather than to OHO, for possible revision of the previous decision.

The pre-hearing case review will not delay the scheduled hearing unless the claimant agrees in writing to continue the review and delay the hearing.

Routing

[DI 12010.015](#)

The FO transmits the case to the DDS notifying DDS the case is an informal remand. The FO will also forward a copy of the hearing request to the OHO office that would have received the case.

If there is doubt whether an informal remand is appropriate, send the case directly to OHO. OHO can still make the decision to direct the case to DDS for a remand.

DDS Action**[DI 27520.005](#)**

The case will be reviewed immediately by an adjudicator who did not participate in either the initial or reconsideration determination.

If a reversal is warranted, the DDS will follow the usual process for a revised determination and, in addition, show "Informal Remand Case" in the remarks section of the SSA-831. They will also send a copy of the determination to OHO.

If a fully or partially favorable revised determination cannot be made based on the evidence of record, the DDS will forward the case to OHO within seven calendar days from the date of receipt of the case in the DDS. The DDS will notify OHO that favorable action could not be taken on the pre-hearing review.

OBJECTIVE 4:

Determine how to process an Appeals Council case.

Appeals Council Review

[GN 03104.000ff](#); [DI 81010.155](#); [DI 81020.120](#); [DI 81010.150](#)

Definition

An Appeals Council (AC) review is the third step in the administrative appeals process. The Appeals Council considers ALJ decisions and orders of dismissal either at the claimant's request or on its own motion. When the AC grants a claimant's request for review or reviews a case on its own motion, the AC may render the ALJ decision final, issue an order of dismissal, or remand the case to an ALJ for further proceedings.

HA-520-U5

There is no Title II AC level event in MCS. The request for review may be submitted on the HA-520-U5, "Request for Review of Hearing Decision/Order," or other written document. The request must be received within 60 days after the date of receipt of the ALJ's decision or dismissal. The agency presumes the claimant receives this notice within five days after the date of the notice, unless there is a reason to the contrary. The AC must make the decision to extend the time for filing a request for review.

If the request is made by phone, mail the Form HA-520-U5 to the claimant for completion. If the claimant writes to the FO complete form HA-520-U5 and type the claimant's name in the signature block. Fax the original letter into the electronic folder along with the HA-520-U5. You will use the letter's postmark as the date of the request for review. See [GN 03104.200](#) for instructions on completion of the HA-520-U5.

Requests for review are loaded into EDCS as long as a hearing level denial exists within EDCS for the case. You will not be able to access the

transfer screen in EDCS on an Appeals Council case. The case will automatically transfer to the Office of Analytics, Review and Oversight (OARO) within one business day of establishment in EDCS.

If a paper folder exists, forward it to OARO within one business day of receipt of the request. The address is: OARO, Office of Appellate Operations, 5107 Leesburg Pike, Falls Church, VA 22041-3255.

If the appellant's request for review is granted, the AC will send a letter informing him/her of the right to appear before the AC and/or to file a brief or further written statement. An individual, whose request for an appeal or whose appeal has been denied by the AC, may file a civil action in the Federal District Court. Civil action in Federal District Court is applicable after the claimant has exhausted the three levels of appeal and the same 60-day time limit for filing applies.

Internet i520

The i520 (Request for an Appeals Council Review) can be completed online and transmitted electronically to SSA. The i520 seamlessly accepts both Medical (Disability) and Non-Medical (Non-Disability) appeals. Claimants or their appointed representatives have the ability to submit the electronic version of the HA-520 and supporting documentation through the internet.

Tracking Appeals Council Reviews

Record the date of receipt of the HA-520 along with any subsequent actions on the MDW. Post the decision and date on the MDW. Use the MDW in non-disability cases. Once the Appeal Council Review is established in EDCS, an action item will appear when the AC completes action on the appeal. Do not control Appeals Council cases in MCS because the claim will archive before the AC makes a decision, and you will not be able to update the MCS tickles with follow-ups and other information.

Information on the status of Appeals Council cases is in:

- ARPS (Appeals Review Processing System) - used to check AC level claims only.

- CPMS (Case Processing Management System) - used to check the status of hearings and AC level claims.

Subsequent Claims Involving Disability

[GN 03104.370](#); [DI 81010.155](#); [DI 12045.027](#); [DI 51501.001](#)

Subsequent Claim – Same Title AND Same Benefit Type

[DI 51501.000ff](#)

Effective July 28, 2011, field offices will not accept a new disability application if a prior disability application for the *same title* and *same type of benefit* is currently pending at any level of review.

EXAMPLE: Wendy Robinson currently has a claim for DIB pending with the ALJ. Today, Wendy comes in to file a new DIB claim based on the same condition. We will not take a new disability application. Inform Wendy we will forward any additional evidence to the hearing's office and it will be associated with the pending claim.

Wendy also has the option to withdraw the pending appeal and only pursue the new initial claim. You must inform her she will lose all rights to the application if she withdraws the appeal. If she still chooses to withdraw the appeal, she must submit a written statement to the FO indicating she understands the effect of the withdrawal and intends to file a new application.

There is one exception to the rule regarding subsequent disability claims of the same title and type. If the claim is currently pending at the Appeals Council level, the claimant CAN file a new application if:

- He/she submits additional evidence of a new condition with an onset after the date of the hearing decision, AND
- He/she wants to file a new disability application based on the evidence, AND
- The AC agrees the claimant should file a new application.

Instructions on how to get AC approval of the new application can be found in [DI 51501.001 C.3.](#)

Subsequent Claim – One Title Pending at Reconsideration or ALJ Level AND a New Claim of Different Title and Type is Filed

Take a claim or closeout entitlement according to procedure when the following conditions are met:

- A T16 claim is filed and a T2 only claim is pending administrative review at the Reconsideration or ALJ level. [DI 51501.001 C](#)
- A T2 claim is filed and a T16 only claim is pending administrative review at the Reconsideration or ALJ level. [DI 51501.001 D](#)

For additional information on how to process subsequent claims when one title is pending at the Reconsideration or ALJ level and the claimant files a new application, refer to [Exhibit 3.](#)

Subsequent Claim – Different Title or Different Benefit Type – and AC Review Filed simultaneously

When an individual requests AC review on a disability issue along with filing a new subsequent initial claim on a different title or different type of benefit, take the following action:

- Load the AC request in EDCS and fax the paper form into the electronic folder. The AC request will transfer automatically.
- Process the new claim in EDCS per [DI 81010.155.](#)
- Add a “Subsequent Claim” EDCS flag to the new claim. In the description box, add the request date of the AC review and date of mailing to the AC.
- Transfer the new claim to DDS.

NOTE: The date of onset can be no earlier than the day after the date of the ALJ decision. The period on or before the date of the ALJ decision rests with the AC.

EXAMPLE: Renee Portage’s DIB claim was just denied by the ALJ. Her husband, Dennis, recently passed away. Renee contacts the FO to file an initial claim for DWB and wants to appeal the ALJ decision. Load the AC request in EDCS and fax the HA-520 into the electronic folder. Then process her new claim in EDCS. Be sure to add the “Subsequent Claim” flag to EDCS before transferring the case to DDS. **Note:** Renee’s DWB claim can also be escalated to the AC level if she chooses. The next objective discusses this process.

Subsequent Claim – Different Title or Different Benefit Type – and Claim Pending at the AC Level

When an AC level case is pending and a new subsequent disability initial claim under a different title or a different benefit type is filed, the subsequent claim is processed as a new initial claim under current processing procedures with normal appeals through the filing of a request for a hearing. If a new “subsequent” claim is a CEF you will:

- Establish the claim in EDCS and process per CEF procedures – [DI 81010.000](#);
- Follow the instructions in “New Claims or Appeal Filed While a Prior Claim or Appeal is Pending Before the Appeals Council (AC) – [DI 12045.027](#)”; and
- Add the flag type “Subsequent Claim” in EDCS. In the “Description” box add these remarks:
 - The date the AC review was requested;
 - The Office of Appellate Operations (OAO) Branch with jurisdiction of the ALJ decision and
 - The remark, “Claimant has filed a new application and has an appeal of an ALJ decision on a prior application pending at the Appeals Council. See ARPS Query.”
 - Transfer the new claim to DDS.

Controlling AC Reviews When Subsequent Initial Claims Filed

Control these cases by annotating the MDW and DW01 as follows:

- On the MDW include:
 - An ISSUE “AC APPEAL”
 - In the REMARKS for that ISSUE: Prior claim dated mm/dd/yy pending at the AC; and
 - The date of appeal and date sent to AC.
- On the DW01 include:
 - An ISSUE “AC APPEAL”
 - In the REMARKS for that ISSUE: Prior claim dated mm/dd/yy pending at the AC;
 - The date of appeal and date sent to AC; and
 - Set an appropriate tickle date for the AC decision.

Subsequent claims involving non-disability issues

When a claimant files a subsequent non-disability application with a new issue, process the subsequent application.

If a subsequent non-disability application is filed that has an issue that has already been decided at some level of the appeal process, send the subsequent application to the AC for association.

EXAMPLE: Judy files an application in 06/16 on behalf of the NH’s stepchild. The claim is denied through the ALJ in 12/17 based on failure to submit one-half support. Judy files a new application in 05/18 and provided evidence proving one-half support as of 02/18. Send the subsequent application to the AC. The new evidence relates to the period before the ALJ decision.

EXAMPLE: Same as above, except the NH adopts the child in 02/18. Process the application because the new evidence is an issue that was not previously adjudicated.

OBJECTIVE 5:

Determine how to process special appeal situations.

Special Situations

[GN 03107.000ff](#); [DI 12045.010](#)

Escalating Claims in Title II/Title XVI Cases**DI 12045.010**

A Title II or Title XVI case may be pending a determination or decision at a different level of appeal than its counterpart. When this happens, the FO should clarify whether the claims share a common issue, so both claims can be considered at the same level of appeal. We call this process "escalating a claim."

However, the two claims will not be considered at the hearing level if the ALJ does not agree there is a common issue or the claims be joined, or if the claimant objects to joining the claim.

The procedures for handling Title II/Title XVI common issues at different levels of the appeals process is as follows:

- If the FO receives an initial or subsequent application under one title and develops the case to the extent that the only unsettled issue is identical to the issue in a pending reconsideration request under the other title, the application will be "escalated" to the reconsideration level of the other claim.

EXAMPLE:

A claimant files for Title II disability but not for SSI due to excess resources. The initial disability claim is denied. When he files reconsideration, you discover he is now eligible for SSI and take the application. Since the medical issue is common to both claims,

the SSI claim escalates to the reconsideration level with the Title II disability claim.

- Upon receipt of an initial or subsequent application or reconsideration request under one title which presents the same issue as in a pending request for hearing under the other title, the FO will telephone the hearing office and request advice on joining the claims. The Administrative Law Judge will agree or disagree to join the claims. [DI 12045.015](#)
- The FO and DDS will process an initial disability claim or reconsideration request under one title independently of a claim awaiting AC review or Court review under the other title, regardless of whether it presents a common issue. The FO will document the EDCS 3367 with any information about prior claims. Appropriate remarks to enter on the 3367 include “Title II reconsideration pending”; “Title II appeal at ALJ level”; or “new Title XVI claimant has claim under (SSN) pending at ALJ level”, etc.

Expedited Appeals Process

[GN 03107.100](#) defines the expedited appeals process (EAP) and explains the criteria for using it. You should be aware of the following important points:

- The EAP permits an individual to go directly to U.S. District Court (after a decision at the reconsideration level or higher is made) as an alternative to pursuing the regular administrative appeals process.
- The purpose is to save time for the individual, as well as SSA, in situations where the facts of the case are not in dispute. The sole issue must be the constitutionality of a provision of the law.
- Use of the EAP is voluntary on the part of both the individual and SSA. However, once both parties sign an agreement, neither may withdraw from it.
- Send the EAP request to the appropriate PC, ATTN: Reconsideration and Disability Review Branch, for review. Treat a denied EAP request as a request for a hearing or AC review – as appropriate – and send to the Office of Hearing Operations (OHO).

OBJECTIVE 6:

Determine who represents the claimant and the forms needed to process the appeal when there is representation.

Representation

[GN 00204.003](#); [GN 03910.000ff](#); [GN 03925.000ff](#)

The Right to Representation

Every person has the right to representation by an attorney or other qualified person in pursuit of a claim for benefits under Title II, XVI, or XVIII of the Social Security Act and Title IV of the Federal Mine safety and Health Act.

Who is a Representative

A representative is an individual attorney or non-attorney. An attorney must meet the following qualifications:

- Be admitted to practice law before a court of the United States.
- Not be disqualified or suspended from representing claimants before SSA.
- Not be prohibited from acting as a representative.

A non-attorney must meet the following qualifications:

- Generally known to have good character and reputation
- Capable of giving help to the claimant in connection with the claim

- Not disqualified or suspended from representing claimants before SSA
- Not prohibited from acting as a representative

A person helping the applicant answer questions or submit evidence is not necessarily a representative. See [GN 03910.020 B.4.](#)

If someone is helping the claimant during the claims process, and it is not clear whether the individual is a representative:

- Explain to the claimant his/her right to representation and the fee authorization process
- Ask if the claimant wants the individual to represent him/her
- If so, have the claimant appoint the person as a representative

Role of the Representative

[GN 03910.025](#)

The following list indicates some of the representative's authority and privileges. The representative:

- Obtain information about the claim that would generally be provide to the claimant
- May be informed of evidence required to support the claim
- May be present at any interview
- Must be notified of all decisions made on the claim, including decisions made on auxiliaries
- May request any level of appeal

The representative may *not*:

- Sign an application on behalf of the claimant, unless he/she is a proper applicant. [GN 00204.003](#)
- Testify in place of the claimant
- Relegate authority to represent the claimant to anyone

Contacting Represented Claimants

[GN 03910.050](#)

All contacts with a represented claimant must be made through the representative unless:

- the representative gives permission for SSA to deal directly with the claimant, or
- the claimant requests notices by first class mail with a follow-up telephone call, or
- information regarding the representative's appointment is unclear.

Send any request for claim development items to the representative with a copy to the claimant. Document any contacts with the representative in the claim using the RPOC or by documenting the DW03.

If you contact the claimant to read a notice, DO NOT initiate a request for any information or ask additional questions unless the representative has given permission for direct contact with the claimant. [GN 03910.050](#)

Role of the Field Office

Correctly documenting the claim file and SSA's records regarding representative involvement is essential. It ensures SSA will contact the claimant through, or with permission of, the appointed representative. SSA must provide the representative a copy of all notices, authorize any fee a representative can charge, and withhold any portion of any past due benefits for direct payment of an approved fee.

Revocation of Representation

[GN 03910.040](#)

A claimant may revoke the appointment of a representative at any time. A revocation of appointment must be in writing and signed by the claimant. SSA does not have a standard form for revoking the appointment of a representative. Therefore, we need to ensure the representative whose appointment has been revoked is properly advised, either by obtaining the representative's signature on the revocation, or by sending the

representative a copy of the statement of revocation signed by the claimant.

Documenting a revocation of appointment or a representative's withdrawal from a case ensures SSA does not erroneously disclose information to a former representative or incorrectly withhold a fee based on an appointment no longer in effect.

Use of Forms in Representative Cases

Forms used in representative cases:

FORM	USE
SSA-1694	Request for Business Entity Taxpayer Information
SSA-1695	Identifying Information for Possible Direct Payment of Authorized Fees
SSA-1695 Acknowledgement Letter	Notice that must be sent upon successful processing of the SSA-1695. The notice is available in DPS.
SSA-1696	Documentation of the claimant's decision to appoint a representative and it is limited to an appointment of an individual, not an entity.
SSA-1699	Registration of Individuals and Staff for Appointed Representative Services
SSA-1697	Formal acknowledgment of the appointment; used when SSA-1696 or similar is received
SSA-1560	Petition to Obtain Approval of a Fee for Representing a Claimant Before the Social Security Administration; it must be completed before an attorney representation fee may be approved
SSA-1128	A "flag" which must be attached to the bottom right corner of a paper claims folder. (If the rep is not an attorney, cross off the word "attorney".)
SSA-3288	Consent for release of information. Claimants use it to authorize SSA's disclosure of their non-tax return information in SSA's possession.

NOTE: Procedures previously discussed which eliminate the signature requirement for an appeal request do not change the signature and documentation requirement for appointing authorized representatives, revoking representation, etc.

Firm or Organization Named as Representative

[GN 03910.020 B.3 & .040](#)

SSA does not recognize firms or entities as representatives. However, claimants will complete notices of appointment that appear to be appointments of a law firm or other entity. In such cases, SSA will recognize the individual, not the firm, who signs the notice accepting the appointment. One or more persons in a firm, corporation, or other organization can be appointed as representative(s), but a law firm, legal aid group, corporation, or the organization itself may not be appointed. Disclosure of information is permitted to the representatives' designated associates (i.e. clerks) who perform administrative duties, such as, photocopying information, and requesting copies of a claimant's folder if the appropriate box is checked on the SSA-1696.

EXAMPLE: A claimant submits an SSA-1696. On the form, the claimant's representative is listed as "Hawthorne and James, a Professional Corporation" as the claimant's representative. The form is signed by Henry James, accepting the appointment. In this case, SSA will recognize Henry James as the claimant's representative.

Representation Fee

[GN 03940.001](#); [GN 03940.004](#); [GN 03940.005](#)

Many representatives charge the claimant a fee for their services. If the representative does not wish to charge a fee, he or she must sign the Fee Waiver statement on the SSA-1696.

If the representative decides to charge a fee, he/she must request SSA's authorization by submitting a fee agreement to SSA before the date of SSA's favorable decision on the case. A representative will receive payment only when the claimant and/or any auxiliaries are awarded past due benefits. The fee agreement must be approved by SSA whether the

representative receives payment directly from SSA or collects the fee from the claimant.

The amount certified to the representative under the fee agreement will be the smallest of:

- 25 percent of the past-due benefits payable (including auxiliary benefits) through the month before the month the favorable decision is effectuated (i.e., adjudicated), or
- The amount which SSA has fixed as a reasonable fee
 - \$5,300 if the fee agreement is approved between 02/01/02 and 06/21/09
 - \$6,000 if the fee agreement is approved on or after 06/22/09, or
- The amount the claimant and attorney agreed upon as a fee.

If a fee agreement is not in file at the time of a favorable decision, the representative may petition SSA for approval of any fees charged for services in connection with a claim for SSA benefits, per [GN 03940.003](#). The PSC handles the fee petition process. [GN 03930.001](#)

Representatives, whether attorneys or not, must register if they wish SSA to withhold the fee from past due benefits and reimburse the representative directly.

Appointed Representative Registration

Non-attorney Representatives

[GN 03920.018](#)

While non-attorney representatives usually must collect their fee directly from the claimant after the claim is approved and past due benefits are released, they can be paid directly by SSA.

Those non-attorney representatives who wish to receive direct payment of their fee from SSA must meet certain requirements. The minimum pre-requisites the non-attorney representative must meet are:

- Possess a bachelor's degree, or qualifications equivalent to a bachelor's degree;
- Obtain liability insurance or equivalent insurance adequate to protect claimants in the event of malpractice by the representative;
- Pass a criminal background check;
- Pass an examination testing knowledge of relevant provisions of the Social Security Act and the most recent developments in Agency and court decisions affecting Titles II and XVI of the Act; and
- Satisfy a representational experience requirement.

Registration for Direct Payment

[GN 03910.042](#); [MS 09101.001 - 09103.008](#)

Attorneys and non-attorneys who receive direct payment of fees of \$600 or more in a calendar year will receive a Form 1099-MISC from SSA to file with their yearly tax return. Appointed representatives who receive direct fee payment must register and provide SSA with the information required to issue the 1099. SSA maintains the information in the Registration, Appointment and Services for Representatives (RASR) database.

This includes a representative who:

- has not waived a fee or direct fee payment see [GN 03920.017](#); and
- is an attorney or a non-attorney approved to receive direct fee payment [GN 03920.018](#).

The representative must register for SSA to withhold past-due benefits for direct fee payment.

To register the representative must complete Form SSA-1699 and/or Form SSA-1694. Currently, representatives register by printing the SSA-1699 found at www.socialsecurity.gov/ar/ then faxing the completed form to the Office of Earnings Operations (OEO). If the FO receives the form, fax the completed document to (877) 268-3827. Check the Registration, Appointment and Services for Representatives (RASR)

database to determine if the registration has processed and then shred the form.

After entering this information into the database, see [GN 03910.042](#) for further directions.

NOTE: Beginning March 16, 2012, any appointed representatives requesting direct fee payment, must file all **medical** reconsideration and hearing requests using iAppeals.

Linking the Representative to the Claimant

The representative must submit a Form SSA-1695 (Identifying Information for Possible Direct Payment of Authorized Fees) for every claimant he/she represents if the representative wants to receive direct payment on the claim(s).

Every SSA-1695 submitted must have:

- Name of Claimant and SSN,
- Wage Earner's (W/E) name (if different) and W/E SSN (if different),
- Representative's name, SSN, address, phone number, and FAX number,
- EIN, if representative is a partner or employee of firm or other business entity (if 1694 was submitted), and
- Information about other claimants connected with this claim.
Note: Representatives are not required to provide SSNs for auxiliaries

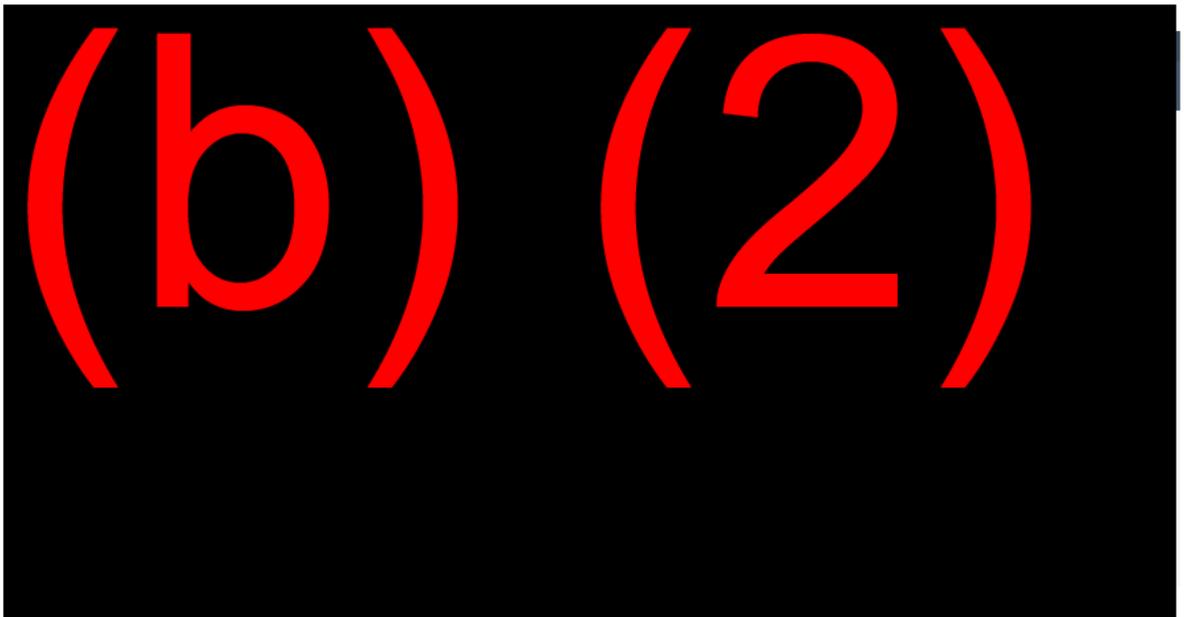
If the 1695 is incomplete, try to contact the representative by telephone to obtain needed information before properly disposing/shredding the form(s). If contact is not successful, return the form(s) to the representative using the notice displayed in [GN 03910.090 Exhibit 8](#). The notice is in DPS, National/General, titled "Atty Fee Returning Registration Forms (Fee 127)"

The information on the form allows you to establish a link between the claimant and the representative in the Registration, Appointment and Services for Representatives (RASR) database. The RASR information

then propagates to the claims record and automatically sends the confirmation notice to the representative.

We search for the link between the claimant and representative in RASR by:

- Selecting the Registration Appointment and Services for Representatives (RASR) link from SSA's (b) (2) page. This will open the RASR application to the RASR Homepage
- Enter the SSN for the claimant and select the Search button to see if information already exists in RASR.



After adding or updating the 1695 information in RASR, you will need to send the confirmation notice(s) through RASR and properly dispose/shred the form.

NOTE: These processes are in place with the RASR release in March 2018 and may differ from what is currently shown in POMS. In the interim, see (b) (2)(b) (2)(b) (2)(b) (2)(b) (2) for more information.

Instructions for establishing the representative information in the RASR are in the (b) (2)(b) (2)(b) (2)(b) (2)(b) (2) in the instructions for "ATTORNEY FEE CODING FOR T2 INITIAL CLAIMS.

Case Processing Procedures

Flag the Claim File

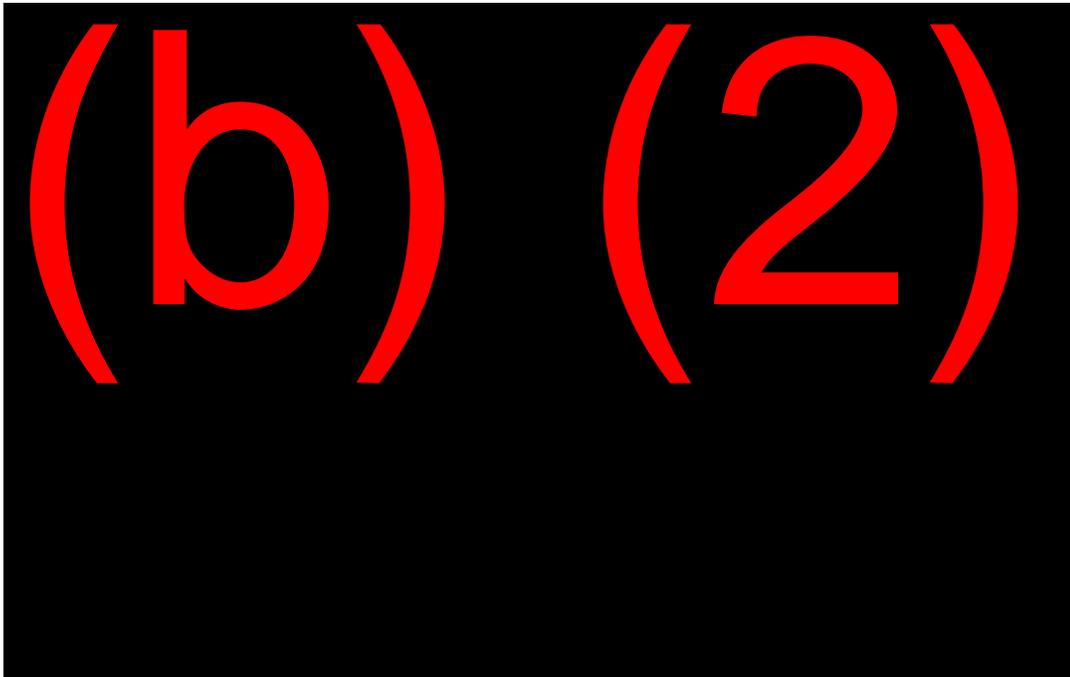
When an attorney or non-attorney representative is involved with a case, it must be annotated. Activate the Representative flag in EDCS for an electronic folder or affix form SSA-1128 (Attorney Representation Card) to a paper folder by stapling it to the front lower right corner.

NOTE: Disability claims at all levels of appeal, involving an appointed representative, are excluded from the Non-Medical Completion (NMC) process. Input of an NMC decision for these claims may result in an incorrect payment and notice to the attorney. This exclusion does not apply to cases when the representation fee is waived.

NOT2 Screen

[MS 03509.009](#)

Complete the NOT2 screen for all claims with a representative regardless of whether or not the representative is charging a fee. This screen contains data necessary for the proper content and direction of notices and payments. See below for a facsimile of the NOT2 screen:



Select Appointed Representative Type

The “Appointed Representative Type” propagates from the Authorized Attorney Data Base (RASR). If no entry propagates, enter the appropriate selection.

Fee Waived

If the claimant’s attorney or non-attorney waived direct payment of the fee, enter “Y”.

Last Withholding Date (LWD)

[GN 03930.035 E.1](#)

Initial Coding—Prior to Adjudication

When entering the representative information prior to time of adjudication, the last withholding date is still unknown and will be left blank.

Adjudicating an Approved Claim

You must complete this field at the time of adjudication for all fee agreements (approved, disapproved, or undecided) and for all fee

petitions/probable fee petitions. The date should be the month before the month of adjudication. If the claim had been in non-medical completion previously, be sure to update the adjudication date on the DECI screen.

EXAMPLE: If the month of adjudication is anytime in December 2018, enter 1118. If the month of adjudication is anytime in January 2019, enter 1218.

For Auxiliary claims protected by the NH's appeal, enter the LWD for the NH's claim, regardless of the adjudication date of the auxiliary claim.

Appointed Representative Name and Address

The name and address will propagate when a registered attorney or non-attorney is linked to the claimant in the RASR database. If the appointed representative has not been linked in RASR, the first line of the ADDRESS field on the NOT2 screen must show "ATTORNEY FOR" or "ATTY FOR" followed by the NH's name (or the name of the beneficiary the attorney represented) to enable SPS to automate the attorney payment. If the representative is a non-attorney but eligible for direct payment of a fee, show "REP FOR" followed by the NH's name (or the name of the beneficiary the representative represented) on the first line of the address field.

Pending Fee Agreement

On initial awards for the primary beneficiary and subsequent awards for auxiliaries, enter the maximum fee amount specified in the approved fee agreement (based on 25% of the beneficiary Past Due Benefits and up to usually \$5,300 or \$6,000 depending on the date of the fee agreement approval). If the NH is already entitled on the MBR, MCS will determine and withhold the proportional share of the fee for the newly entitled auxiliaries. If the maximum fee payable to the appointed representative was withheld from the primary beneficiary, (NH) as indicated on the MBR, then EC will not withhold any past-due benefits from the auxiliaries. In order for MCS to determine the proportional share to withhold or not to withhold, complete the NOT2 for each auxiliary according to current operating procedures for both initial and subsequent awards.

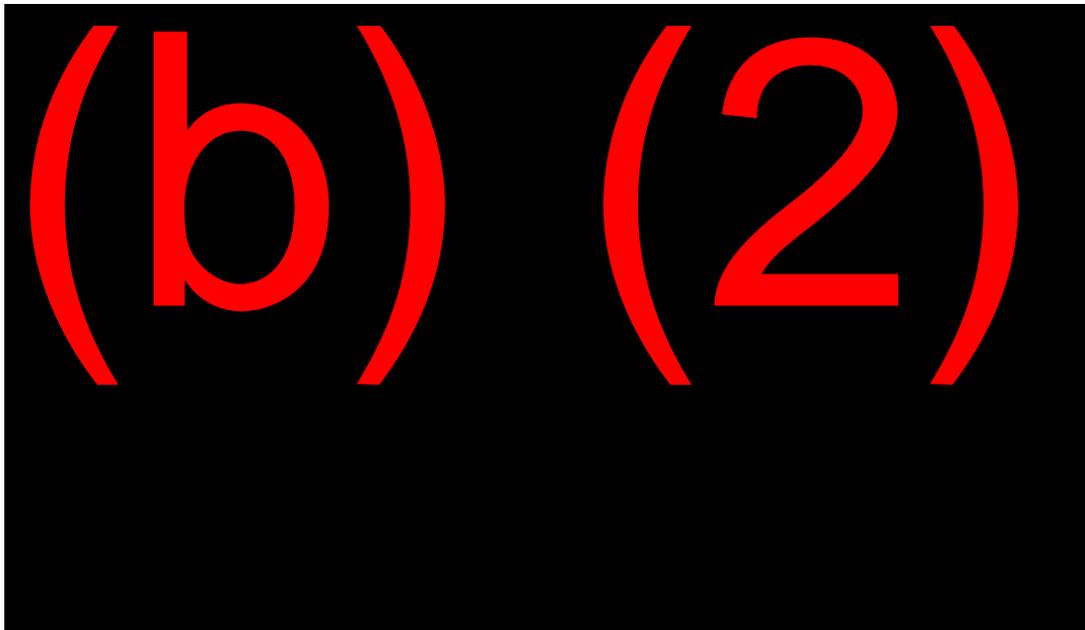
NOTE: Input of the Last Withholding Date (LWD) enables the Earnings Computation (EC) facility to compute the specified percentage (Fee Agreement % Rate) of the beneficiary Past Due Benefits (PDB). EC

compares this percentage of PDB with the entered Pending Fee Agreement Amount (PFAA) and uses the lower of the amounts as the approved fee. This amount posts to the MBR in the Authorized Fee field of Appointed Rep data. Keep in mind that any time the percentage specified in the fee agreement is less than 25%, the CS MUST manually calculate the Past Due Benefits and the amount(s) to be input on the Pending Fee Amount on the NOT2 screen in order to determine the “lesser of” amount.

Select the fee agreement type (approved, disapproved, or undecided) to determine the agreement between the claimant and their appointed representative regarding any fee to be recovered for compensation for services to the claim.

NOTE: Include a Diary Code 99 on the DECI screen for cases where the fee agreement was disapproved or if the attorney presents a fee petition instead of a fee agreement.

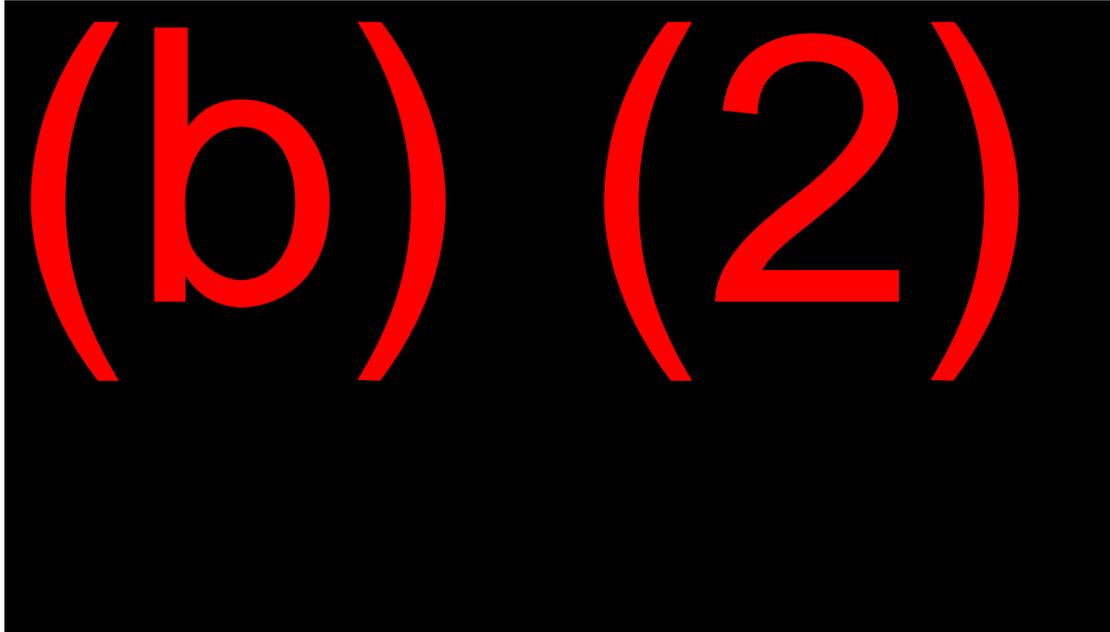
NOT3 Screen



[MS 04802.003](#) lists the different MCS paragraphs for attorney and non-attorney fee agreement claims. You must fully review your claims before adjudicating and include any appropriate paragraphs on the NOT3 screen in the MCS clearance path as required.

DW01/DW02

Use the DW01/DW02 to capture important information on attorney/non-attorney cases.



Post the appropriate issues to the DW01/DW02 to include:

- ATY** - Used for an attorney or non-attorney representative approved for direct payment. Access a list of all possible codes through the F1 help key.
- EDPNA (Eligible Direct Payment Non-Attorney) Determine if a non-attorney representative is eligible for direct payment by checking SSA's list at: (b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2) .
- 1696 – Documents appointment of representative received.
- FEEAGR – Documents receipt of a fee agreement.

Show the ATY** issue for any claim that includes the following:

- Attorney representative on the Notice 2 (NOT2) screen,
- Non-attorney representative approved for direct payment on the NOT2 screen,

- Fee Waived and Direct Payment Waived fields on the NOT2 = “N”, or
- Claim decision on the Decision (DECI) screen equals an allowance or partial allowance.

Refer to [MS 03508.004](#) for a list of ATY** codes. All ATY** issues must have a corresponding receipt date (REC) present. This date should be equal to the date of adjudication.

If the ATY** issue and receipt date are NOT present on the DW01 or DW02 for these claims, you will receive the following adjudicative edit:

“ATTORNEY ISSUE (ATY00-ATY10 OR ATYPY)-MUST BE PRESENT ON THE DEVELOPMENT WORKSHEET.”

Appointed Representative Portal

Refer to the [\(b\) \(2\)\(b\) \(2\)\(b\) \(2\)\(b\) \(2\)\(b\) \(2\)](#) for a workflow on coding claims when an attorney or non-attorney representative is involved. The link is under Component Information, titled “Appointed Representative Fee Coding for T2.”

OBJECTIVE 7:

Process appeals using the Appeals Program.

“Banana” Appeals Program

The Appeals Program completes all the MCS and MSSICS screens needed to establish a reconsideration request or a hearing request on most denied T2, T16, concurrent, CDB, or DWB claims and completes them all in about 2 minutes. This program eliminates manual re-keying of data into MCS or MSSICS for appeals. The Banana application will also work with both T2 and T16 iAppeals.

Appeals Program Setup

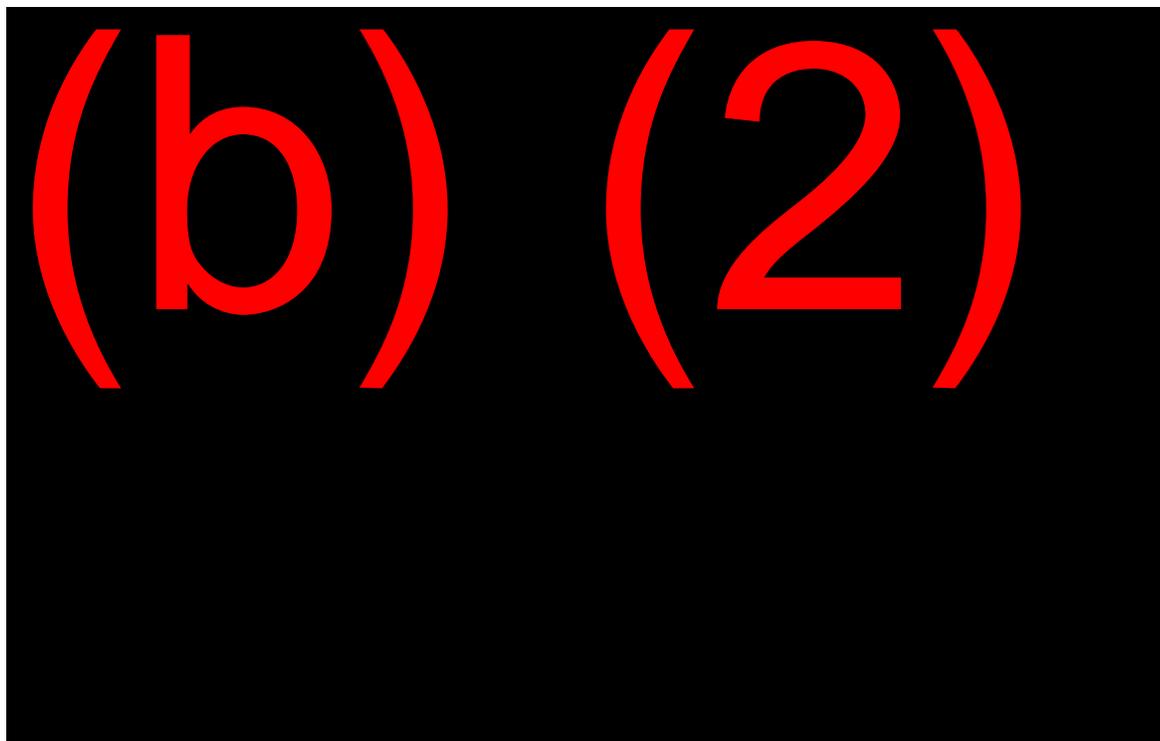
The Appeals Program button is on your PCOM toolbar. If the program is not present on your toolbar, ask your SLC or office management for assistance with creating a link to the program on your PCOM toolbar. You may also find the Appeals program in the Kitchen Sink program labeled as “Banana”.

The first time you run the program, you will need to complete the CR Information Selection Form.

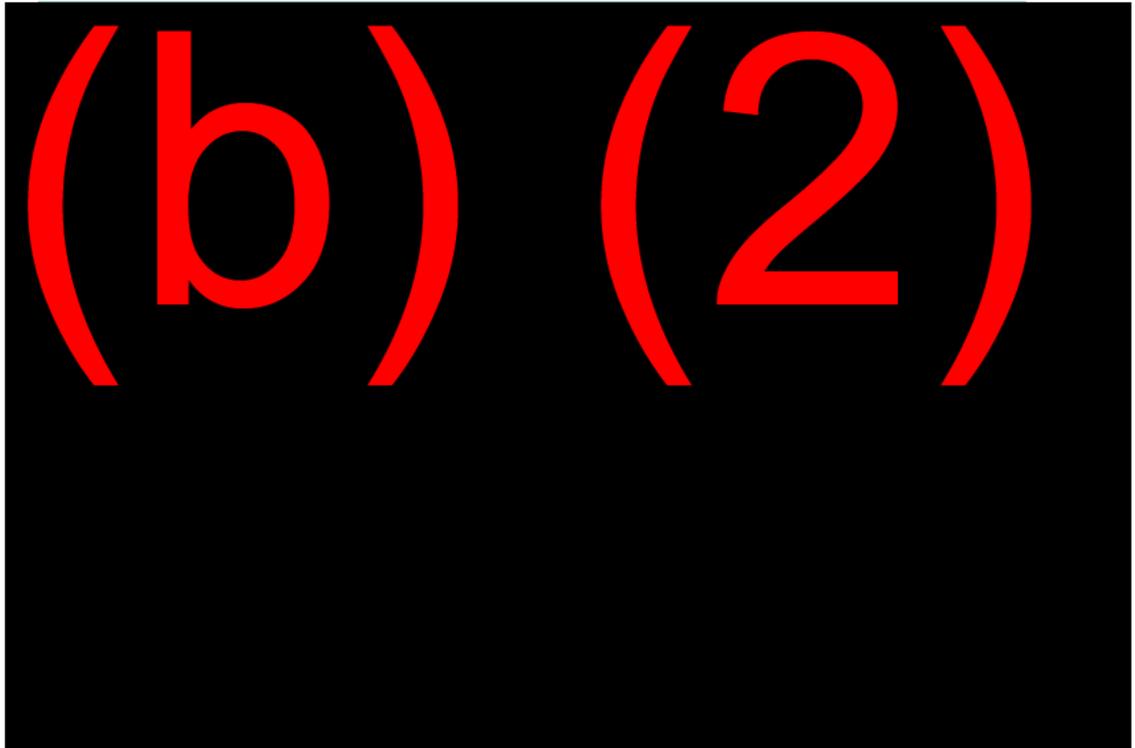
- From the Main Menu (first screen that pops up when you open Banana):
 - Select Local Database
 - Select Office Information to open the *Technician Information Selection Form*



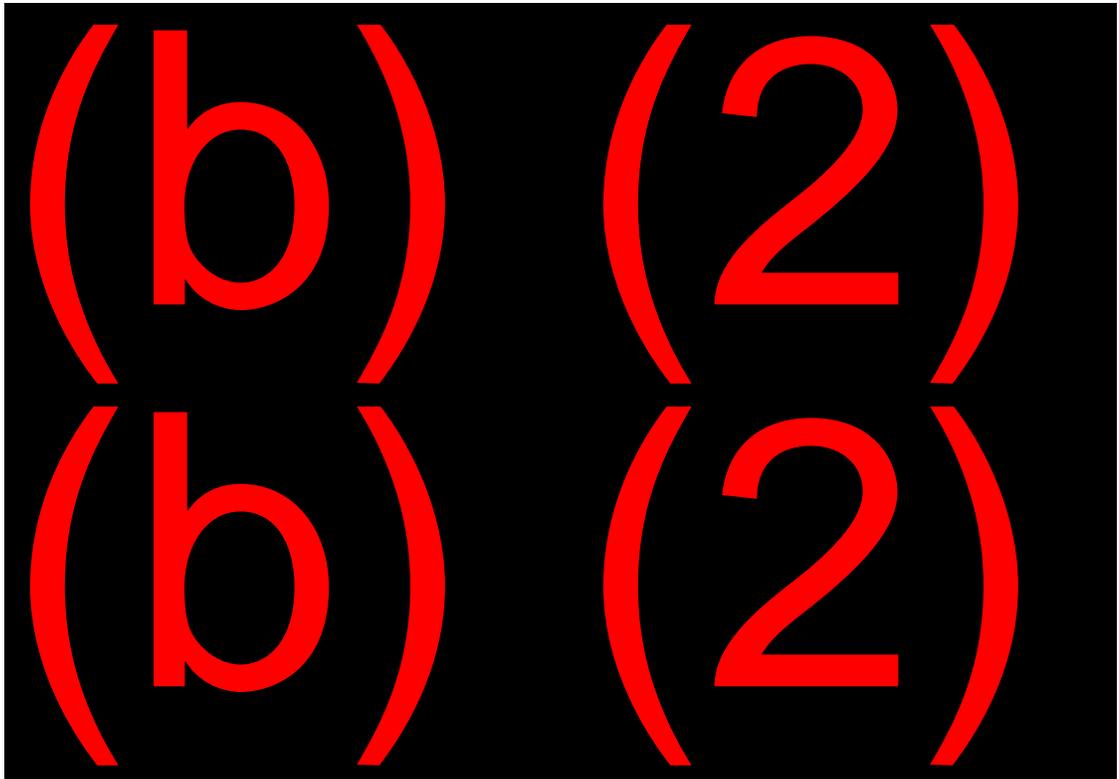
- Select the Modify Office information dropdown menu



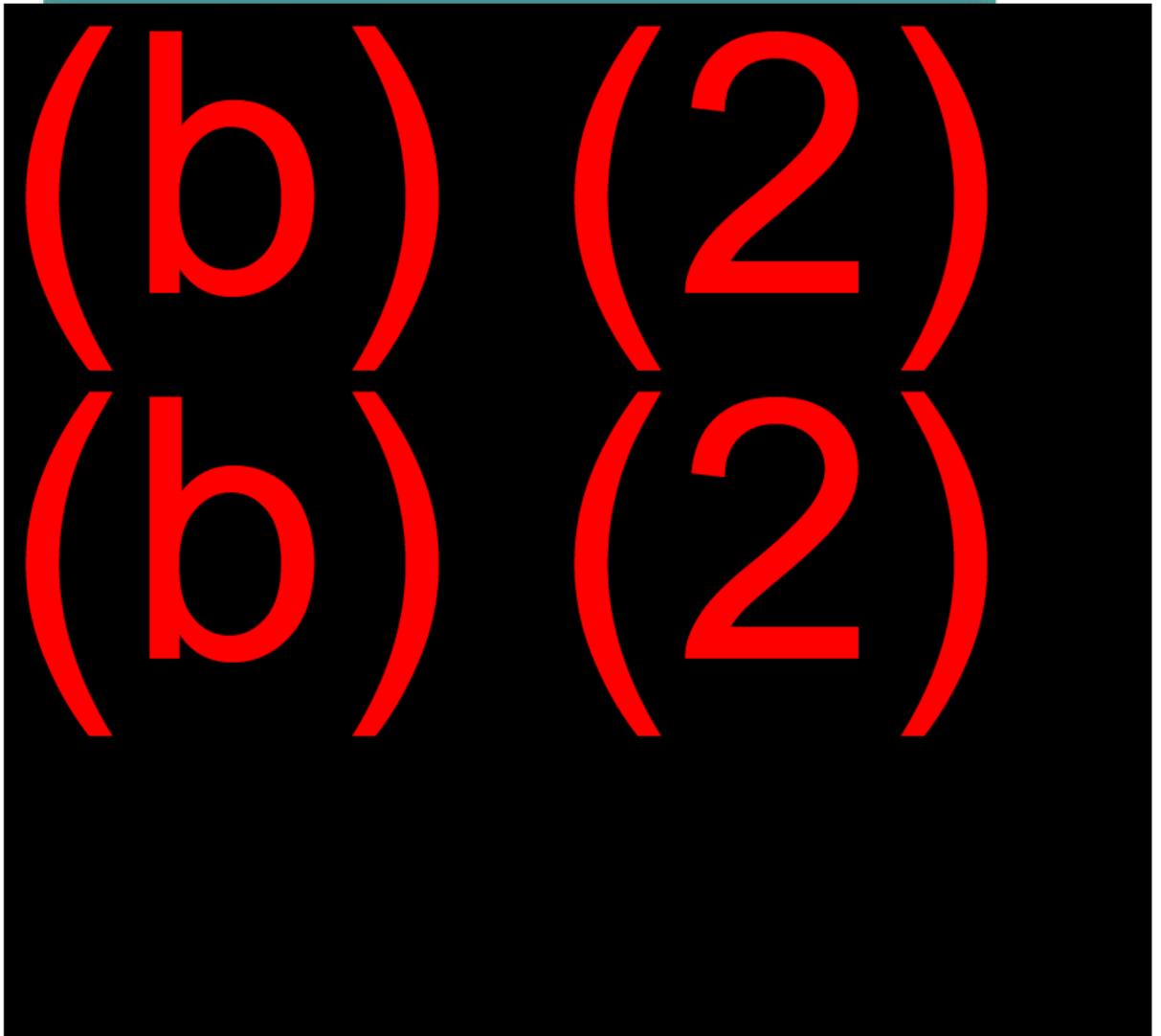
- Select the Modify Office information dropdown menu



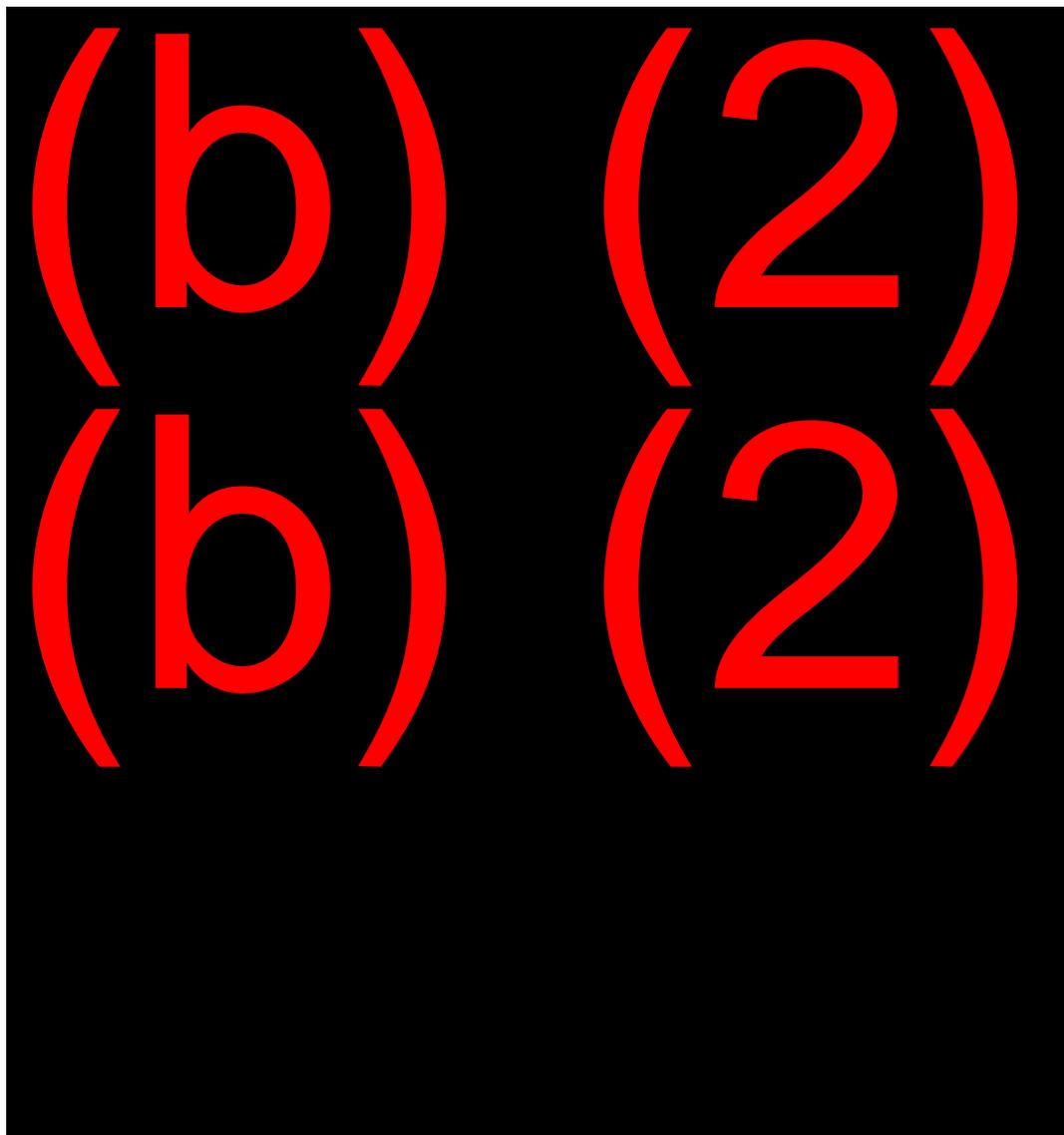
- Select "Add Info"
- Then select "Technician Information"



- This opens the CR Information page



- Key the unit, name, and work break down
- Submit

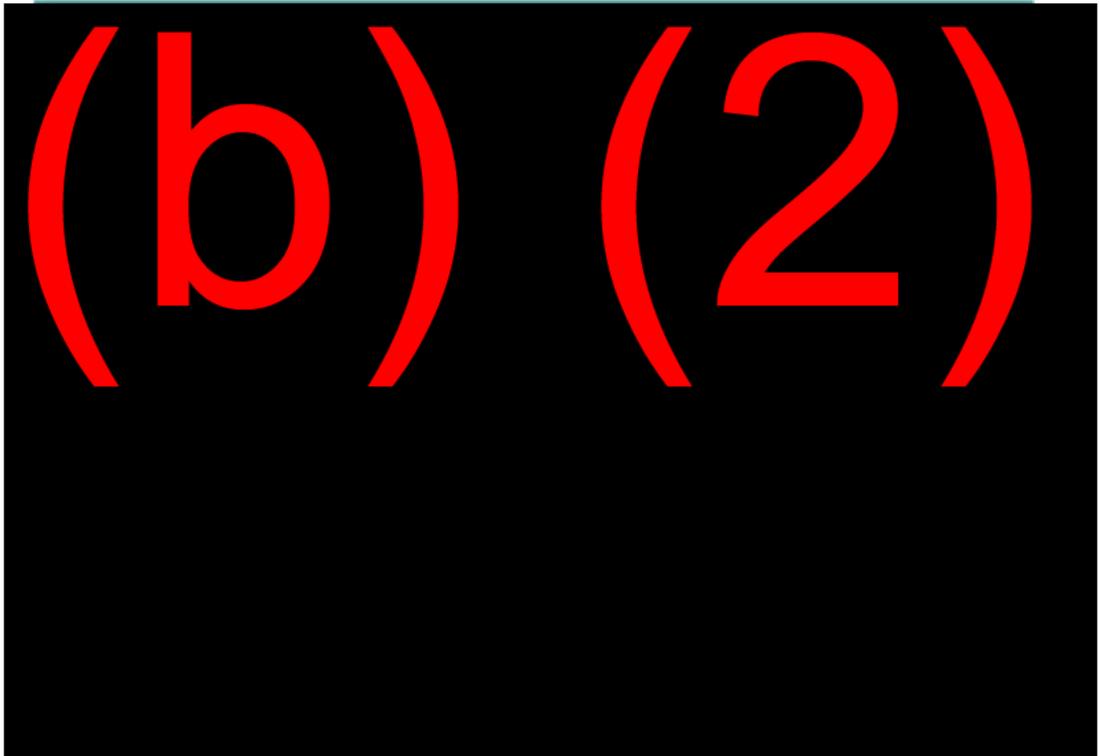


- Notification that change was saved.



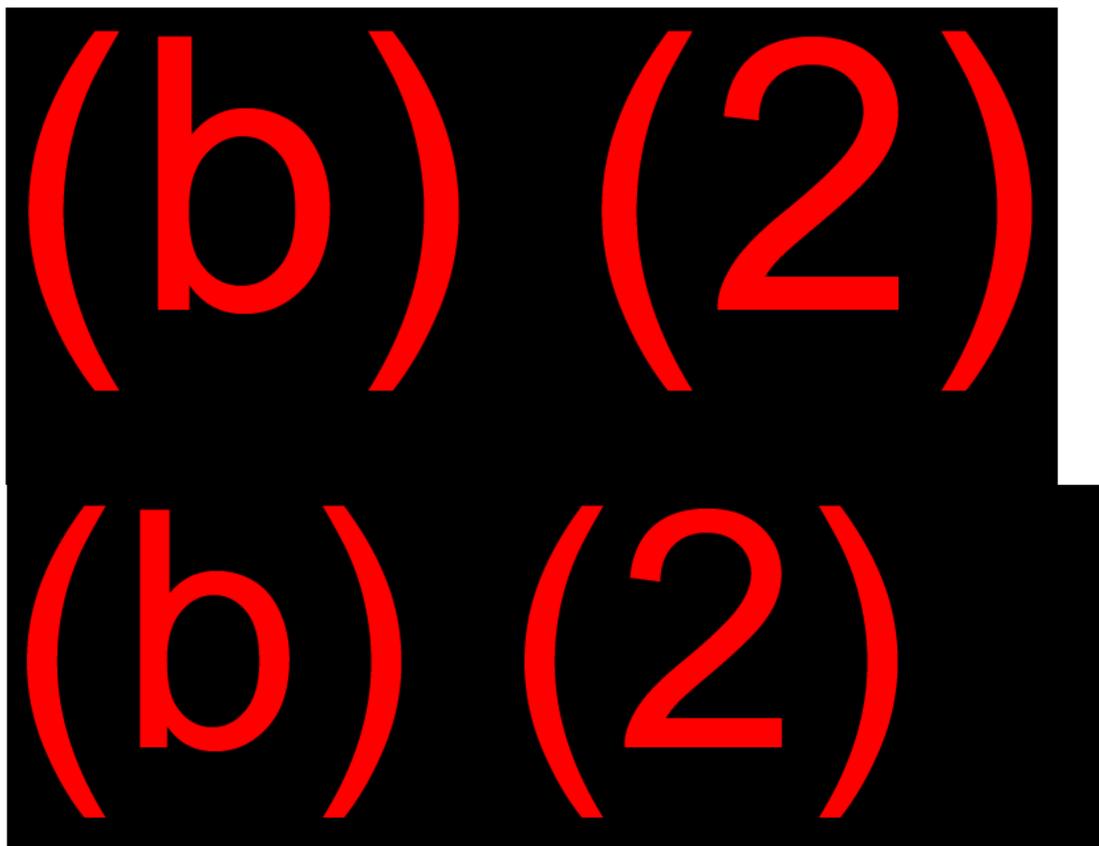
(b) (2)

- The new employee's name now appears in the employee list



(b) (2)

- The same options are available on other screens
 - Select Local Database
 - Select Office Roster (instead of Office Information)



Additional set-up instructions are available at the [\(b\) \(2\)\(b\) \(2\)\(b\) \(2\)\(b\) \(2\) \(b\) \(2\)\(b\) \(2\)](#)

If needed, have your mentor or another experienced CS help you with your set-up.

Using the Appeals Program

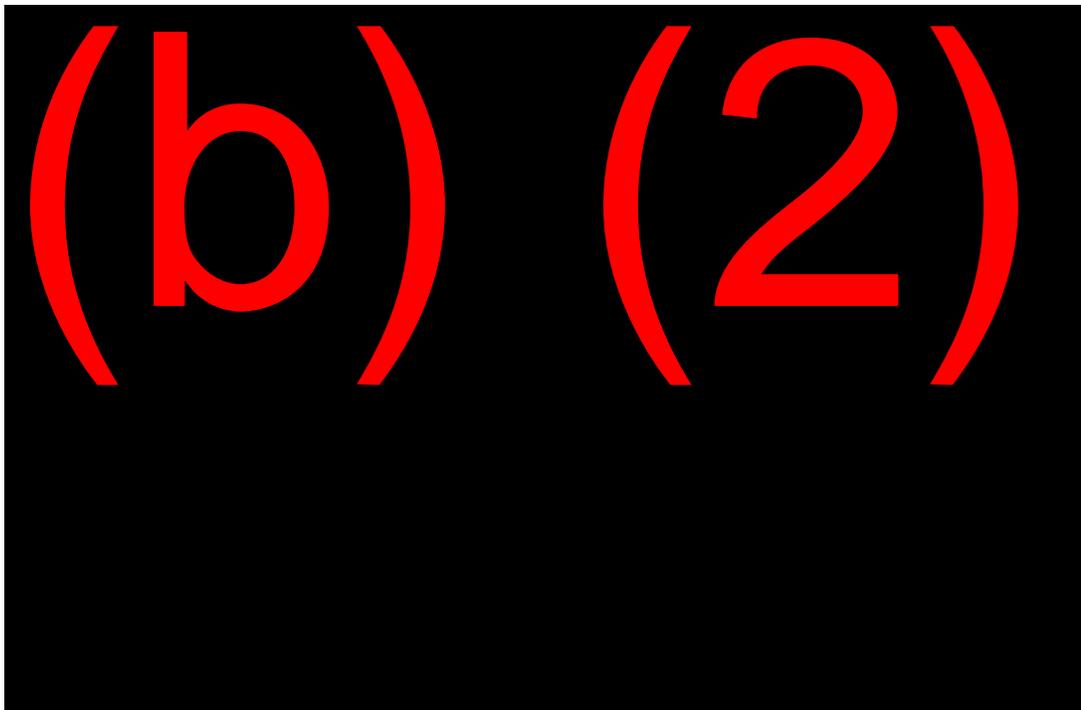
To run the appeals program, you can begin on any screen in PCOM. The program will then find the correct screen and begin the appeal. If the appeal is an iAppeal, you can also begin the Banana from the Internet Appeals listing in WAC. If the claim segment being appealed is not closed, or if the segment has been archived, you will NOT be able to use

the program. You must first follow the instructions in the MCS EC claims workflows page titled "(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)"

When you open the Banana program, a pop-up box appears with two radio buttons for an iAppeal or a Paper Appeal as shown below:



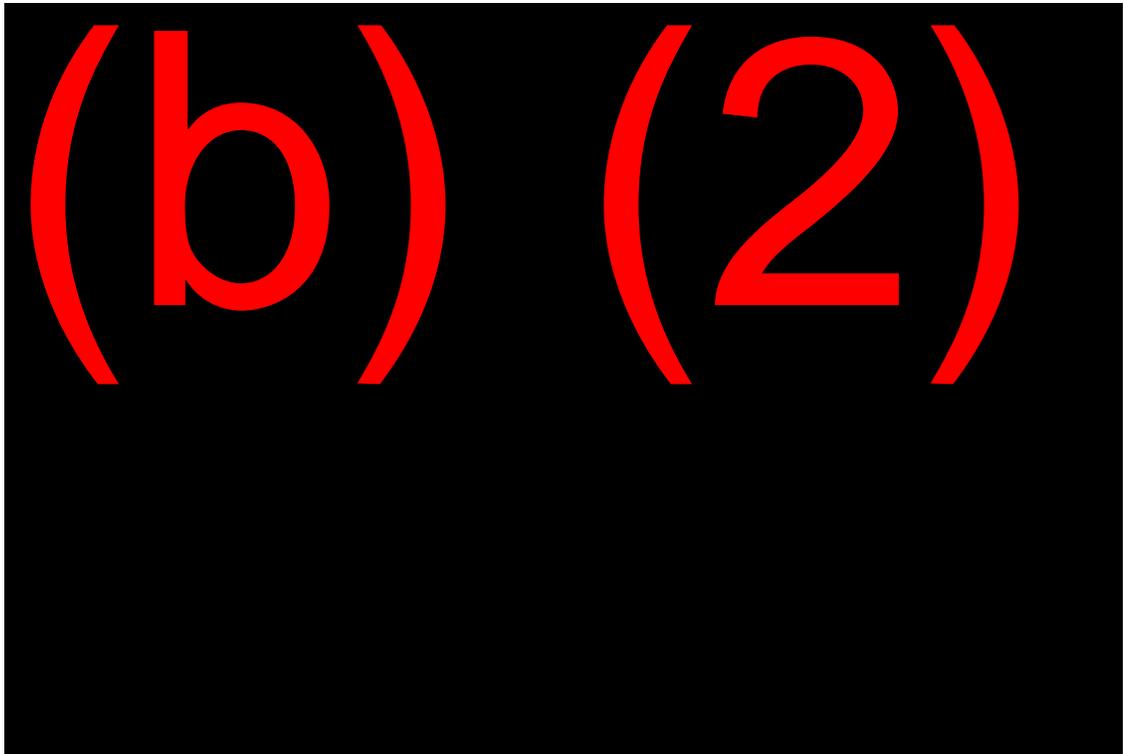
If the claimant filed through iAppeal, select the iAppeal button and the internet information will propagate to the appropriate fields. If you have received a Paper Appeal, select the Paper Appeal button. The next screen to appear is shown below:



On this screen, you select the radio button for the appropriate level of appeal (reconsideration or hearing), the type of claim (T2, concurrent, T16, DWB, or CDB), and whether or not a representative is involved.

For an iAppeal the date of the determination from the denial notice and the date the appeal request was received will be reflected in the boxes provided. If you are processing a paper appeal, you will show the dates in MM/DD/YYYY format.

The buttons at the top of the window provide access to the following queries (DDSQ, MBR, SSID, etc.) and applications like RASR, EDCS, eView, CPMS, or DPS.



The next screen will ask you to annotate which technician is processing the appeal and verify the DDS or OHO responsible for processing the appeal.

You will also click the radio buttons to tell the program if your PIN allows you to do appeals-related inputs. Select the radio buttons as appropriate and the program will keep you from going to actions you cannot do. The Appeals program does not actually prohibit access – that is done in PCOM – but completing this form accurately will lessen the frequency of getting the "Access Denied" messages in PCOM.

In some offices, the T2 part of an appeal goes to one CS and the T16 part goes to different CS. If this is the case in your office, select the appropriate radio button for “Can You Process T2 [or] T16 Appeals”. This will tell the program to stop when going into the T16 part of a concurrent appeal and give you the CS list again to change the CS and Unit to the appropriate CS for the T16 part of the appeal.

When the all sections are completed, click the “OK” button.

If you omit any fields or input a date incorrectly, the program will ask you to correct it. You will then need to click the “OK” button again. A box will appear stating “Wait Working on Completing Screens.”

NOTE: If claimant files the appeal more than 65 days from the determination date, the program produces a “Late Filing Box” and automatically sets up a DW01 issue. In the box provided, type in the reason for late filing. Click on OK, and the program will resume processing the appeal.

If an attorney or non-attorney representative is involved, the program will present any available information from RASR under the RASR tab. If there are no active appointments in RASR for the claimant or if you need to change the information shown, click the “Add / Update RASR” button. After completing your entries in RASR, you can return to the Appeals program and click the “Refresh – After RASR Updates” button. This adds the representative’s data and you can continue loading the appeal.

On some screens, the program will ask you to verify that the entries are correct. You are responsible for verifying that the entries are appropriate for your case and for making any changes as needed. In addition, the RCN1 or HNG1 screens ask you to check the appeals documents to see if there has been a change of address for the claimant. Pay close attention to the standard (default) information entered by the program, such as Additional Evidence (N) on the RCN1/HNG1 and Filed by Appellant (1) on the RCN2/HNG2 screen. If information needs to be changed, click YES and follow the program prompts to make the necessary changes.

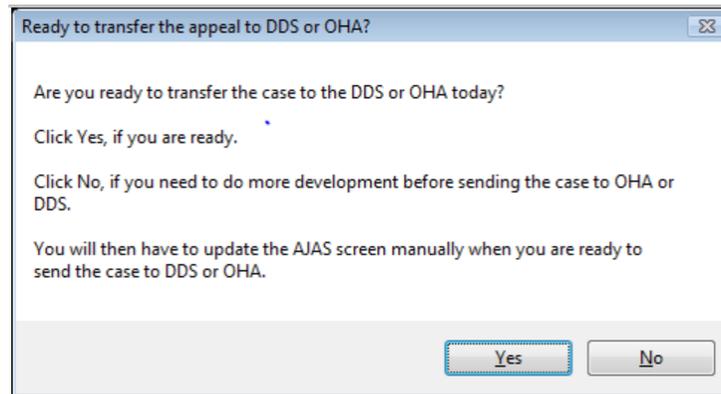


The Appeals Program also completes the DW01 and is usually correct. However, if MCS propagates extra issues to the DW01, it can throw the sequence of entries off. If this happens, or if you need to make special entries due to your office procedures or preferences, then click the “NO – I NEED TO MAKE CORRECTIONS” button and read the instructions that pop up. Click “OK” on that box and make the corrections to the DW01 and subsequent screens until the program resumes control of the input.

Print and store the request via the PRST screen to ensure proper storage of the appeal request to ORS.

CAUTION: If there is an auxiliary lead listed on the DADE screen or if an auxiliary claim was taken, the Appeals program will tell you there is an auxiliary claim in this path. This means there are extra screens in the path that must be completed manually. Pay close attention and read this alert box. You may see a second significant alert box labeled “OOPS.” Click “OK,” then click somewhere on the PCOM screen; F3 back to MCS systems menu. The program will start up again and go on to complete the DW01. If you click “Cancel” instead of “OK,” you will terminate the program and will then have to finish manually.

For Hearings cases, the program will complete the Case Movement screen to transfer control to OHO. Click “Yes” to input the transfer. If the case cannot be transferred, clicking “NO” will end the program and you will need to finish the rest of the process manually.



Once the entire process is complete, you will receive dialog boxes notifying you to input the 3441 into EDCS and to activate the representative flag in EDCS if an attorney/representative is involved. It is important to remember to input your 3441 in EDCS and transfer to the appropriate DDS/OHO once the Appeal Program is finished in MCS.

If you "lose" the Banana window while working on an appeal, minimize each open window on your desktop to find it. Do not use the Show Desktop button. Once you locate the Banana window, answer the question and the program will pick up where it left off. The program window will be back at the front of your screen for the next question.

EXHIBIT 1: MASTER BENEFICIARY RECORD (MBR/AACT)

FACT DTE:02/20/18 SSN:XXX-XX-XXXX BIC: DOC:735 UNIT:SSA PG: 001+
 STATUS MBR YES LOU-07/20 DATA FILES YES LOU-07/20 SSACCS NO LOU-07/21
 CPS NO
 ACCOUNT PCOC-6 SEX-M MS-DER TAC-D CDY-0 DRAMS READ INACTIVE ACCT
 PMT CYC CYI-2 PCEFD-07/21/2006 PCCOM-07/06 PCCR-I
 PRIMARY JETHRO L CLAMPETT DOB-XX/XX/19XX LSPA-\$0.00
 INSURED CLAIM TYPE-DISABILITY DATE OF FILING-07/15/2006 DIB QC EARNED-00
 FULL QC REQUIRE-25 FULL QC EARNED-33 CURR QC EARNED-00
 HLTHBEN QC EARN-00 CONVERTED
 CLAIM TYPE-DISABILITY DATE OF FILING-11/25/2014
 FIRST MET-07/2010 LAST MET-12/2019 WAIT PER START-12/2014
 NONX NO GMS USED-07/2010 EXC NO GMS USED-07/2010
 20/40 EXCLUSION-TEST MET 20/40 NON EXCL-TEST MET
 DIB QC REQUIRE-20 DIB QC EARNED-37 FULL INS EXCL-TEST MET
 FULL INS NONEXCL-TEST MET FULL QC REQUIRE-33 FULL QC EARNED-40
 CURR QC EARNED-00 HLTHBEN QC EARN-00
 PAYMENT PIC-A MPA-\$0.00 DOC-735 RD-07/02/15 LAP-X SERVICE IND-6
 TELE NO BTN-555-555-5555 BTC1-U CPND-07/2015
 PAYEE JETHRO L CLAMPETT
 PAYEE UPDATED-03/12/2015
 ADDRESS 1234 W ANY ST ANYWHERE KS 66222
 ADDR UPDATED-07/21/2002
 SCC-17450 ZDPC-604 SOURCE-X
 BENEFIT BIC-A JETHRO L CLAMPETT SB-M DOB-XX/XX/19XX B ABN-DXCL LAF-ND
 MBP-\$0.00 DRD-03/12/15 LANG-E
 HIST TOC TOC-5 START-CONV
 BEN DENY DATE OF FILING-07/15/2006 APP RECEIPT-00/00/0000 ID CODE-A
 CUR ENT CODE-DISABLED DIB ONSET-05/28/2006 DISALLOW/DEN RSN-0H1
LEVEL OF DENIAL-INITIAL CONVERTED
 DATE OF FILING-11/25/2014 APP RECEIPT-12/16/2014 ID CODE-A
 CUR ENT CODE-DISABLED DIB ONSET-11/20/2014 DISALLOW/DEN RSN-0H1
LEVEL OF DENIAL-RECON
 DIB DDO-05/28/06 **LOD-1** BDC-H1 DSD-07/06
 DDO-11/20/14 **LOD-2** BDC-H1 DSD-07/15
 CITIZEN START-XX/XX/19XX COUNTRY-UNITED STATES PROVEN

 +++ TRANS UPDATED THRU 02/24 +++
 TRANS RD-3/12/16 LAP-X MCS PIC-A
 RD-7/02/16 LAP-X MCS PIC-A

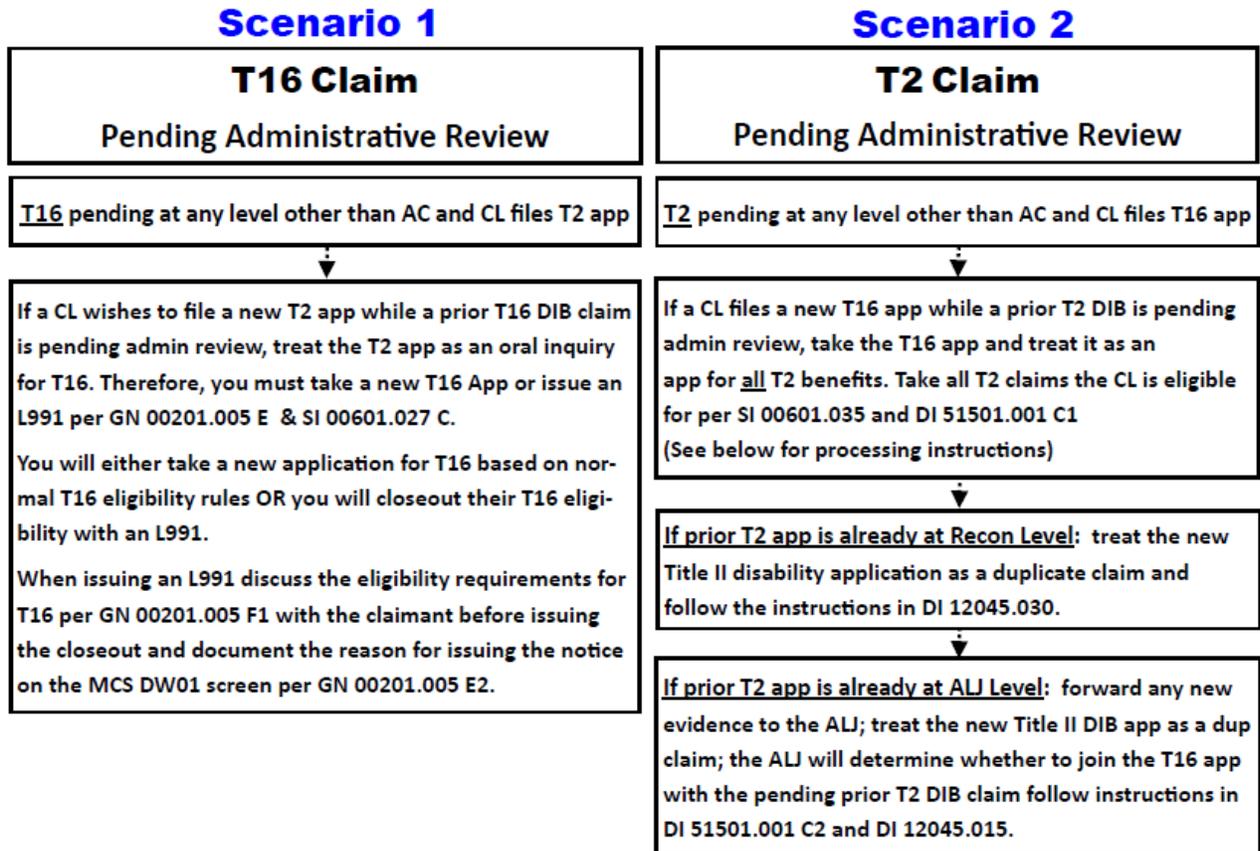
EXHIBIT 2: “BANANA” APPEALS PROGRAM

Sample Workflow – Disability Hearing

- Title II Request for a Hearing – Log on to PCOM Session A.
- Click the Banana Icon.
- Enter the correct information for this case.
- Select the Hearing radio button.
- Type of Claim = Select appropriate claim type.
- Date of determination = date of notice. (An iAppeal will propagate this information)
- Date of appeal = date appeal filed. (An iAppeal will propagate this information)
- If entry needed for date of determination or appeal, make sure you use MM/DD/YYYY format.
- Add/update attorney or representative info via RASR (if applicable). Select appropriate radio button.
- Click OK.
- The program will ask if all information is correct. Read the question carefully; the correct answer may be No.
- Remember to check the DW01 to ensure all issues are accurately posted.
- If everything is accurate, send the case to OHO by clicking Yes.
- Print and Store via the PRST. Give the claimant a copy of the request. Once the program stops running, you are done with MCS.
- Input your 3441 in EDCS and send to OHO the same day.

If you can input a hearing, you can input a reconsideration. The inputs required for a reconsideration are almost identical.

EXHIBIT 3: CLOSEOUT PROCEDURES FOR SUBSEQUENT CLAIMS



EXERCISE #1

Use OBJECTIVES 1 – 3 to complete the following questions. Assume these cases are not subject to Prototype procedures.

Determine what level of appeal (if any) should be filed and/or what actions are necessary in each of the following situations.

1. Mark Budson is in the office regarding the initial denial of his disability claim. He received the denial letter 2 weeks ago saying that his condition was not severe enough to prevent him from working. You have provided an explanation of the denial and the disability requirements and he wishes to file an appeal. He has not worked since he filed his initial claim (folder is CEF).
2. Alexander Larue visits the field office and presents the notice, which he received in today's mail, telling him that his initial claim for disability benefits has been denied. He wants to know why his claim was denied and what further action he can take. What would you tell him?
3. Mr. Larue states that he believes his claim was unjustly denied and wishes to appeal the decision. In addition to the action you have already taken, what additional action should you take to assist Mr. Larue?
4. Let's say now Mr. Larue did not inquire about an appeal until more than 60 days after he received the initial determination. What additional development should you undertake?
5. Mr. Larue receives a reconsideration notice affirming the initial determination in his case. He comes into the office and states he is still not satisfied and wishes to pursue his case further. What is the next course of action available to him? What is the time limit for requesting this action? What forms are completed?
6. Lucinda Megahan was denied RIB because she had not attained age 62. This was affirmed at the reconsideration level and she does not wish to pursue this case further. However, her son Rudy calls and says that although his mother is satisfied with the determination, he wishes to pursue an appeal of the case. Mr. Megahan is not eligible for benefits on his mother's record. What should you tell Mr. Megahan?

7. Joanne Jones filed for disability benefits on July 19th. She received a disability denial three months later. On November 19th, she filed a request for reconsideration. The reconsideration determination, which was sent the following January, affirmed the initial decision for the same reason. On February 21st, Ms. Jones returned to the FO to request a hearing. She says that her condition has worsened and she was hospitalized for 2 weeks and released yesterday. She submits hospital records that show her cancer has spread and she does not expect to recover. The folder is an CEF. What forms should you complete? Where do you send the file?

8. Susie Malone has just received a denial notice stating that since she has never worked under Social Security, she cannot receive retirement benefits. Ms. Malone states that she never worked at all, but she is 75 years old and she feels she should draw something because all her friends receive benefits. What action would you take?

9. Mrs. Malone insists on appealing this determination. Where would you route her request for reconsideration?

10. Jan Ross calls to ask about the status of her hearing request. What system do you use to determine the status?

11. Dixie Evan's claim was approved at the hearing level and no auxiliaries were alleged at the time of filing. What additional actions do you take?

EXERCISE #2**OBJECTIVE 4: Determine how to process an Appeals Council case.**

1. A claimant has received a hearing decision notice affirming the denial decision made at the hearing level. She contacts the FO within 30 days of receiving the notice and states that she wishes to appeal the decision of the Administrative Law Judge (ALJ). What action should you take?
2. You receive a letter from a claimant who states that she disagrees with the decision of the ALJ and she wants to appeal the decision. What development must be undertaken? What is the effective date of her request?
3. You have assisted a claimant in completing an HA-520, "Request for Review of Hearing Decision/Order." He says he has additional evidence to support his disability claim, but he did not bring it with him. How long should you hold the request in the FO awaiting the additional evidence?
4. The claimant has exhausted all avenues in the administrative appeals process and is still dissatisfied. He asks where he may take his case for further consideration. What would you tell this claimant?

EXERCISE #3**OBJECTIVE 5: Determine how to process special appeal procedures.**

1. A claimant says that he disagrees with the initial determination made on his disability claim and that he intends to take his case to court. What would you tell this claimant regarding his intention to take this matter to court?
2. Mary Morelock has a Title XVI disability reconsideration pending at the DDS. Her claim was initially denied because her impairment was determined to be slight. She phones the DO and states that she is certain that she has enough work to draw Social Security disability on her own work record and she has not filed an application. You take her application and you find that she is insured for disability. What will you do?

EXERCISE #4

OBJECTIVE 6: Determine who represents the claimant and the forms needed to process the appeal when there is representation.

1. Mr. O'Neill comes into the DO with his brother to request a reconsideration on his claim for disability benefits. During your questioning, Mr. O'Neill consults with his brother about names, dates and places before answering. Should you bring up the question of a representative?
2. Mr. O'Neill comes back into the DO to request a hearing. His brother again accompanies him. During the questioning, Mr. O'Neill's brother answers the questions and Mr. O'Neill does not object. What would you do?
3. Nancy Davis received a denial letter on her request for reconsideration. She visits the office and after consulting with a CS, wants to appeal this decision. Ms. Davis states she now has to wear a full back brace. She is scheduled for a back operation and she is unsure of whether she will appear at a hearing. The applicant wants her attorney, Grant Seagraves, to represent her in this case. She will have Mr. Seagraves submit up-to-date medical records after the surgery. The claims file is CEF. Please indicate what level of appeal, forms, actions, and routing are necessary.

EXERCISE #5**OBJECTIVE 7: Process appeals using the appeal program.**

This is a hands-on exercise. Consult with your mentor and load iAppeals using the “Banana” Appeals Program. If possible, also load paper appeals using the Banana Program.

EXERCISE ANSWERS

Exercise #1

1. A reconsideration is the level of appeal for Mr. Budson. You can load the reconsideration onto the MCS system via the Appeals program. The updated medical information is obtained by completing a 3441 in EDCS. Also, obtain an SSA-827s and transfer the case to DDS. Provide Mr. Budson with a list of legal referral and service organizations.
2. Explain the issues involved, inform him of his right to reconsideration appeal, and explain the nature of the appeals process.
3. Assist the claimant in filing a reconsideration request using the Banana Appeal Program; accept any evidence offered; obtain necessary forms, including an SSA-827; forward the request and development to the DDS. Provide Mr. Larue with a list of legal referral and service organizations.
4. On the RCN2 screen in the Explanation field, enter his reason for the delay in requesting review. Ask him for any appropriate documentation to support his explanation. Since he is in the office, you will need to obtain his good cause statement. You will also need to make the determination on the Good Cause, because the FO is responsible for making Good Cause determinations on Medical Reconsiderations. Follow the steps in [GN 03101.020 D](#).
5. The next level of appeal is a hearing. Mr. Larue can file the appeal within 60 days of the receipt of the reconsideration determination. You will need to load the appeal request using the Appeal Program into the MCS system. The required medical forms are 3441 and an SSA-827 using the EDCS system.
6. Explain that only the claimant, his or her appointed representative, representative payee, or third party has the right to request a hearing. Rudy is not a proper applicant. [GN 03103.010 B](#) ; [GN 00204.003](#)
7. Complete the MCS screens for a hearing request using the Appeals Program. Using the EDCS system complete a 3441 and 827 on EDCS. Send the folder to DDS under informal remand procedures. [DI 12010.015](#)
8. Give Ms. Malone a thorough explanation of the reason for the denial and explain her right to appeal. Make sure Ms. Malone has been screened and formally closed out for SSI benefits.

9. To the servicing PSC
10. Use the Case Processing Management System (CPMS) to determine the status of her hearing and provide information to Ms. Ross.
11. Receipt in the OHO issue. PSC is responsible for processing the claim and establishing a record for Mrs. Evan.

Exercise #2

1. Encourage the claimant to file the appeal online (i520) or complete the HA-520 paper form along with any other necessary documentation. Load an Appeals Council request in EDCS and fax a copy of the HA-520 into the electronic folder. The request will automatically forward to the Appeals Council along with any supporting documents.
2. Complete an HA-520. Enter any statement from the letter, other than a simple request for review, in the remarks section of the HA-520. Fax the letter and the original HA-520 into the electronic folder. Establish the Appeals Council request in EDCS so it can transfer to the Appeals Council. Enter the postmark date of the letter as the date of the request. Fax the written AC review request into eView. [GN 03104.100 B](#)
3. Do not hold the request in the FO. Establish the Appeals Council request in EDCS immediately. When the additional evidence is received, fax it into the electronic folder.
4. That he may file a civil action in the U.S. Federal District Court of the judicial district in which he resides or has his principal place of business. The time limit is 60 days from the date of receipt of the Appeals Council decision. [GN 03106.001](#)

Exercise #3

1. Court action may be filed only after he has exhausted all his administrative appeals (reconsideration, hearing and Appeals Council, in that order) unless the conditions for expedited appeals process are met. [GN 03106.005](#)
2. Escalate the T2 claim to the recon level and forward to DDS for simultaneous processing at the Recon level with the Title XVI reconsideration. [DI 12045.021](#)

Exercise #4

1. No. His brother is helping him supply information, but is not acting as a representative.
2. There is a possibility that Mr. O'Neill's brother is acting as his representative. Ask Mr. O'Neill if he wishes to have his brother represent him and if this brother will assume the responsibility. If yes, explain the responsibilities and authority of a representative and have them complete the SSA-1696.
3. A Hearing request should be completed in MCS using the Banana Appeal program. Make sure to give a copy to Ms. Davis. Enter the 3441 and 827 into EDCS. Obtain the SSA-1696 form Mr. Grant Seagraves. You will also need the SSA-1695, SSA-1699, and/or SSA-1694 (if NOT already registered in RASR) if the attorney intends to request direct payment of his fee from SSA. Update the NOT2 to include attorney rep information once it is submitted.

Once the SSA-1695 information links in the RASR, follow policy to mask and return the form to the appointed representative. Send the SSA-1695 Acknowledgement Letter and SSA-1697 via DPS. See (b) (2)(b) (2)(b) (2)(b) (2) for more information.

Update the DW01 to show all relevant issues and the tickle date for the hearing decision. The Banana Appeal program will complete the MCS case movement. Transfer EDCS to the appropriate OHO office.

Exercise #5

1. Have all cases loaded using the Dallas Banana Appeals Program reviewed before transferring and then transfer to appropriate component.

AS WE REDESIGN ENTRY-LEVEL TRAINING, WE ARE ELIMINATING THE NEED FOR PAPER COURSE MATERIALS. THE MATERIAL PREVIOUSLY TAUGHT FOR THIS MODULE HAS BEEN CONVERTED TO ONLINE CONTENT. ALL NECESSARY INFORMATION IS EMBEDDED WITHIN THE ONLINE OBJECTIVES. THEREFORE, THERE ARE NO CORRESPONDING PAPER MATERIALS. PLEASE VISIT THE [\(b\) \(2\)\(b\) \(2\)\(b\) \(2\)\(b\) \(2\)\(b\) \(2\)\(b\) \(2\)\(b\) \(2\)](#) TO FIND MORE INFORMATION CONCERNING THIS TOPIC.

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LESSON PLAN

Objectives

At the completion of this lesson, the students will be able to:

1. Apply the concept of due process and determine the proper action upon receipt of a report.
2. Determine the servicing office, request assistance using the proper format, and respond to PC memos via MDW and PCACS.
3. Identify acceptable requests for direct deposit and Direct Express. Determine when a PE action will affect payment and how to make Title II PE direct inputs
4. List, obtain, and read the PHUS queries. Obtain a Payment History through QRSL. Properly Use TCIS. Identify and Process Court Order Garnishments (COGs).
5. Identify types of checks issued. Describe procedures for endorsement and negotiation. Identify and process critical case situations.
6. Determine if proper use, improper use, or misuse of benefits is involved.

Length of Lesson

8 hours

BACKGROUND AND RATIONALE

Purpose

This chapter discusses the proper methods of processing post-entitlement (PE) reports, with an emphasis on the procedures for protecting the individual's rights, evaluating reports, and using SSA's automated systems.

Promptness and Accuracy of Payment

The goal of the Social Security Administration may be summarized in two words — promptness and accuracy.

Millions of people receive Social Security benefits. Many of them depend on timely and correct payment of benefits to maintain their standard of living. As part of its service to the public, the Administration has the responsibility for paying benefits promptly and accurately. Exercise this responsibility in post-entitlement (PE) situations as well as initial claims.

In previous chapters, you learned about events that cause termination, suspension, or reduction of benefits. Being prompt and accurate in the payment of benefits also implies being prompt and accurate in stopping benefits which are not due.

Post-entitlement

In processing PE changes to a record, SSA relies heavily on voluntary reporting by the beneficiaries and their representative payees or agents. Take special care to ensure beneficiaries and those acting on their behalf have a thorough understanding of their reporting responsibilities, the consequences of those reports, and their right to appeal a determination or submit evidence.

SSA's Goal

With an understanding of these procedures, employees can meet SSA's goal of "the right check, to the right person, at the right time."

OBJECTIVE 1:

**Apply the concept of due process
and determine the proper action
upon receipt of a report and identify
non-payment events including
prisoner and alien suspension**

Due Process

[GN 03001ff](#)

Property Rights

Due process derives from the Fifth Amendment to the U.S. Constitution, which provides no person shall be deprived of property interest without due process of law. Decisions in several court cases have established the continued receipt of Social Security benefits is a statutorily created "property" interest for the purpose of applying the Fifth Amendment. **[DI 28080.001](#)**

Due Process

For Social Security purposes, due process means each beneficiary receive informal advance notice and a subsequent formal written notice explaining any adverse action taken against their Social Security benefit. An adverse action is a benefit reduction, suspension, or termination of entitlement. Due process is important because it protects the beneficiary's right to file an appeal and submit evidence, which may show SSA's reason for taking action is incorrect.

Types of Reports

[GN 03001.005](#)

Types of Reports

There are three types of reports SSA receives which may result in an adverse action against an individual's benefit. [GN 03001.005 B](#)

- First Party report;
- Third Party report;
- SSA discovered event.

Identity of Reporter

Before taking an adverse action on an unsolicited report, we identify the person making it. The reporter's identity determines whether SSA treats the report as a first party or third party report. The type of report SSA receives determines what type of action and due process is appropriate. [GN 03001.012](#)

Alleges to be Beneficiary

Identify the reporter by obtaining their name, mailing address (or RTN and DAN), and SSN or claim number. [GN 03001.012 B.1](#)

Alleges to be Other than Beneficiary

If the reporter alleges being someone other than the beneficiary, identify him/her by obtaining:

- The name, mailing address (or RTN and DAN), and SSN or claim number of the beneficiary;
- The name, address and phone number of the person making the report;

- The relationship of the reporter to the beneficiary; and
- A reasonable explanation of why they are reporting on the beneficiary's behalf. [GN 03001.012 B.2](#)

NOTE: Reasonable explanations include, but are not limited to, the beneficiary's inability to hear, speak English, or access a telephone. An example of what is generally not considered a reasonable explanation is an individual who is not the representative payee or authorized representative reporting for a capable beneficiary "because he or she always handles the individual's affairs." If you are uncertain whether the explanation is reasonable, treat the report as a third party report and follow instructions in [GN 03001.025](#).

First Party Reports

[GN 03001.020](#)

First Party Report

A first party report is an event reported by:

- The beneficiary;
- The representative payee;
- The beneficiary's agent (lawyer or accountant, i.e., appointed representative);
- A competent adult entitled on the same SSN who is acting at the request of the beneficiary; or
- A relative, friend, or neighbor, who is acting at the request of the beneficiary. [GN 03001.012 C.1](#)

Complete Reports

For a report to be complete, it must include the claim number benefits are paid under, the name of the beneficiary, and sufficient information to make

a determination (see [GN 03001.005 B.5](#) and [GN 04001.060](#) for diligent pursuit).

Processing First Party Reports

Upon receipt of a first party report, take immediate action to suspend, adjust, or terminate benefits if there is no indication the report is inaccurate, and SSA takes action no later than 6 months after the month of the report.

Unless there is evidence to the contrary, SSA assumes the reporter understands the impact of his reports and is in effect, asking SSA to take appropriate action. [GN 03001.020](#)

Direct Deposit Exception

Reports to begin, change, or cancel direct deposit can only be accepted from the beneficiary or representative payee. [GN 02402.025 B.1](#)

Reports by a Child

A first party report made by a child under age 15 does not require verification if the child is their own payee and the report does not affect the benefits of other beneficiaries entitled on the record. If one of these two conditions is missing, verify the report before taking action. [GN 03001.020 B.2](#)

Due Process for First Party Reports

SSA sends formal notice to the beneficiary or representative payee after taking adverse action, explaining the action and advising the beneficiary of their right to appeal.

Third Party Reports

[GN 03001.025](#)

Third Party Report

Third party reporters are people outside of SSA who are not acceptable first party reporters. Third party reports include reports that do not contain sufficient evidence to be first party reports nor allow SSA to take action.

[GN 03001.005 B.3](#)

Processing a Third Party Report

You must send informal advance written notice to the beneficiary and the representative payee, if there is one, before taking an adverse action. Benefits cannot be reduced, suspended, or terminated until the beneficiary receives the opportunity to confirm, or deny, the accuracy of a report that may result in an adverse action. The advance written notice is required for all third party reports except those involving:

- The death of the beneficiary;
- An undeliverable check;
- The death of a representative payee;
- Representative payee refuses to serve;
- Beneficiary is legally incompetent and representative payee is unavailable;
- Evidence of misuse of funds by representative payee and substitute payee is unavailable.

Advance Notice Content

The notice must state the pending adverse action, the reason for the action, the evidence used to make the determination, the effect on benefits, and the number of days the beneficiary has to respond before SSA takes action. Per [GN 03001.015](#), the notice states that in 10 days

(plus 5 days for mailing) SSA will take the adverse action unless evidence is presented in rebuttal. The advance notice does not provide appeal rights. [GN 03001.005 B.6](#)

Notice Requirement after Adverse Action

We must also send a final formal notice for all third party events resulting in an adverse action after we take the action. The notice must state the action taken, the basis for the action, provide appeal rights, and state the waiver provision if the report results in an overpayment.

SSA Discovered Events

[GN 03001.005 B.4](#)

SSA Discovered Event Definition

An event discovered by SSA could be one of the following:

- Erroneous multiple payments;
- An incorrect original computation;
- An earnings record adjustment which results in a benefit reduction;
- A new claimant's entitlement which causes a decrease in benefits to others already entitled;
- An SSA clerical error requiring a decrease in benefits;
- A claims folder review which discloses a questionable entitlement factor; or
- A case review, system run, diary action, etc., requiring adverse action.

Due Process for SSA Discovered Events

Due process actions for SSA discovered events involving an automated or non-automated match are the same as for third party reports except for the length of the waiting period (30 days plus 5 days for mailing) before SSA will take the adverse action.

Nonpayment Events

[GN 02600.000ff](#); [RS 00201.002](#)

There are certain events that result in the nonpayment of RIB and other Title II benefits.

Events that cause nonpayment of Title II benefits are:

- Claimant fails to provide proof of being a U.S. citizen, a U.S. national, or an alien lawfully present in the U.S. Once citizenship or lawful presence is proven, accrued benefits will be issued.
- Prisoner suspension provision ([GN 02607.500 A.1](#) and [GN 02607.160](#))
- Fugitive Felon suspension provisions ([GN 02613.050](#); [GN 02613.100](#); [GN 02613.150 A](#))
- Deportation ([RS 02635.000ff](#))
- Beneficiary resides in a country to which the mailing of U.S. government checks is prohibited. Once a beneficiary visits a field office in person and presents evidence of identity and eligibility, benefits withheld will be issued. ([RS 02650.000ff](#))
- Non-U.S. citizen resides outside the U.S. for at least 6 full consecutive calendar months (various exemptions apply depending on the country involved). ([RS 02610.000ff](#))
- Member of a religious order granted a tax exemption (generally, only members of Amish or Mennonite congregations qualify under this provision). ([RS 01802.270](#))

- Individual deprived of certain benefit rights by court sentence after conviction for an offense involving espionage, sabotage, treason, sedition or subversive activities. ([GN 02602.010](#))

Prisoner Suspension Provision

[GN 02607.000ff](#)

When Benefits are Suspended

Beginning April 1, 2000, Title II benefits are suspended if a beneficiary was convicted of a criminal offense and confined to a penal institution for more than 30 continuous days. Benefits that are withheld under this provision are not paid to the prisoner after his/her release. If the NH is the confined individual, benefits to other family members on the record will continue. ([GN 02607.160](#))

Example:

Judy was confined June 19th. She was held until her trial on December 22nd and was convicted on that date. The judge sentenced her to time served. There is no period for which Judy is both convicted and confined, so her benefits will not be suspended for any month.

Example:

Cindy was sentenced on January 3rd and confined until February 1st (30 days). She would not be suspended, as there must be more than 30 days of continuous confinement.

Example:

Don has been held on a murder charge since February 3rd. He is convicted on November 15th and sentenced to 25 years in prison. The action to suspend benefits will be taken 30 days after November 15th

(count the day of conviction as the first day of the period and add 30 consecutive days to this day to equal 31 or more days ([GN 02607.160 A.1.b](#)). On the 31st day, December 15th, we will suspend benefits back to the first month the beneficiary is both convicted and confined, November.

What Benefits are Suspended

Title II benefits must be suspended for the entire month if during any part of the month the person is **both** convicted and confined.

Example:

Don was convicted and confined in April. May 15th we determined that his benefits should be suspended. We will suspend his benefits for April since it is the first month in which he is both convicted and confined. This will be done retroactively due to the 30-day time frame.

FO Role in Initial Claims

If you have an initial Title II claim and the claimant has a conviction or a period of prisoner confinement that would affect the payment of benefits, you must develop the prisoner suspension months before you adjudicate the claim.

Create a new PUPS record before processing the claim if:

- There is no skeleton record on PUPS;
- The claim includes a report of conviction or prison confinement for the claimant; and
- The confinement period includes a period of entitlement when benefits should be suspended.

For information on creating a new PUPS record see [MS 05103.002](#).
When a PUPS record is already established see [MS 00705.027](#).

Take the following action to suspend benefits when you process the initial claim:

1. On the MCS Main Menu select #8 - Suspension Events;
2. On the Suspension Events (SUSP) screen select #15 – Prisoner;

3. Enter the decision on DECI and process the claim through EC.

FO Role in Post Entitlement Situations

When benefits are to be suspended in post entitlement situations, input the suspension through PUPS (Prisoner Update Processing System). You will also develop requests for reinstatement of benefits and input the reinstatement through POS (Post entitlement Online System) via the PRSN screen.

Determining Fugitive Status

[GN 02613.001](#); [GN 02613.010](#); [GN 02613.050](#)

Current Policy

Effective April 1, 2009, SSA's policy is to suspend Title II and Title VIII benefits or Title XVI benefits and prohibit an individual from serving as representative payee any month during which he/she has an outstanding warrant for one of the following offenses:

- Escape (Offense Code 4901),
- Flight to avoid prosecution, confinement, etc. (Offense Code 4902), and
- Flight-Escape (Offense Code 4999)

NOTE: A list of all offense codes can be found in [GN 02613.900](#).

In September 2009, a United States District Court in California approved a nationwide class action settlement agreement (Martinez v. Astrue) that reduced the number and type of felony arrest warrants Social Security will use to prohibit payment of Social Security and Supplemental Security Income (SSI) benefits. For additional Martinez settlement information go to Fugitive Felon – Martinez settlement under “Hot Topics” on PolicyNet.

In May 2011, the District Court for the Southern District of New York certified a nationwide class action suit (Clark v. Astrue), stating SSA will no longer suspend benefits or payments based solely on a probation or

parole violation warrant. This includes all individuals whose benefits or payments were suspended or denied on or after October 24, 2006.

This suit includes both Title II and Title XVI benefits.

Initial Claims

Effective September 27, 2008, we do not ask Title II applicants or claimants about their felony status on any Title II benefit applications.

Processing Instructions

Apply the following instructions to individuals in all states. The Martinez settlement should be used instead of referencing the Fowlkes Acquiescence Ruling (AR 06-1(2)):

1. Initiate action for suspension, non-payment, or claims denial based on an outstanding felony warrant with a felony offense code of 4901, 4902, or 4999 shown on the Fugitive Felon System Control File.
2. If an appeal is pending at the reconsideration, hearing, or Appeals Council Level, apply the new policy when making the appeal decision.
3. If a representative payee applicant or an existing representative payee has an outstanding felony warrant for offense code 4901, 4902, or 4999 the individual will be prohibited from serving as a representative payee. If any felony warrant information comes to the attention of the decision-maker, it will be used to determine an applicant's suitability (or continued suitability) to serve as the representative payee.

Suspension

[GN 02613.010](#)

If an unsatisfied warrant with one of the offense codes listed above is located, then suspension will apply. Suspend benefits beginning with the month the unsatisfied warrant was issued or the date of entitlement to Title II benefits, whichever date is later. The unsatisfied warrant must be in

effect for more than 30 continuous days while the beneficiary is entitled to Title II benefits before suspending benefits effective with the warrant issuance date.

Example:

Carl became entitled to benefits 01/01/2019. He has an unsatisfied warrant (with one of the above offense codes) effective 11/10/18. Count 30 continuous days from the later date, 01/01/2019. Add 30 days to 01/01/2019 and benefits will be suspended 02/01/2019, retroactive to 01/2019.

Alien suspension

[RS 02610.000ff](#)

Benefit Payments to Legal Aliens

[RS 00204.010](#)

An alien who receives SSA benefits and is outside the U.S. for 6 consecutive full calendar months will generally not be paid benefits beginning with the 7th month of absence. The period of absence begins with the month following the month the alien leaves the U.S. The benefits may not be resumed until the alien has been back in the U.S. for one full calendar month.

There are certain exceptions that allow payments to be made and these are listed in [RS 02610.010](#). Also, review SSA Publication No. 05-10137, "Your Payments While You Are Outside the United States," which is available at www.socialsecurity.gov.

Taxation of Benefits for Nonresident Aliens

[GN 05010.000ff](#)

Nonresident Aliens

The 1983 Amendments provide for the withholding of a tax from monthly Title II benefits paid to nonresident aliens after November 1983. Effective 12/31/94, 85 percent of the benefit amount is taxed at a rate of 30 percent (or lower treaty rate). This means 25.5 percent of a nonresident alien's monthly SSA benefit is withheld. [GN 05010.001 A](#)

The withholding rate is based on the actual amount of benefits payable before deductions, withholding, or offset. It applies to Title II benefits paid to nonresident aliens both inside and outside the U.S.

Determining Tax Status

No special effort will be made to identify nonresident aliens already in the U.S. If during normal development, it is discovered a claimant or beneficiary is a nonresident alien, action should be taken to determine their status under the withholding provisions. Obtain a SSA-21 in this situation. It should provide sufficient information for the PC to make a determination on the tax status. Instructions for completing the SSA-21 can be found in [GN 00205.180](#).

When Status is Determined

The beneficiary's status at the time of receiving the monthly benefit and not the status during the month the payment is due determines whether to withhold taxes. [GN 05010.100](#)

See [GN 05010.020 B](#) for developing tax status determinations.

Exceptions: Withholding Tax

Withholding tax applies to nonresident aliens inside and outside the U.S. It does not apply to:

- Nonresident aliens who are citizens of Guam, the Northern Mariana Islands, or American Samoa. This is also true for citizens of Puerto Rico. Most of these individuals are U.S. citizens. For exceptions, see [GN 00303.120](#);

- Nonresident aliens who are residents of countries with which the U.S. has a tax treaty;

Tax treaty countries include: [GN 05010.010 A.2](#)

- Canada
- Egypt
- Germany
- India
- Ireland
- Israel
- Italy
- Japan
- Romania
- Residents of Switzerland are taxed at a lower rate [GN 05010.167](#)
- The U.K. (England, Scotland, Wales, and Northern Ireland)

Incorrect Withholding of Taxes

The nonresident alien withholding tax is refundable if SSA incorrectly imposed the tax. Some refunds must be made through IRS. [GN 05010.130 - .136.](#)

When Taxation Stops

After establishing alien tax withholding on a beneficiary's record, taxation continues until:

- The beneficiary becomes a resident alien, or
- The beneficiary meets one of the withholding tax exceptions mentioned above, or

- The beneficiary becomes a U.S. citizen.

Effect of Taxation on Entitlement

[GN 05001.020](#)

The possibility taxation of benefits could affect the month of election, reinstatement of benefits after suspensions, and/or withholding of benefits to recover overpayments, should not be raised with the claimant. If the claimant raises a question, provide a general explanation of the provision. However, the claimant must make any taxation decisions.

OBJECTIVE 2:

**Determine the servicing office,
request assistance using the proper
format, and respond to PC memos
via MDW and PCACS**

Determining the Correct Servicing Office

Each field office (FO) has a specific geographic area designated as its service area. Therefore, any address in the United States has a “servicing office.”

When you request assistance from another FO or servicing PC, make contacts through appropriate channels and directly to the proper office to avoid unnecessary delays.

DOORS

The Detailed Office Organization Resource System (DOORS) is the system we use to identify the servicing FO in the general service area needed to request assistance.

When determining the correct servicing FO for a specific address, you can obtain office hours, phone and fax numbers, time zones, and e-mail addresses.

DOORS Intranet Application

There are three ways to access the DOORS intranet application: find the link for DOORS Online on I-MAIN; navigate to the DOORS Home Page **(b) (2)**; or access the DOORS Online application via EMIS. You will not need to enter a username and password. The DOORS application authenticates users by using their active Personal Identification Number (PIN) within the Top Secret authentication system.

Modes of Requesting Assistance

[GN 01070.228](#)

An office can request assistance from another component five different ways. In order of preference, these include:

- District Office Telephone Procedure (DOTEL);
- Processing Center Action Control System (PCACS);
- Modernized Development Worksheet (MDW);
- Electronic 562 (e562); and
- Manager-to-Manager (M2M) web application.

High priority requests are those involving award and disallowance situations, start/stop payment actions, appeal situations, congressional inquiries, or public relations problems.

In general, use only DOTEL or PCACS for high priority requests; however, telephone contact usually provides the most expeditious service. "Routine" requests are limited to MDW or PCACS. Regardless of how you make a request, **always** provide priority handling to high priority requests you receive. [GN 01070.420](#)

District Office Telephone (DOTEL) Procedure

DOTEL provides inter-component telephone contact in initial entitlement and certain post-entitlement situations. DOTEL is essentially using the telephone to request **priority handling** by the responding office. DOTEL usage is restricted, so follow the guidelines in [GN 01070.200](#) and [GN 01070.210](#).

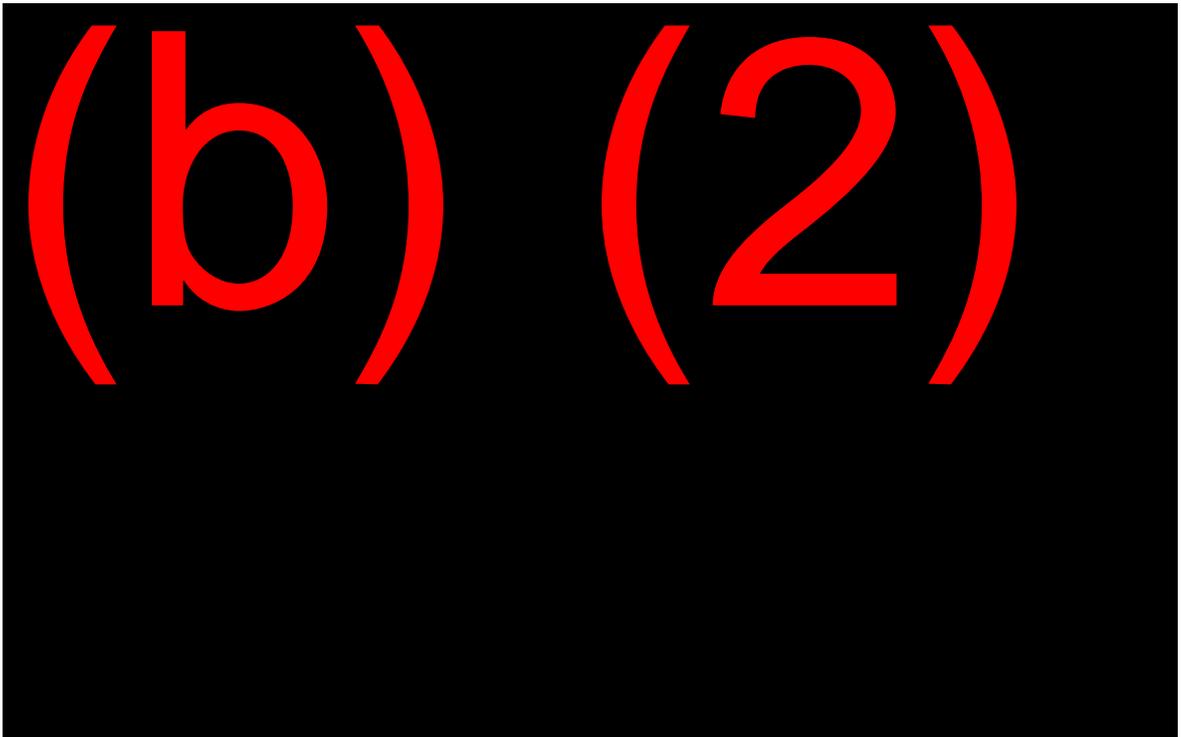
Processing Center Action Control System (PCACS)

MS 04901.001

The Processing Center Action Control System (PCACS) is an automated system that performs a variety of functions including controlling and tracking actions, folders and diaries. The majority of actions through PCACS are restricted to use by Processing/Program Service Centers (PSC) and include requesting assistance from other components. However, FOs can query the system to obtain information about what actions are pending on a particular case, which PC component is working a case, and the location of a folder. If the FO needs a folder for local use, the FO can locate then request it through PCACS.

Requesting a Folder

To request a folder from the PC, enter #26 PC Action Control System on the SSA MENU (MAIN).



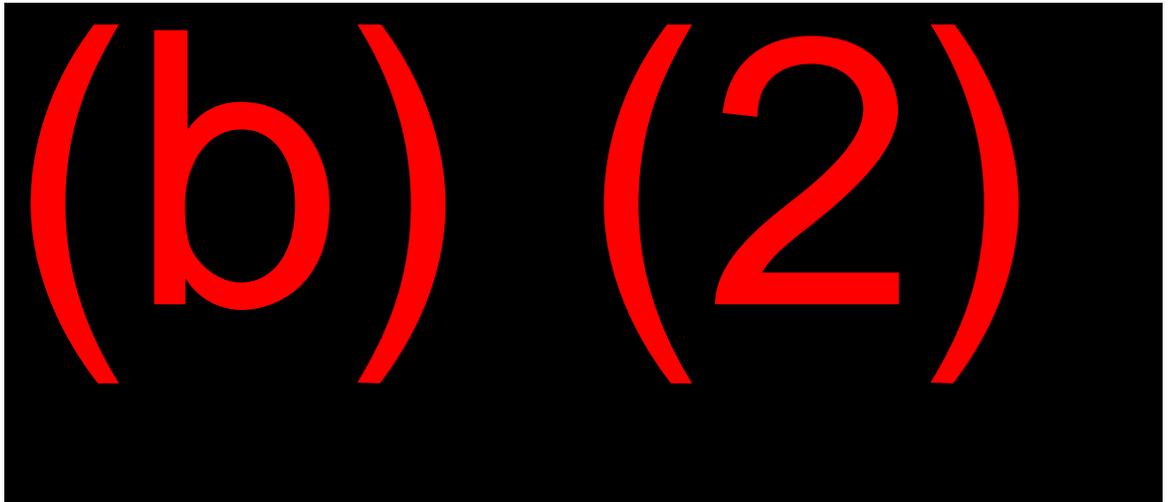
The next screen is the PCACS MAIN MENU (PMEN). Enter your unit and the SSN of the folder you are requesting and select #16 Diaries/Requests.

A black rectangular box containing the text "(b) (2)" in large, bold, red font. This indicates that the content of this section has been redacted for privacy or security reasons.

On the DIARY REQUEST MENU (DRMN) screen, enter #1 (Establish) and #3 (Folder Request).

A black rectangular box containing the text "(b) (2)" in large, bold, red font. This indicates that the content of this section has been redacted for privacy or security reasons.

The FOLDER REQUEST (DIFR) screen appears next. In the Justification Field, write a brief explanation as to why the FO needs the folder, and then type an X next to the entry for the specific folder you need.



Requests for Assistance [MS 04909.001](#)

Occasionally the PC sends requests for assistance to servicing field offices for action or development via PCACS. After you take action on the request, you will use PCACS to reply to the PC.

When you have a PCACS Request for Assistance assigned to you, enter #26, PC Action Control System, on the SSA MENU (MAIN) screen. On the PCACS MAIN MENU (PMEN), enter your UNIT, the SSN controlling the request, and #16 Diary/Requests. After pressing enter, the DIARY REQUEST MENU (DRMN) screen appears. To review the request for assistance, SELECT #3 Query and #4 Field Office Development Request under TYPE OF REQUEST. The PCACS Development Worksheet (PDW1), the first of several worksheets, looks similar to the DW01 in an MCS claim. The purpose of the PDW1 is to:

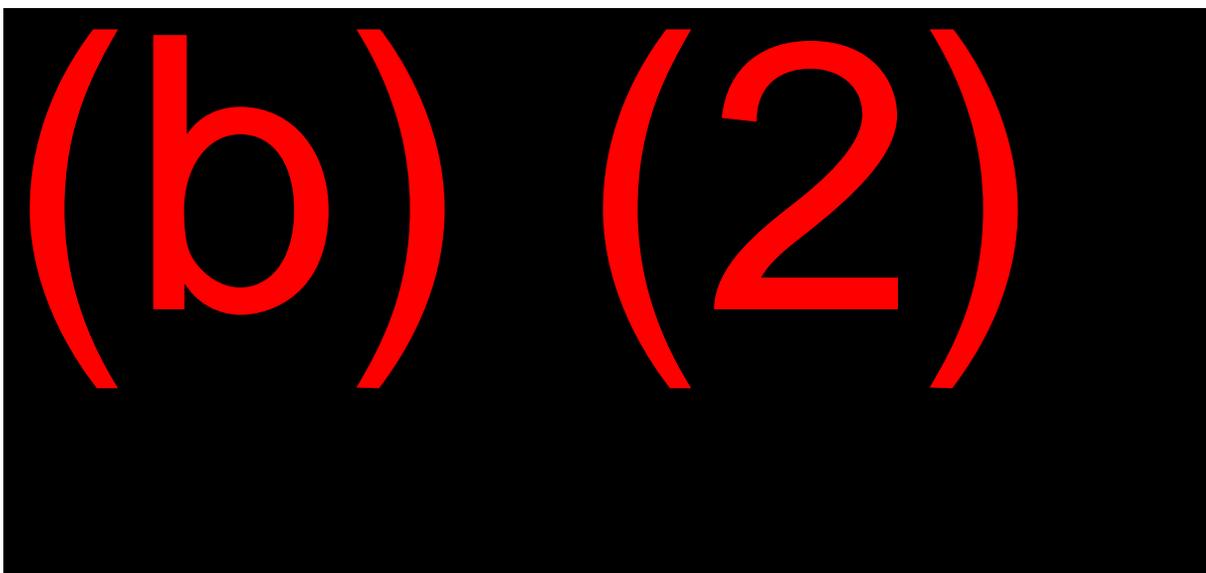
- Show identifying information about the request for assistance;
- Record information about receipt of the request;
- List issues involved;
- Transfer, respond, and clear the request; and
- Post tickle and diary dates.

To view the request, SELECT #1 Request for Assistance and press ENTER. The Request for Assistance (RQF1 and RQF2) screens display the identifying information and text explaining the specific request.

Pressing ENTER returns you to the PDW1 where you can enter issues documenting the actions you take.

Clearing the PCACS Request

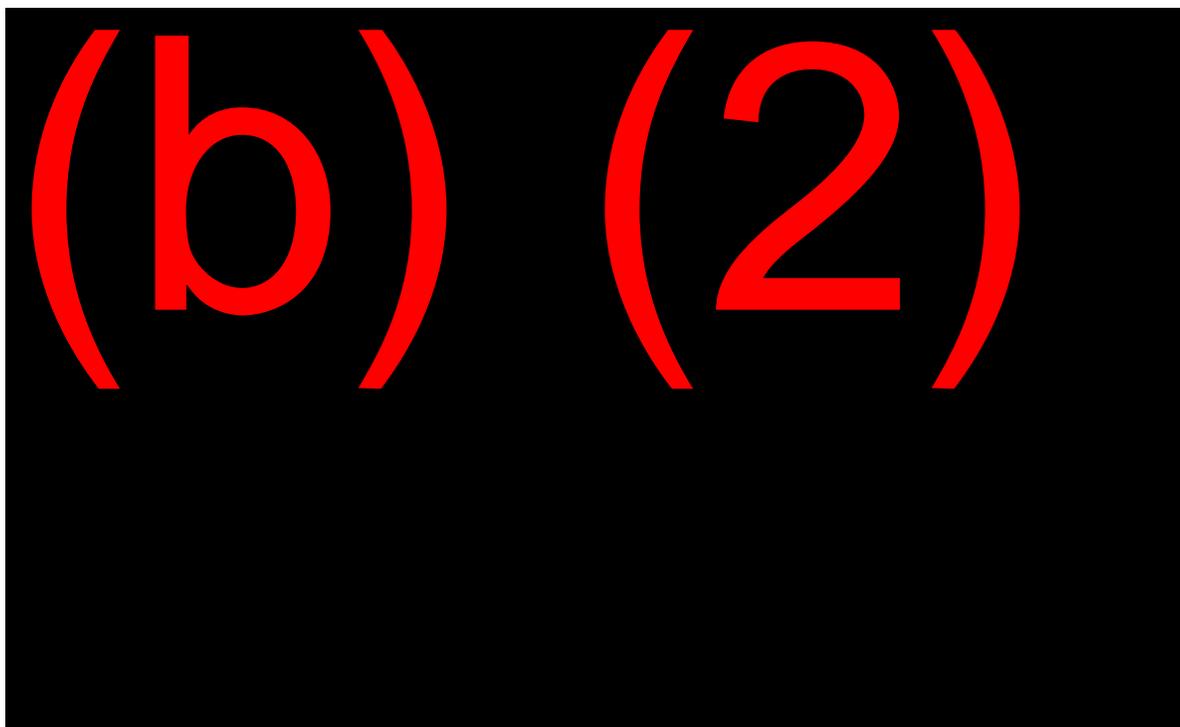
When all actions are complete and you have posted all information and development on the appropriate screens, you are ready to clear the request back to the PC. On the PDW1 screen, SELECT #2 Response to Requestor and press ENTER to go to the RESPONSE TO/TRANSFER OF ASSISTANCE REQUEST (RTAR) screen.



On the RTAR screen, in the Response Sent field, enter #1 Electronically or #2 By Mail to indicate how you are responding to the request. Electronic responses are most common. Actionable material should be faxed into the PC Paperless file and documents stored in eView or NDRED. Document any final remarks in the TEXT field and press ENTER. This transfers the request back to the PC and clears it from your jurisdiction. [MS 04909.010](#)

Controlling PCACS Workloads

There is no pending list for PCACS Request for Assistance. The Tickle List is the only control for these items. PCACS Tickle Lists are available through WAC.



Modernized Development Worksheet (MDW)

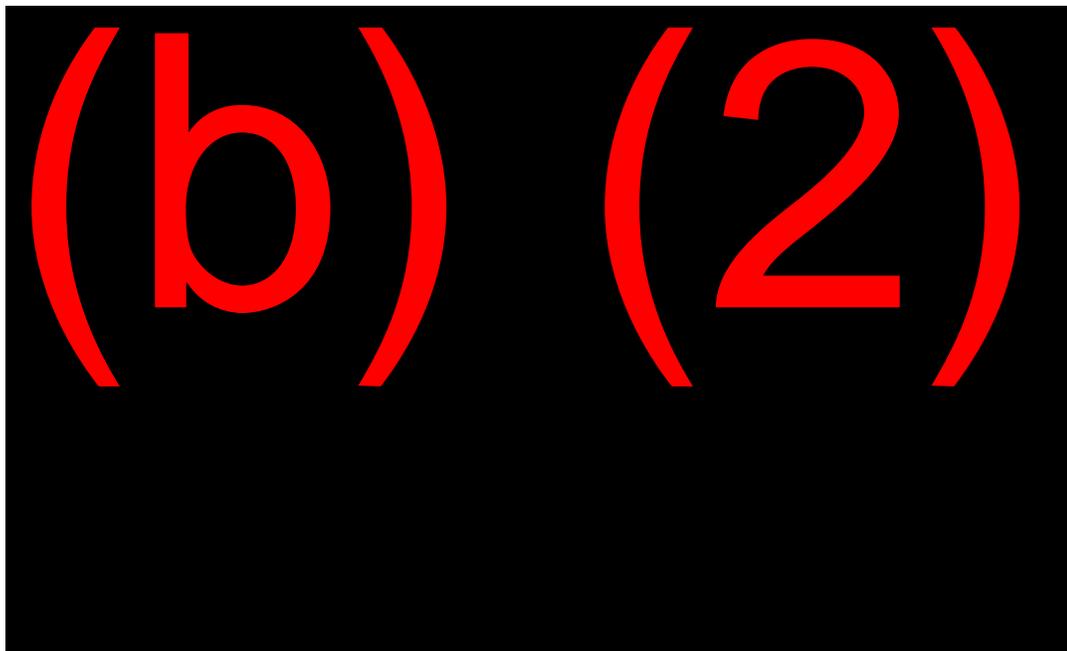
[MS 03901.001](#)

The Modernized Development Worksheet (MDW) is an automated development tool used in a variety of ways to assist SSA staff. We use it to:

- Control pending items;
- Send Administrative Messages or requests for assistance to other SSA FOs; and
- Send messages or requests to a MOD in the PC.

MDW Screens

On the SSA MENU (MAIN), enter #24 Modernized Development Worksheet. This will take you to the Modernized Development Menu (MMEN).

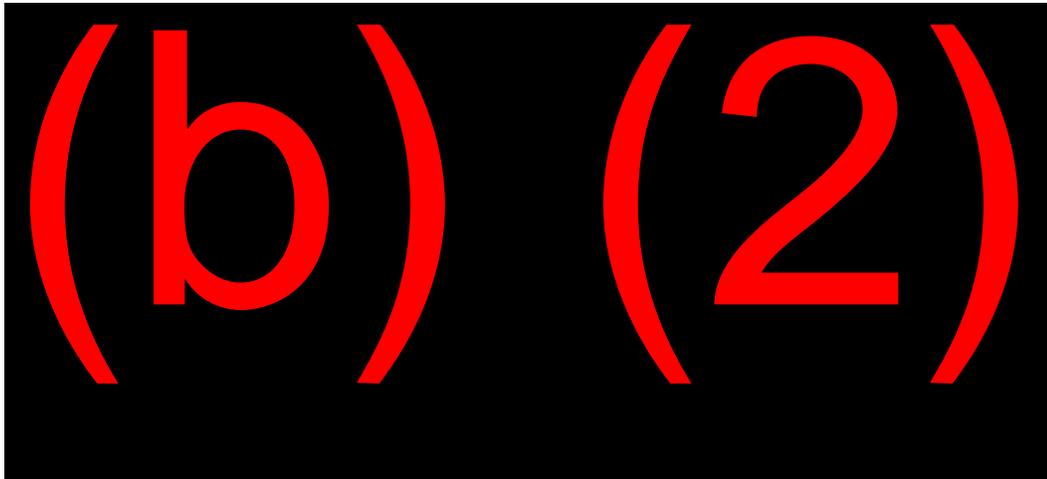


From this screen you can:

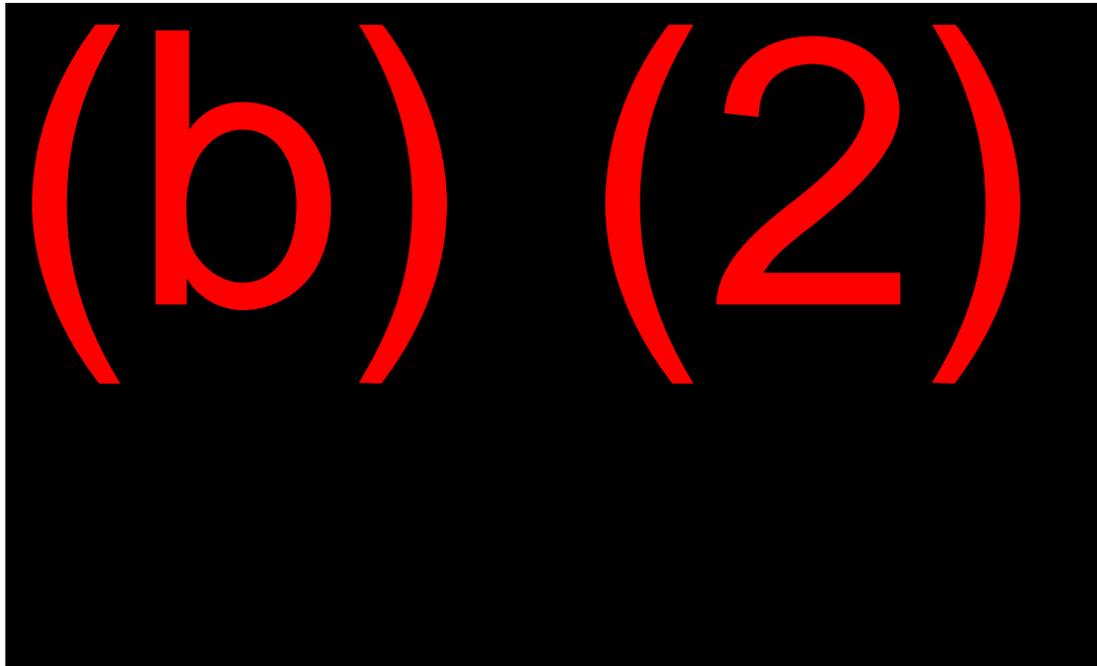
- Establish a new MDW;
- Update an MDW which already exists;
- Query an existing MDW; or
- Query MDW Listings.

Establishing or Updating an MDW

To establish a new MDW or to update an existing one, enter the SSN under which the record is set up, or should be set up. Then SELECT #1 (Establish) or #2 (Update) and #1 (Worksheet) for SELECT THE DESIRED FUNCTION.



The next screen is the Modernized Development Worksheet (MMDW). This screen is very similar to a DW01 screen in the MCS claim path. Only three fields on this screen require completion: UNIT, FO, and CLAIMANT NAME. However, to provide the best possible record, add detailed information.



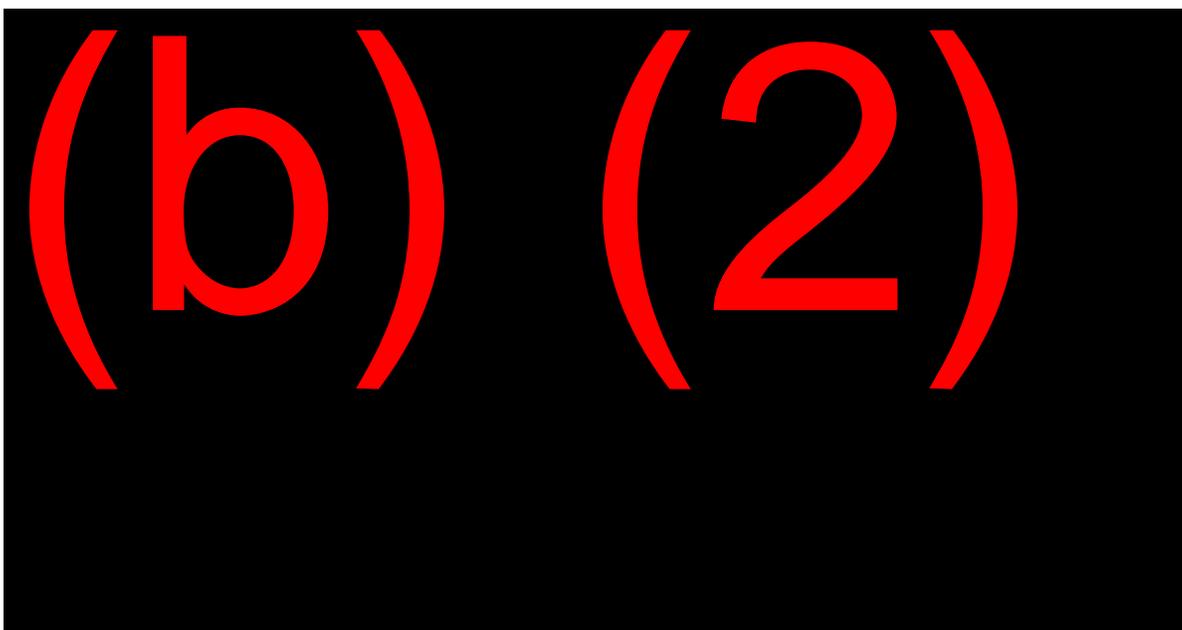
When you establish a MDW, the FO field pre-fills with your office code. The office code and jurisdiction on the MMDW screen remain under your office unless you change the pre-filled code. This is important, because the jurisdiction on the MMDW determines which office receives information about the MDW on its tickle and pending lists. If you are setting up the MDW for your own use, and it should remain in your jurisdiction, be sure to show your own unit designation.

If you want the MMDW to be under another FO jurisdiction, key that office's code over the pre-filled FO code and show "NEW" in the UNIT field. A designated employee in each office regularly checks their office's MDW listings. When a component sends a MDW to another office, "NEW" appears in the UNIT field on the listing printout, alerting the receiving office to assign the request to their own appropriate unit for necessary action.

If you want the MDW to be under the jurisdiction of the servicing PC, key the appropriate PC code (e.g., PC1, PC2, etc.) in the FO field, leaving the UNIT field blank. After completing and entering through this screen, the MDW system automatically determines the correct MOD in the PC and posts it in the UNIT field. As in FOs, a designated employee in each MOD regularly checks their MDW listing and assigns the incoming requests to the appropriate unit within the MOD.

Use the bottom half of the MMDW screen to post issues, tickle dates, and receipt dates. Use specific codes as Issue Categories on the MMDW. When you press F1 on the MMDW screen, the system displays a list of the acceptable codes. If you need additional space, put a "Y" in the MORE ISSUES and/or REMARKS fields at the bottom of the screen.

After pressing enter, the MDW REMARKS (MRMK) screen appears.



The MRMK provides up to nine additional screens for posting instructions, information, requests, or actions taken.

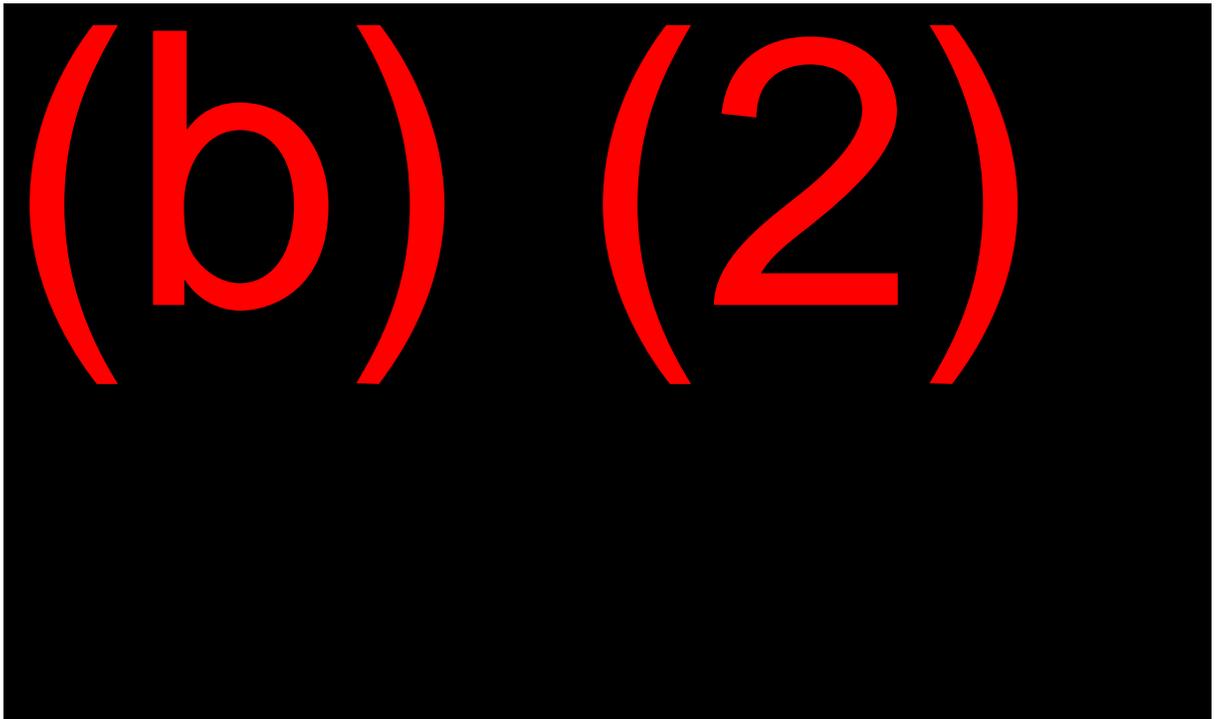
Responding to an MDW

When responding to an MDW request, give thorough, complete, and accurate information. Include your name, office code, and phone number in case the other component needs to contact you. Over-key the routing FO Code with the originating office and the UNIT, if known. If the original UNIT is not shown, complete the UNIT with NEW. Be sure to enter a TICKLE DATE of the **next day** so the MDW will show up on the receiving office's list promptly.

See [Exhibit 1](#) for a handy reference guide about the "Do's and Don'ts" of working with MDWs.

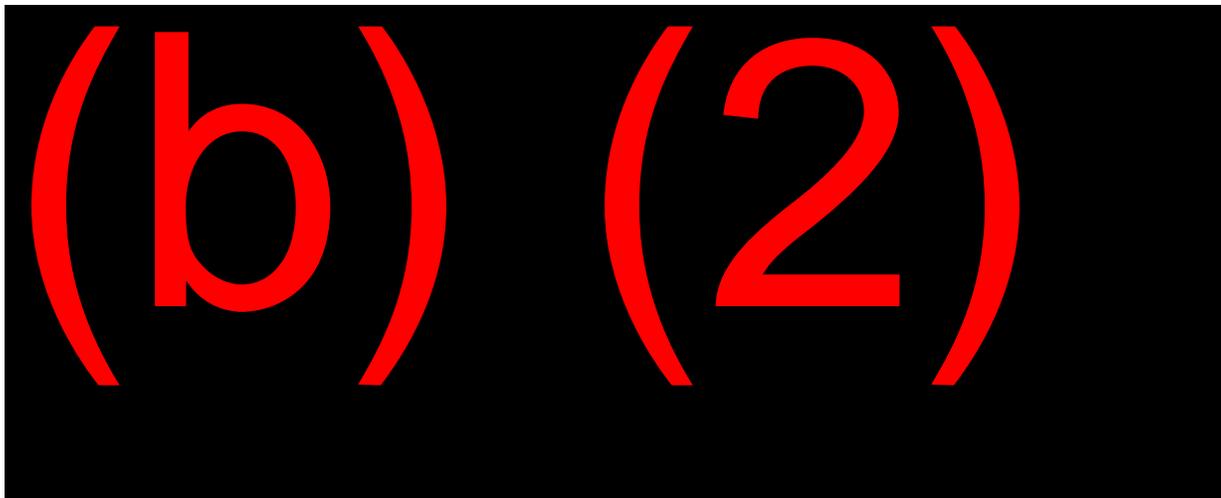
Controlling MDW Workloads

To maintain control of your workload, view your MDW listings regularly on Workload Action Control (WAC). You can request an MDW listing from the WAC navigation page.

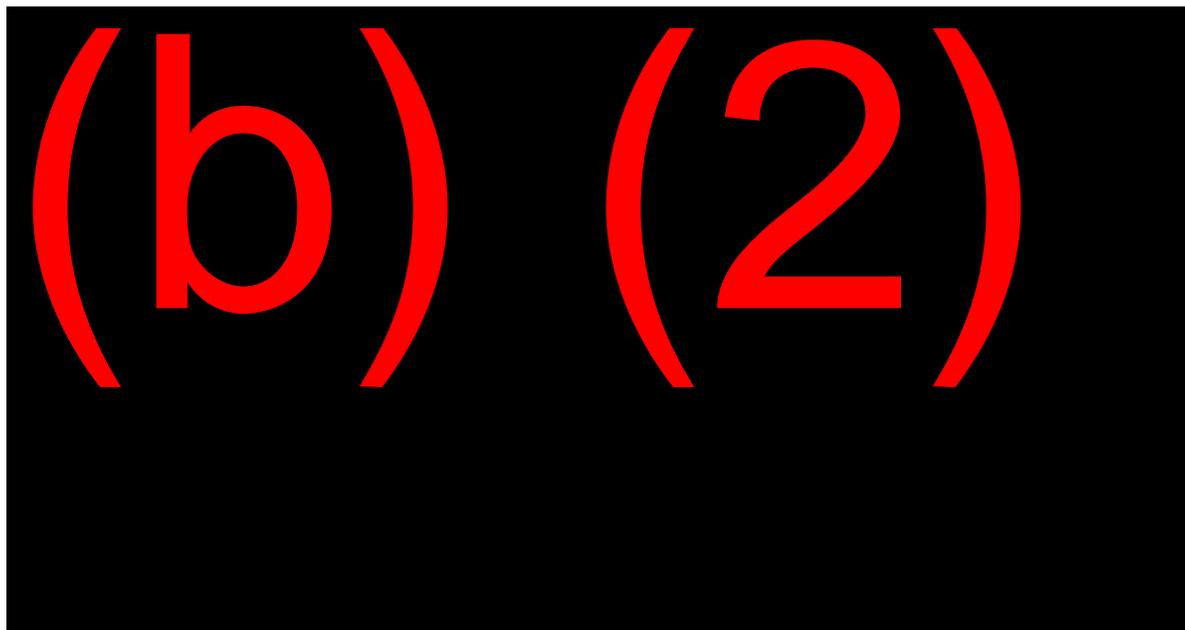


Once the pending MDW list is revealed you can quickly see which cases have expired tickles (reflected in blue) and thus require immediate attention. To access and address these cases highlight the individual line

and click on the Work MDW link, or just double click on the line itself to be taken to the MDW for the claimant.



Once on the MDW screen, review and address the pending issue(s), as needed.

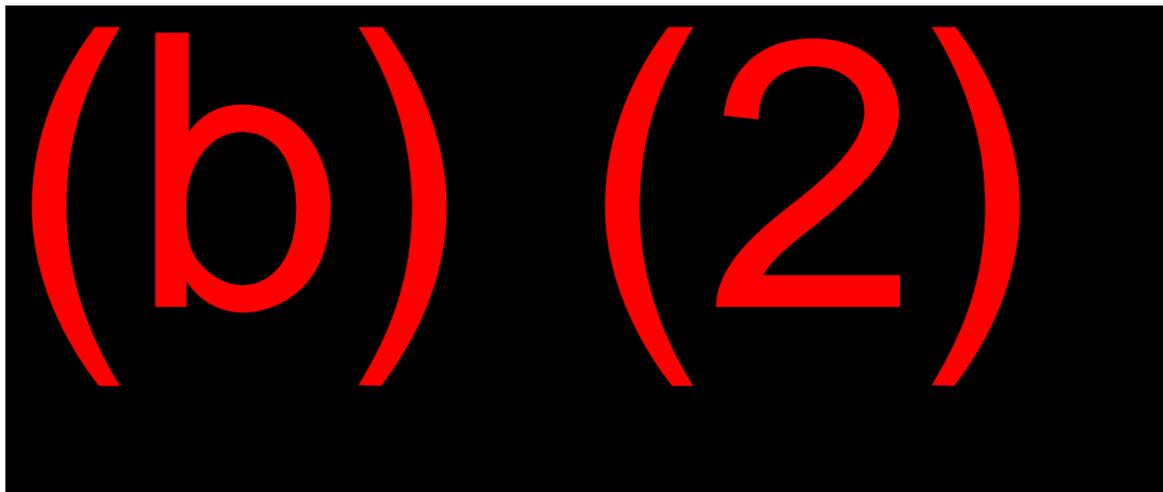


Electronic 562

The e562 application is an online version of the paper form SSA-562, **Request for Assistance/Certification of Document(s) or Record(s)**. It

also tracks the development of the 562 and automatically sends a follow-up when needed. You can also generate reports showing pending requests.

The Main Screen



Individual 562 Action

Used to View a 562, Create a new 562, Transfer a 562, or Delete a 562 if necessary.

Reports and Listings

There are three listing types available: pending E562s your office has requested, pending E562s where your office is the assisting office, and recently cleared E562s.

Follow-ups

The E562 Program is set up to do follow-ups automatically. If a case reaches 21 days old without clearing, the system sends an email message to the assisting office. If the case is complete, the assisting office clears it. If the case is not ready to clear, the assisting office should enter appropriate comments in the Development field of the E562.

For instructions on completion and use of the e562, see the (b) (2) (b) (2)(b) (2) site.

-

Manager-to-Manager (M2M web application)

The Manager-to-Manager web application is a communication tool used by managers in Field Offices, Processing Centers, and National 800 Number Network sites to initiate inquiries **which require priority attention**.

These high priority requests include:

- Terminal illness (TERI cases), including AIDS;
- Homicidal, suicide, or potentially violent behavior threats;
- Dire need situations, including eviction and/or homeless situations;
- Public relations issues;
- Other cases as required by POMs (e.g., Martinez cases).

Conduct subsequent follow-ups of a development request between managers as required in [GN 01070.440](#).

OBJECTIVE 3:

**Identify acceptable requests for direct deposit and Direct Express;
Determine when a PE action will affect payment and how to make Title II PE direct inputs**

Direct Deposit**[GN 02402.001](#)****Direct Deposit Policy**

On December 22, 2010, the Department of Treasury mandated all individuals who file for benefits on or after May 1, 2011, to select a form of electronic payment. This electronic payment could be in the form of either direct deposit or the Direct Express® debit card. Effective March 1, 2013, all current beneficiaries must receive electronic payments. Some exemptions from the EFT requirement exist; however, Treasury is responsible for determining if an individual is eligible.

Treasury automatically grants EFT exemption

- Beneficiary was born prior to May 1, 1921 and continues to receive payment by check; or
- The payment is not eligible for deposit to a Direct Express® prepaid debit card account; or
- Beneficiary or recipient's Direct Express® debit card has been suspended or cancelled.

Treasury may grant EFT exemption

Beneficiary has requested exemption and:

- Has a mental impairment which impedes the ability to handle their payments electronically and is not assisted by a representative payee; or
- Lives in a remote geographic location, which does not have the infrastructure necessary to receive payments electronically. [GN 02402.001 B](#)

Direct Deposit Process

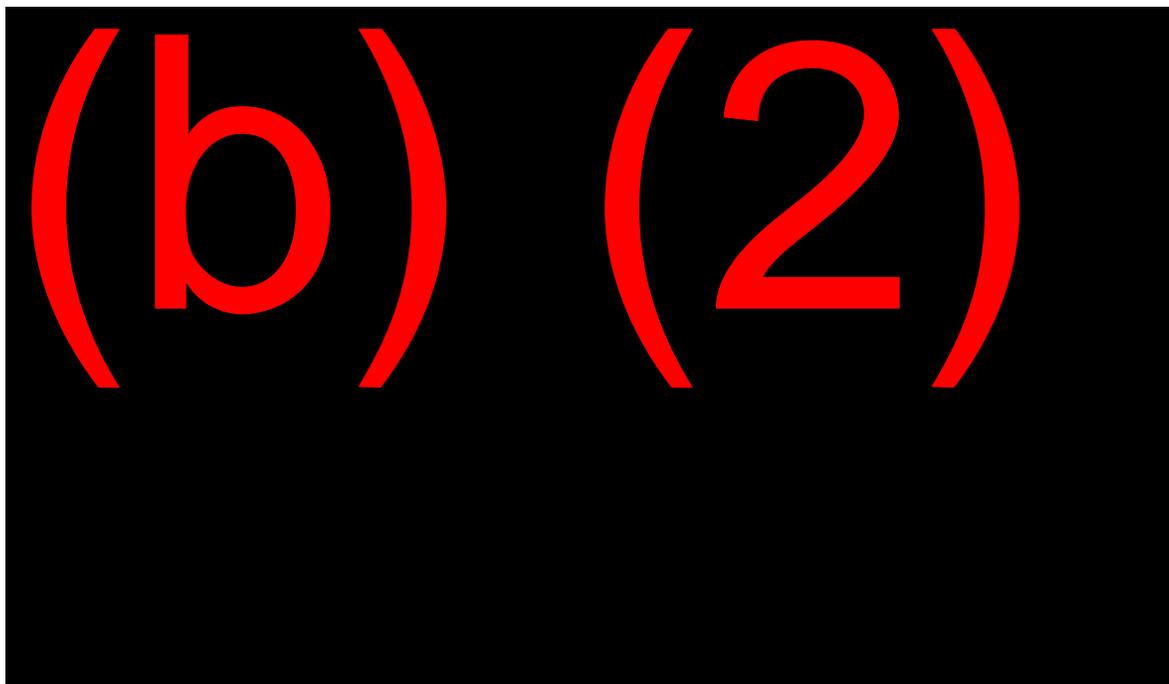
1. Advise the individual of the electronic payment requirement;
2. Discuss its advantages as stated in [GN 02402.005 H](#);
3. If no bank account, discuss the Direct Express® debit card and its advantages as stated in [GN 02402.007](#);
4. If the individual does not agree to electronic payment, tell him/her, "We will temporarily pay you by check and Treasury will contact you at a later time to discuss how you will receive your benefit payments in the future."

NOTE: Treasury is responsible for reviewing the request for exemption, making a decision, and contacting the individuals directly once they make a decision.

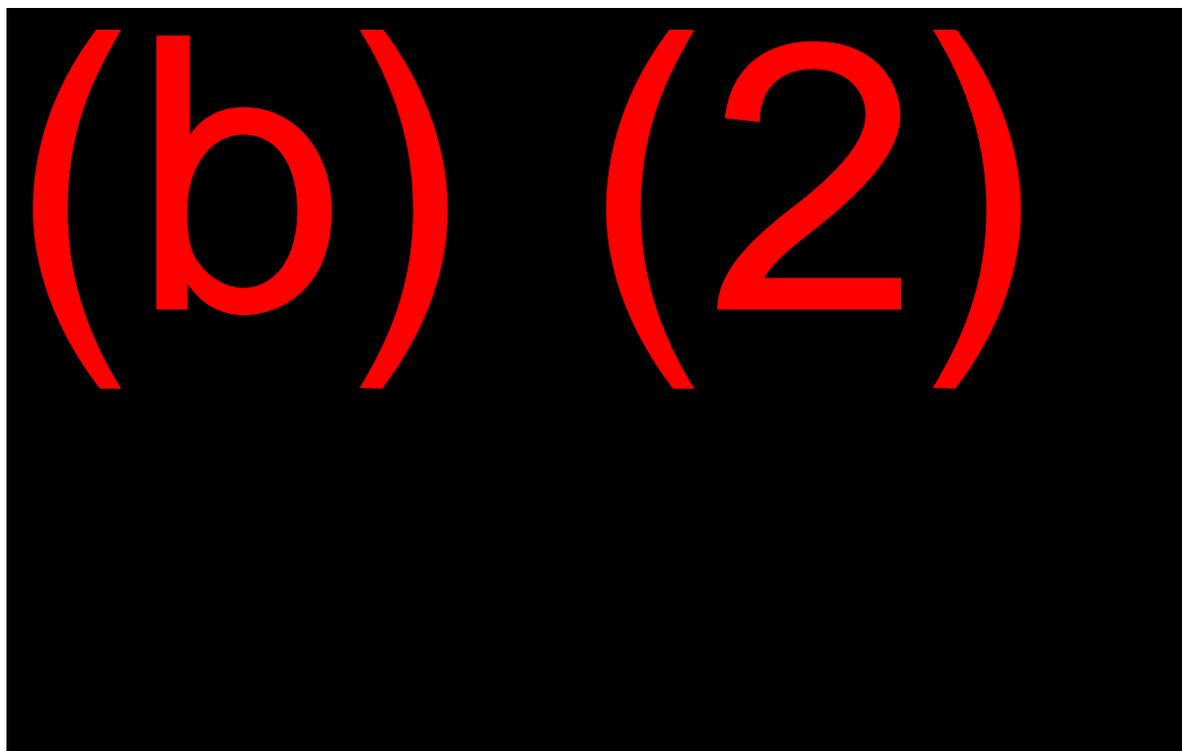
For a claimant providing direct deposit information, obtain the bank routing number, account number, and ask whether it is a savings or checking account.

The form SF-1199A provides information regarding the beneficiary's bank account for use in processing a request for direct deposit but is not required. Find bank account information on checks or other bank information the beneficiary may have. If the beneficiary has the account number but not the routing information for the bank, you may obtain access to financial institution routing numbers through Master File Queries.

To access this facility, select "#9" from the SSA MENU (MAIN). From the Master File Query Menu, select "#16" = MISM.



From the Miscellaneous Menu, select "#12" = RTND (Routing Transit Number). On this screen, select the destination of your query response (printer, screen) and enter.



Once on the RTND, enter the name and location (two-letter state abbreviation) of the financial institution. [MS 05205.005](#)



Financial Institutions

[GN 02402.030](#)

Acceptable Financial Institutions

Direct deposit payments can go to any of the following types of financial institutions (FI):

- Banks;
- Savings and loan associations;
- Credit unions; or
- Thrift institutions.

These institutions meet certain acceptability criteria established by the Treasury Department and have Routing Transit Numbers (RTN) assigned to them.

Unacceptable Financial Institutions

Direct deposit payments cannot go to any of the following institutions:

- Finance companies;
- Insurance companies; or
- Other non-traditional financial service companies.

Although the above entities may be associated with a financial institution, they do not meet appropriate Treasury Department criteria.

Special Situations

[GN 02402.035ff](#)

Ownership

Some direct deposit situations require special handling.

An account title must indicate ownership by the beneficiary. Beneficiaries who are payees of their own benefits may have their payments deposited to a single or joint ownership account. Show the beneficiary as an owner of the account.

Example:

Jon and Mary Smith are entitled to benefits and want their payments to go to the same account. Acceptable account titles include John and Mary Smith, Mr. and Mrs. John Smith, John or Mary Smith, Mr. or Mrs. John Smith.

Rep Payee Checking Account

A representative payee can only use a beneficiary's benefits for the beneficiary's needs. If a payee requests direct deposit, the account title must show they have only a fiduciary (not personal) interest in the account. [GN 02402.055](#)

A representative payee's request for direct deposit to a checking account may meet approval if:

- The account title reflects the beneficiary's ownership of the funds, and
- The payee establishes a separate account for each beneficiary they serve and request direct deposit.

Example:

Mary Smith is payee for her cousin, Jane Jones. Acceptable account titles include: Mary Smith for Jane Jones, Jane Jones by Mary Smith, Jane Jones by Mary Smith, trustee, or Jane Jones by Mary Smith, guardian.

The Guide for Representative Payees

(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2) includes a section discussing account titling in representative payee situations.

Exception

There are exceptions to the general rule that the title of the account must show the beneficiary's ownership of the funds. The exception applies only if the title meets all of the following conditions:

- The payee is the spouse, natural parent, adoptive parent, or step-parent of the beneficiary; and
- The payee and the beneficiary live in the same household; and
- The payee requests direct deposit to the payee's personal checking account; and
- The FO verifies with the payee that they will use the benefits for the beneficiary's current expenses and there will be no accumulation of funds in the account.

Rep Payee Savings Account

Approve requests for direct deposit to a savings account by a representative payee if:

- The account title reflects the beneficiary's ownership of the funds but does not allow the beneficiary direct access to said funds, and

- The payee establishes a separate account (or sub-account) for each beneficiary.

Example:

A widow and her three children are entitled on the record of Harry Brown. The widow requests the children's payments deposit into a savings account titled "Susan Brown for minor children of Harry Brown." The FO cannot approve the request because all conserved funds must be in a form which show the individual beneficiary's ownership of the funds. The FO can only approve the widow's request for direct deposit to her own checking account if the request meets all of the conditions shown above.

Establishing Direct Deposit**[GN 02402.025](#)****Policy**

A beneficiary can change financial institutions at any time. If the request is for a change from one financial institution to another or one account to another, advise the beneficiary to keep the old account open until the first payment deposits to the new account.

Who May Request Direct Deposit

Remember, only the beneficiary or their representative payee may request/change direct deposit of their benefits to a FI. They may make these requests online, by phone, in person, or by mail. Do not honor requests made by any other person.

Initial Claims

Establish direct deposit in MCS claims by the completing the appropriate fields on the CADR screen.

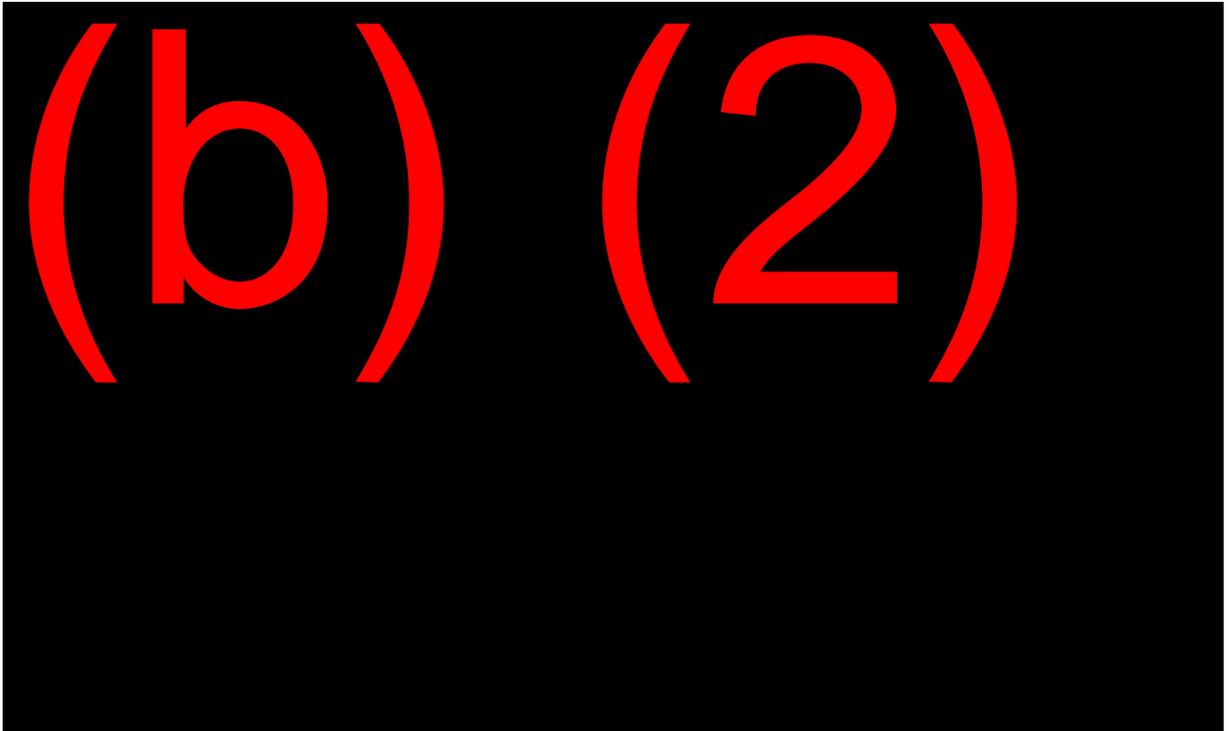
Code direct deposit data on A101s and EF-101s.

Add direct deposit in eRPS if a payee is involved.

Post entitlement

Advise beneficiaries that, with a password, they may initiate direct deposit or correct bank information via online input at www.SocialSecurity.gov by establishing a [my Social Security](#) account.

In PE situations, SSA personnel establish, change, correct or cancel direct deposit on the PEAD screen of the Post-entitlement Online System (POS).

**Direct Express**

[GN 02402.007](#)

Direct Express Policy

The U.S. Department of the Treasury's (DT) Financial Management Service (FMS), in collaboration with Comerica Bank, a U.S. financial institution (FI), established the "Direct Express card" program, which allows beneficiaries without bank accounts to have direct deposit of their

benefits. This service is available for individuals receiving Federal Government benefit payments, such as Title II and/or Title XVI payments. The individual may use Direct Express even if they already have a bank account.

Rules regarding establishing Direct Express debit card accounts are generally the same as the rules for establishing direct deposit.

Advantages

- **Safe, easy delivery** - beneficiaries can receive their payments every month without the expense or inconvenience of cashing checks or the risk of lost or stolen checks;
- **Easy access to information** - Internet access to Comerica Bank information about Direct Express® is available at **(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)** .
- **Card can be used without any fees** - It is possible to use the card free of charge. There is no sign-up fee, no monthly account fee, and no minimum balance requirement. Fees are only charged for optional transactions.

Differences from direct deposit

Comerica Bank sends automated enrollment information to the MBR or SSR (for Title XVI recipients). The beneficiary does not need to provide that information to SSA.

When individuals are concurrently entitled, they receive only one Direct Express card.

Representative payees receive a separate Direct Express card for each beneficiary. Only the representative payee's name will appear on the card even though the account is for the beneficiary.

Establishing Direct Express

[GN 02402.007](#)

Enrolling

There are many ways to sign up for Direct Express. An individual can call SSA's toll free number at 1-800-772-1213, go to a local field office, call Comerica Bank, or go to Comerica Bank's Direct Express website [\(b\) \(2\)](#) [\(b\) \(2\)](#)(b) (2)(b) (2)(b) (2).

If a beneficiary contacts SSA to enroll, process the request via the PEAD screen in POS. If the beneficiary elects Direct Express, you only need to enter a "Y" in the Direct Express (Y): field. You do not need to enter a routing or account number. This information updates to the claimant's record by Comerica Bank once the bank assigns an account number. Check the MBR BANK line to ensure the system properly established a Direct Express account. The routing number (RTN) for all Direct Express accounts is 072413133.

Post Entitlement Actions

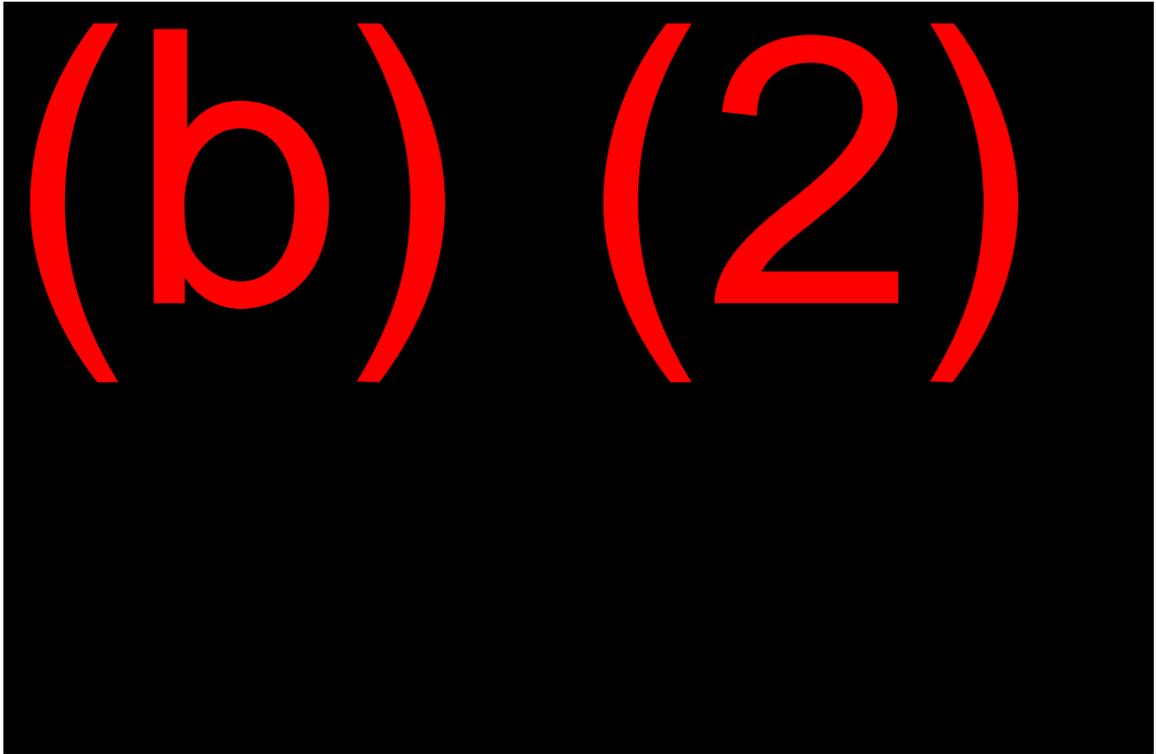
[MS 06302.001](#); [MS 06307.001](#)

PE Inputs

Two online systems used to input PE reporting events are:

- Post-entitlement Online System (POS): [MS 06302.001](#), and
- Miscellaneous Online Edit Transaction (MONET): [MS 06307.001](#).

Access both systems from the SSA Main Menu #2, Title II/PE.

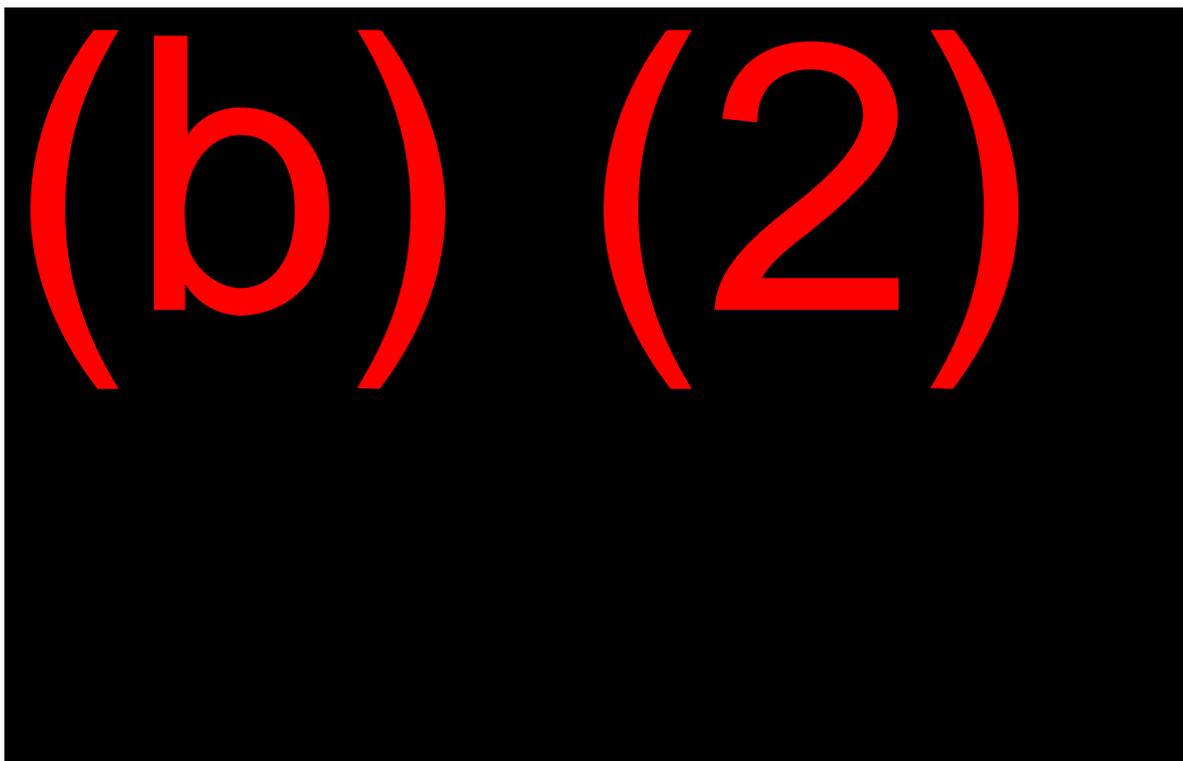


POS System [MS 06302.001](#)

Post-entitlement inputs done through POS (#1 on the T2PE menu) include:

- Change of Address/Telephone Number
- Death
- Direct Deposit
- Voluntary Tax Withholding
- Annual Reports
- Work Notices
- CDR Suspension
- Rep Payee Suspension
- No Child-In-Care

- Medicare Related Requests
- Change in Marital Status



See [MS 06302.003 C](#) for the complete POS selection list (PESL).

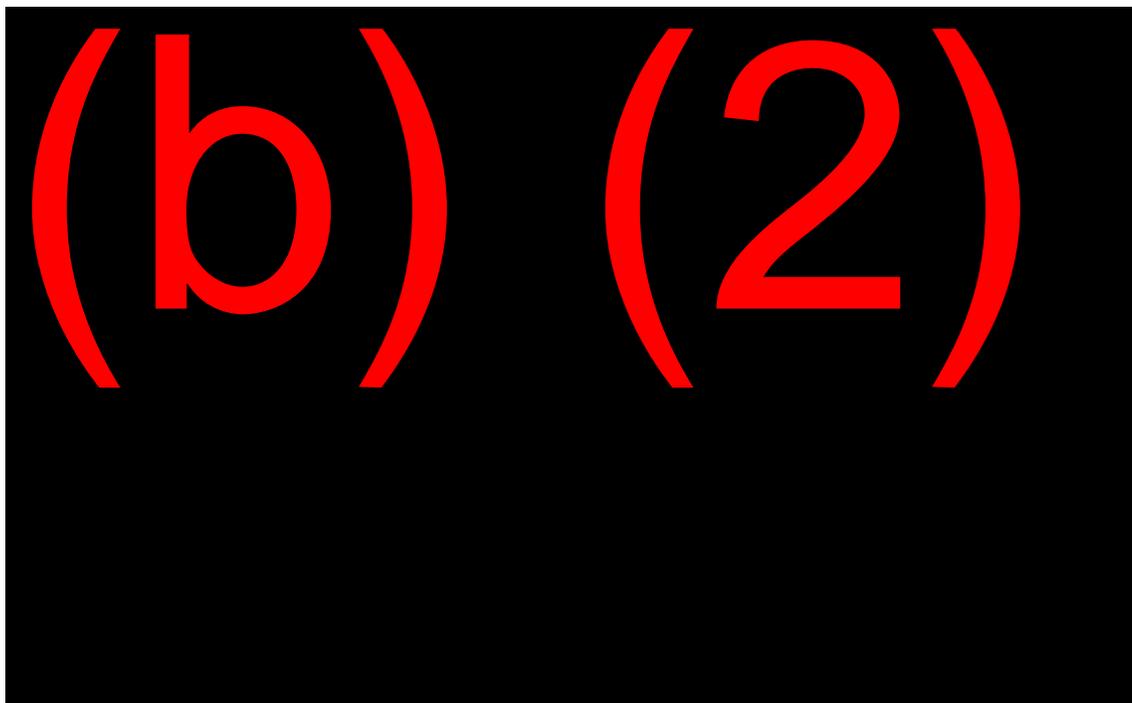
MONET [MS 06307.002 B](#)

The Miscellaneous Online Edited Transaction (MONET) system consists of annotation-only data collection screens. These screens provide the user with the capability to add, modify, or delete certain MBR items. (#2 on the T2PE menu)



Some of the data, which can be input or corrected, using MONET, are:

- Special messages;
- ACCOUNT data (e.g., sex or military service);
- Attorney information;
- BENEFIT data (e.g., DOB and proof code);
- Beneficiary reference data; and
- Cross reference data.



MBR

[SM 00510.050](#)

MBR Coding

PE events appear in a number of fields on the MBR. Some of these are:

- Proof of death in the PODF field on the ACCOUNT line;
- Date of death of the NH in the DOD field on the PRIMARY line;
- Change or addition of telephone information on the TELEPHONE (TELE NO) line;
- Direct deposit information on the BANK INFORMATION (BANK) line;
- Type of action processed and the date processed on the TRANSACTION (TRANS) line .

Post-entitlement Schedule

[GN 02407.010](#)

Current Operating Month (COM)

The Current Operating Month (COM) is the period when you can make PE changes to affect the payment due for the current month. For example, COM 02/19 refers to the payments due for February 2019, payable in March 2019. Changes made after the end of the COM will affect the next payment.

Example:

The 08/18 COM began 07/27/18 and ended 08/23/18. Changes made to the payment amount from 07/27/18 – 08/23/18 affected the benefits for August 2018 payable in September 2018. Changes made to the payment amount 08/24/18 and later affected the benefits for September 2018 payable in October 2018.

Payment Cycling

[GN 02407.005](#)

Originally, Social Security benefits were paid on the 3rd of the month. However, as the number of beneficiaries increased, it created an uneven workload pattern and caused difficulty for the public in contacting SSA at

the beginning of each month. For this reason, SSA implemented payment cycling for all claims filed May 1, 1997 and later.

The 3rd of the month is Cycle One and will continue for those who have a filing date before May 1, 1997 and those who are exempt from payment cycling. See exclusions to payment cycling in [GN 02407.005 B.4](#). The most common exclusion is for beneficiaries who also receive SSI payments

Beneficiaries are assigned a payment day based on their date of birth. .

Date of Birth	Assigned Payment Day	Cycle
1 st – 10 th	Second Wednesday	2
11 th – 20 th	Third Wednesday	3
21 st – 31 st	Fourth Wednesday	4

PE Events in the “Window” Period

Due to payment cycling, the agency established “windows” so certain changes could take place following the COM cutoff but still be early enough to affect the benefits paid in cycles 2, 3, or 4. Some examples of these types of changes include: COA, DD, Representative Payee changes, and some termination or suspension actions which cause overpayments. The cut-off dates for these changes typically occur 6 weekdays prior to the payment cycle delivery date.

Example:

The 09/18 benefit for beneficiaries in Cycle 4 is due on 10/24/18. A change to Direct Deposit information must be made by 10/17/18 to affect the October payment, which the beneficiary receives on 10/24/18. If a NH requests a change after 10/17/18, it will not take effect until the following payment made in 11/18.

Cut-off Dates

It is important for you to know the current month’s cut-off dates so you can advise a beneficiary when an input will take effect. Each month offices

receive notification of cut-off dates for COM via an Administrative Message on PolicyNet under Daily updates.

Find links for various Systems Calendars by going to FORCE. Then in the Search box, type in Systems Calendar. Below is a link to the Chicago Guide for the Systems Calendar:

(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)

LAF S6

[SM 00619.085](#)

LAF S6

If a beneficiary's address is unknown, the PC will put the record in suspense (LAF S6) until the beneficiary provides SSA with a correct address. A change of address input will reinstate the benefits. [SM 00619.085](#)

If you have contact with a beneficiary whose MBR shows LAF S6, it is imperative you develop for the correct address.

Instructions on how to update the MBR when the record is in LAF S6 are in the (b) (2)(b) (2)(b) (2) under the (b) (2)(b) (2) link.

Special Handling Situations

Certain inputs require special handling procedures.

- When there is a request to add, cancel, or change direct deposit, you must speak directly with the beneficiary or their representative payee to verify the request or have their signature on a Form SF-1199A or other written request authorization [GN 02402.025](#).
- Address changes from a foreign to a domestic address or vice versa can be input via POS. See [RM 00499.004](#) for country abbreviations and [RS 02650.001](#) for Treasury Department Restrictions. A change of address from one foreign country to

another can be processed unless the new address is in a barred-payment country.

- Records on which no entitlement exists (including lump-sum only cases, withdrawals, denials, and uninsured VA payment cases) require no systems action.
- Reports involving Department of Labor Black Lung Records should be handled by the agency with appropriate jurisdiction [TC 08001.010](#).
- Do not use the name correction event to change the beneficiary's name due to marriage or divorce. Process the name change via SSNAP and obtain the appropriate evidence per [RM 10212.010](#). Then enter the appropriate information via the marriage or divorce input screens in POS.
- Process change of payee actions through the Electronic Representative Payee System (eRPS).

Online Services and *my* Social Security Accounts

Whether an individual receives Social Security benefits, is nearing the age or time to receive benefits, or is decades away from becoming eligible for benefits, be sure to tell them that they can create a “*my* Social Security” account at no charge by visiting <https://www.ssa.gov/myaccount>. A SSA or Medicare beneficiary can use a “*my* Social Security” account to:

- Get benefit verification letters (includes Medicare and SSI);
- Check payment, benefit, and earnings record information;
- Change address and telephone number;
- Start or change direct deposit;
- Request a replacement Social Security card if they meet certain requirements;
- Get a Medicare replacement card;

NOTE: Beneficiaries needing immediate proof of Medicare entitlement can get a benefit verification letter online by logging into their own “*my Social Security* account.”

- Obtain a replacement Form 1099/1042, which is the yearly Social Security Benefit Statement; and
- Report wages when working and receiving DIB.

Individuals who are not receiving SSA benefits can use a “*my Social Security*” online account to:

- Get a Social Security Statement to review
 - Estimates of their retirement, disability and survivors benefits;
 - Their earnings record; and
 - The estimated Social Security and Medicare taxes paid.
- Request a replacement Social Security card if they meet certain requirements; and
- Check the status of an application or appeal.

Individuals do not need a “*my Social Security*” account to:

- Select or change the way information from Social Security is sent if the person is blind or visually impaired.
- Block electronic and automated telephone access to personal information.
- Apply for extra help with Medicare prescription drug plan costs.

For a full list of online services, see:

<http://www.socialsecurity.gov/onlineservices/>.

Creating a “*my Social Security*” online account is easy. To create an account, the user simply provides some personal information and answers to some questions they are likely to know. Next, a username and password is created to access the online account. This process protects individuals and keeps personal Social Security information private.

Anyone can create their own account, if they are at least 18 years old and have a:

- Valid e-mail address;
- Social Security number; and
- U.S. mailing address (this includes military addresses, APO/FPO/DPO AE, AP or AA).

A person may not create an account for another person, even with the other person's written consent. This also applies to an appointed representative or someone who has business with that person.

Unauthorized use of this service is a misrepresentation of identity to the federal government and can incur criminal or civil penalties, or both.

A person may be unable or unwilling to create an online account if he or she:

- Blocked SSA from electronic access to personal information;
- Recently moved or changed names;
- Placed a freeze on their credit report;
- Have been the victim of domestic violence or identity theft; or
- Are uncomfortable with or unable to use the online process for some other reason.

Even in these cases, that individual may still may create an account in person by visiting the local Social Security office.

OBJECTIVE 4:

List, obtain, and read the PHUS queries; Obtain a Payment History through QRSL; Properly Use TCIS; Identify and Process Court Order Garnishments (COGs)

The PHUS Queries

[SM 00545ff](#)

PHUS

SSA is required to provide an annual benefit statement to each Title II beneficiary. The Payment History Update System (PHUS) was established for this purpose. The MBR contains a record of entitlement and what **should have** been paid, while the PHUS shows what **actually was** paid. The PHUS contains a historical record of Title II payment related actions starting with the year 1984.

The PHUS can also be used as a supplement to the MBR to:

- Determine how an overpayment occurred;
- Determine how a non-receipt occurred;
- Check U.S. Treasury disposition/status of non-receipts;
- Explain Current Month Accrual (CMA) and Prior Month Accrual (PMA) checks.

There are three types of PHUS queries [SM 00545.001](#):

- PHU1 (PAYMENT HISTORY BY BIC) – This option allows selection by BIC for payment history of specific tax years;
- PHU2 (PAYMENT HISTORY) – This option allows selection for all BICs on the record by year;

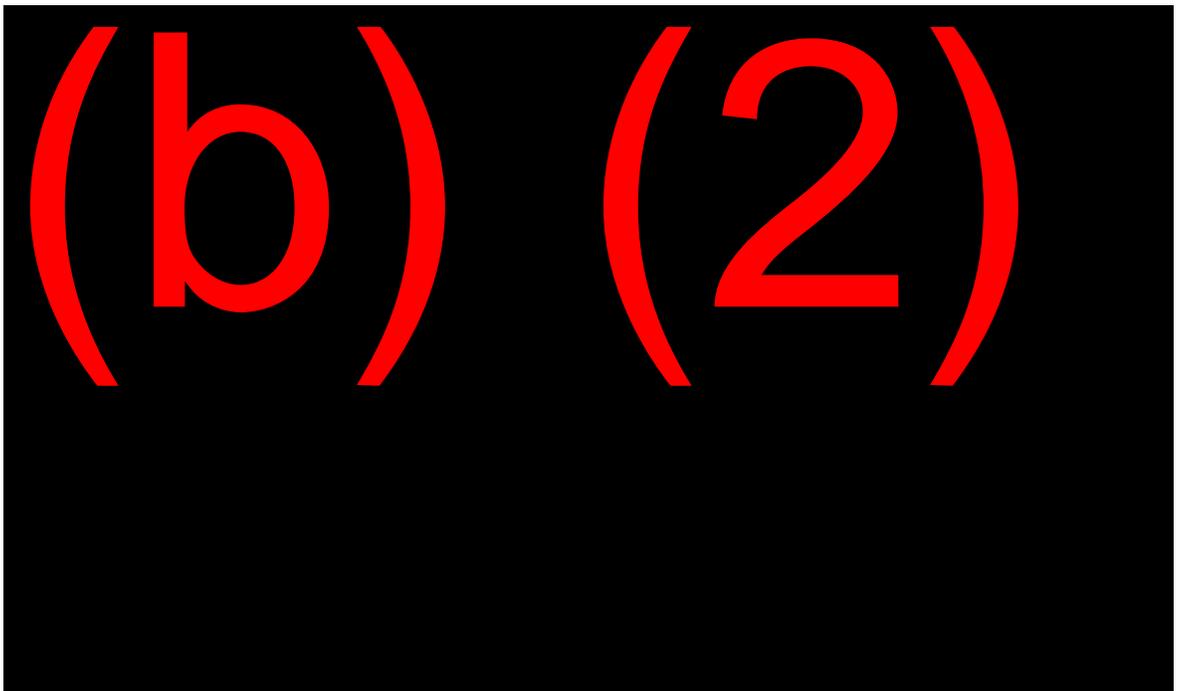
- PHU3 (PAYMENT HISTORY BIC LIST) – This option gives a list of all BICs on the record.

Requesting and Interpreting PHUS Queries

[SM 00545ff](#)

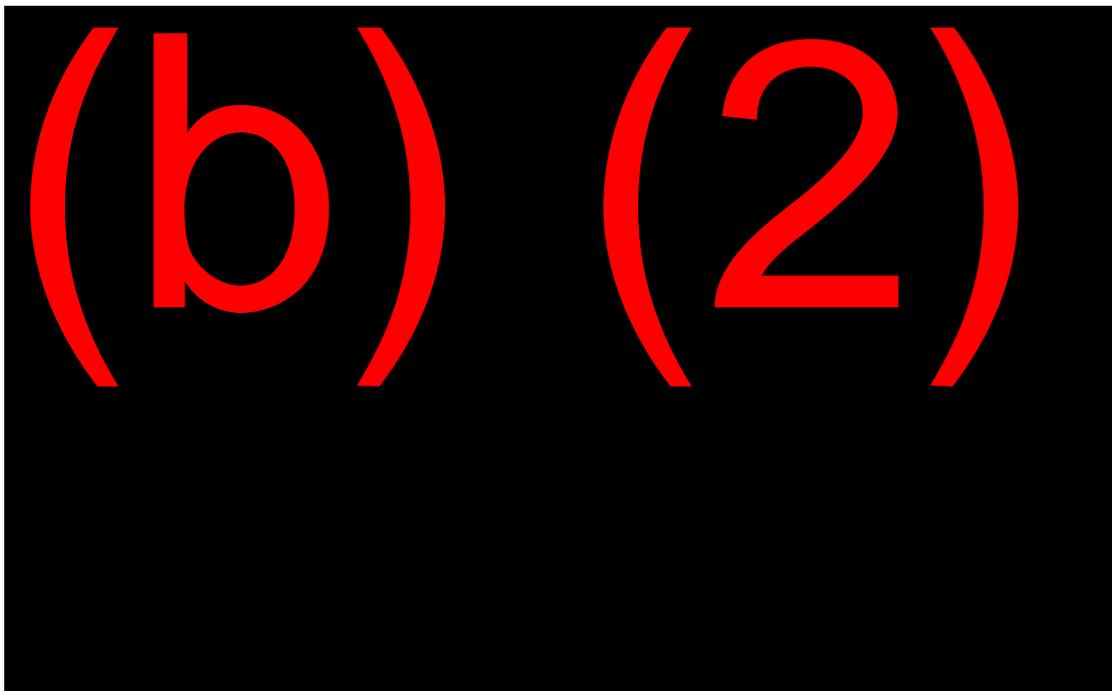
Requesting a PHUS Query

On the SSA MAIN MENU, select #9 MASTER FILE QUERY. Press enter to be taken to the MASTER FILE QUERY MENU. Select #11 PHUS (PHU1, PHU2, PHU3), complete the SSN field, and press enter.



This will take you to the PHUS screen. In the “Select One of The Following” field, enter the number corresponding with the appropriate query.

For a PHU1, you will also need to complete the entries indicating the BIC of the beneficiary whose payment history you want. You can enter as many as nine BICs on the screen. For each BIC, enter the taxable years for the payment histories you want to review. Press enter.



For a PHU2 or PHU3, only enter the taxable years at the bottom of the screen and press ENTER.

Reading a PHU1/PHU3

For instructions on interpreting a PHUS query, see [SM 00545.210ff](#). Other useful tools include the query readers in the [\(b\) \(2\)\(b\) \(2\)\(b\) \(2\)](#) on the intranet and the OQA Toolbar.

Refer to [Exhibit 2](#) for an example of the PHU1 query. Your mentor may provide other examples of PHUS queries.

- Status Line – This line tells whether an MBR, PHUS, or SSACCS has been established and when the records were last updated.
- Query Redirect Line – This is the cross-reference facility. It will refer the queried account number to the account number under which the record is filed.
- Account Line – This line lets the requestor know which PC has jurisdiction of the account, whether there is a questionable event somewhere on the PHUS record, and how many beneficiaries are on the record along with their BICs.

- Person Line – This line contains identifying information about the beneficiary including name, SSN, BIC, and prior BIC(s).
- Master Beneficiary Record Line – This line displays applicable data from the MBR.
- Indicator Line – This line shows benefit data from the PHUS record of the individual identified in the PERSON Line.
- Adjustment Line – This line shows payment adjustment information from the PHUS record of the individual identified in the PERSON Line.
- Event Lines – These show the results of every payment-related action picked up by the PHUS.
- Transaction Line – TRANS contains the payment history data. The ETD (effective tax date) represents the month in which payment was actually issued.

Payment History through the QRSL

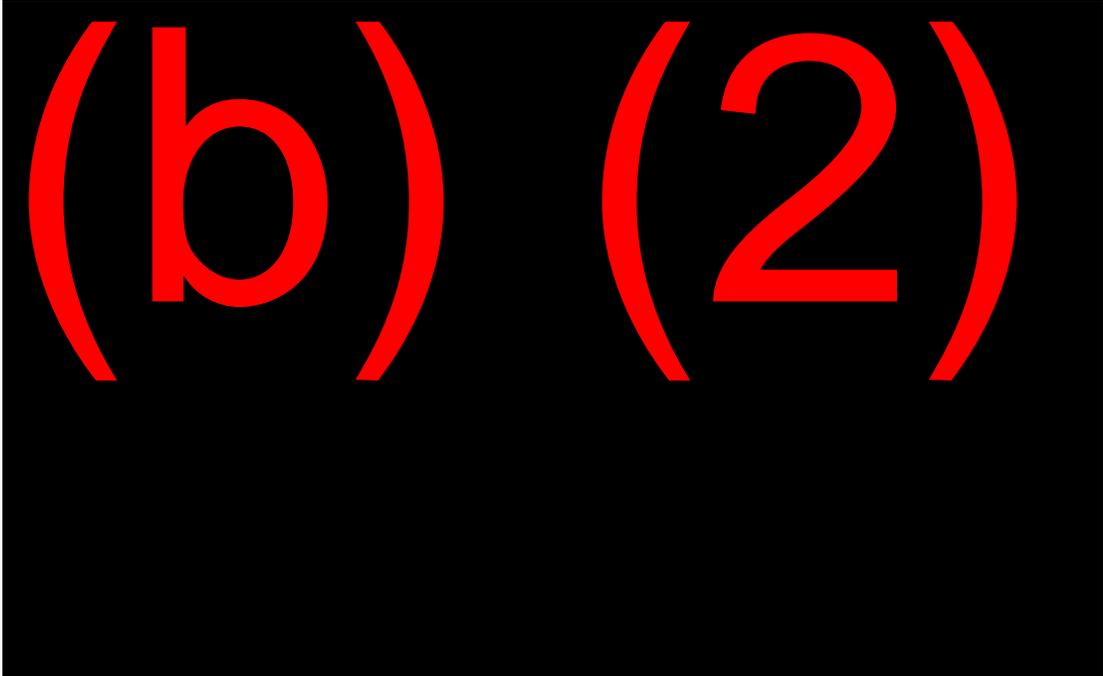
[MS 05206.002](#)

The Query Response Selection List (QRSL)

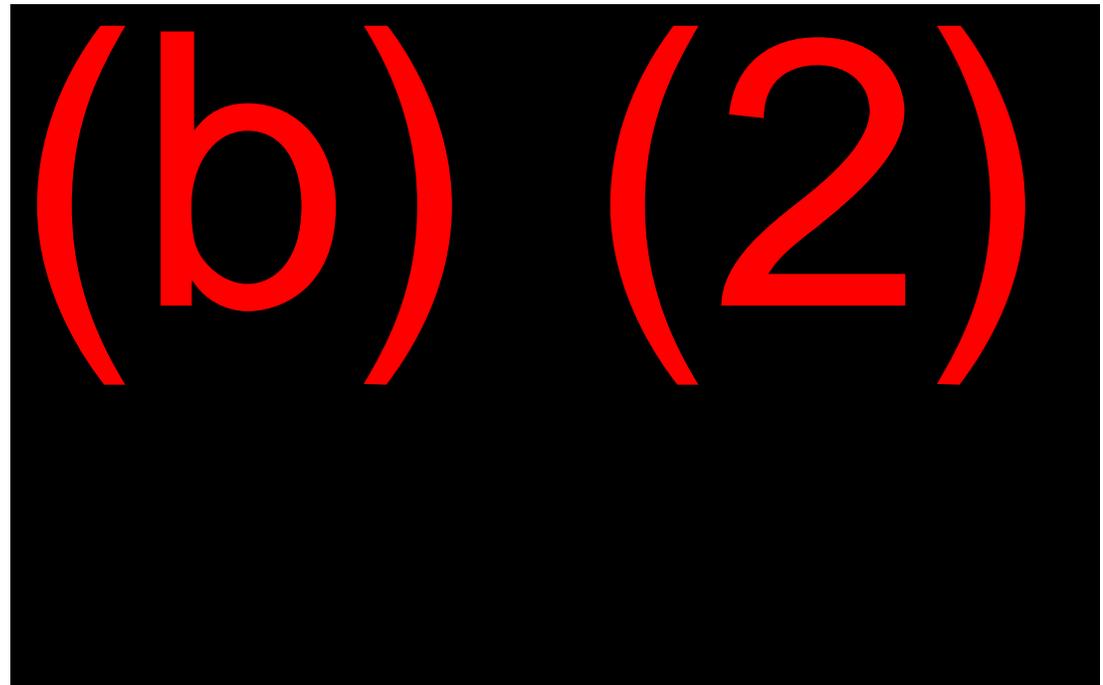
Use the QRSL to obtain a PMTH. Many CSs find the PMTH more convenient and easier to read than the PHU1.

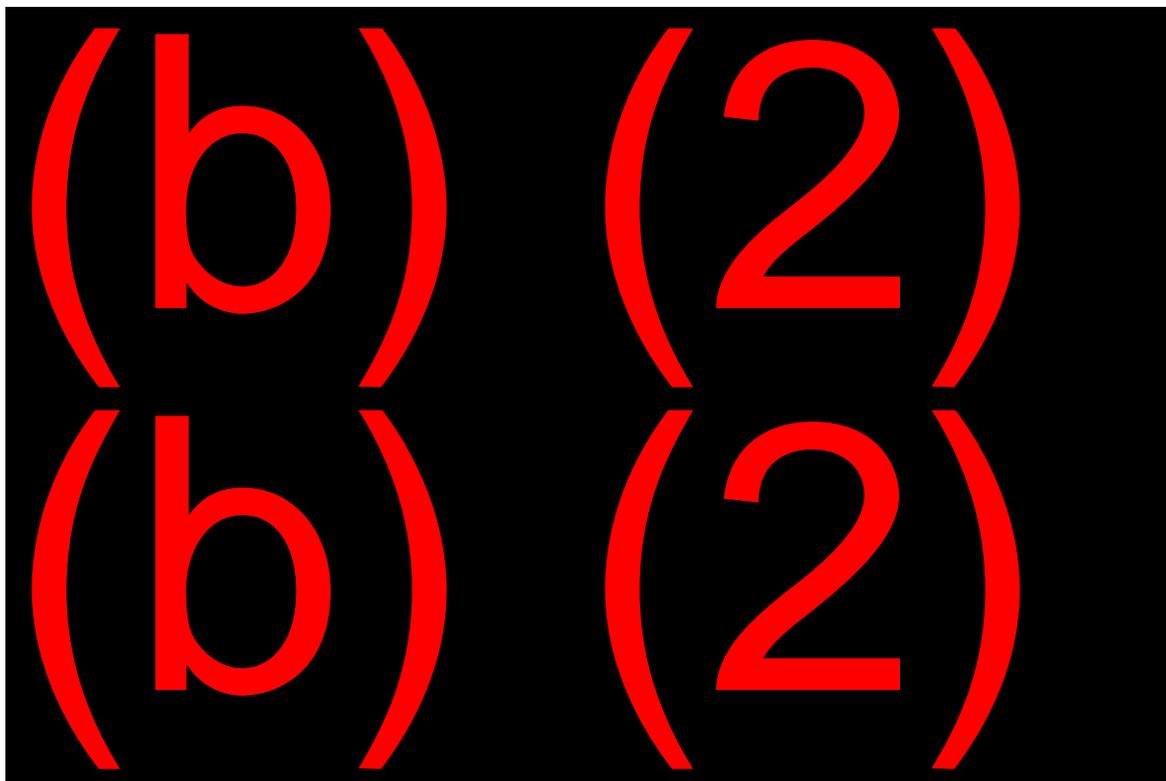
Obtaining the PMTH

Enter "#9" MASTER FILE QUERY on the SSA MENU (MAIN). When you reach the MASTER FILE QUERY, enter "#17" for INQUIRY RESPONSE, the SSN, and the routing instructions.



On the QRSL, enter "E" (PAYMENT HISTORY) and the period for the payment history you want to review. Press enter to be taken to the PMTH screen.





Reading the PMTH

Refer to [Exhibit 3](#) and any other examples your mentor may give you.

- NH – NH's SSN and name
- BN – SSN and name of the beneficiary (field is blacked out if the PMTH is about the NH)
- BIC – Beneficiary Identification Code
- DATE – date of RSI payments
- MONTHLY BENEFIT CREDITED – rounded-down benefit before withholding
- ADJUSTMENT AMOUNT – amount withheld from monthly benefit
- REASON – reason for withholding
- PAYMENT – amount of the monthly or retroactive benefit paid

- PAYMENT INDICATORS – describe conditions that affect payment and other information on the MBR or PHUS relating to the payment; see the payment indicator chart in [MS 05206.015](#).

Treasury Check Information System

[GN 02406.130](#)

When a beneficiary alleges non-receipt of a benefit, in addition to reviewing the MBR, PHUS, and QRSL queries, we can also look at the Treasury Check Information System (TCIS). This query should be used as a last resort after reviewing all SSA records.

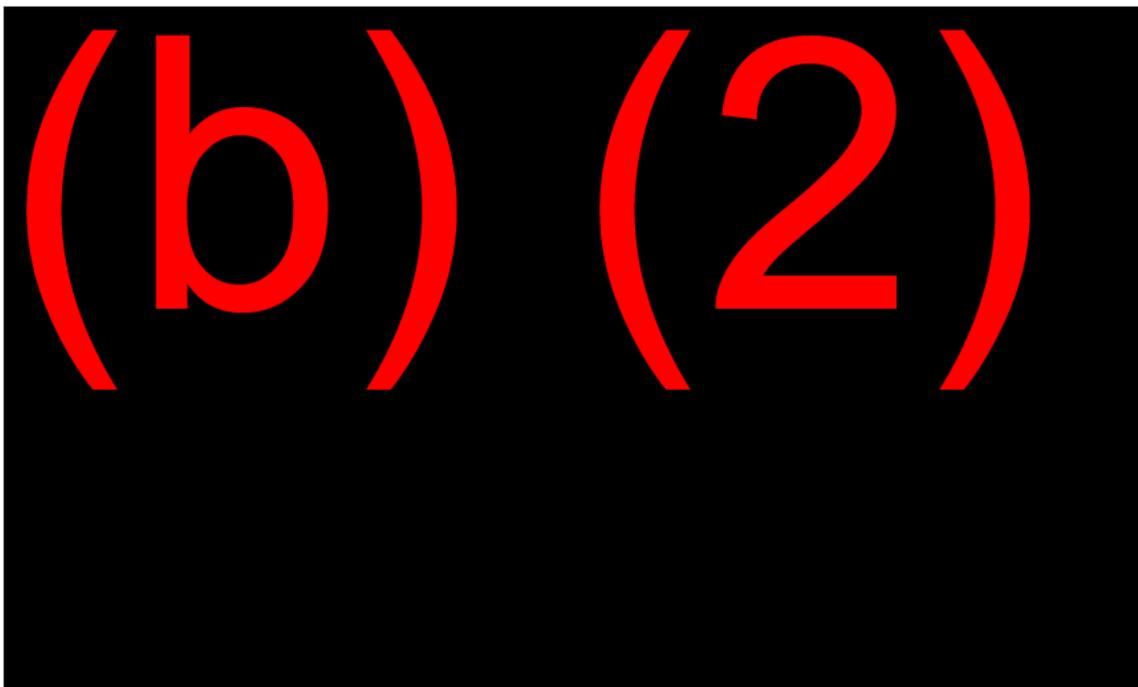
What is TCIS?

TCIS is a system that houses payment data directly from the Department of Treasury's Financial Management Service Bureau. We only have the ability to query data through TCIS. If any action needs to be taken on the payment, (e.g., non-receipt alleged, fraud alleged, photocopy requests, etc.) it must be done through SSA's systems directly.

How Do I Use TCIS?

Access TCIS through iMain. You do not need any special PIN or password.

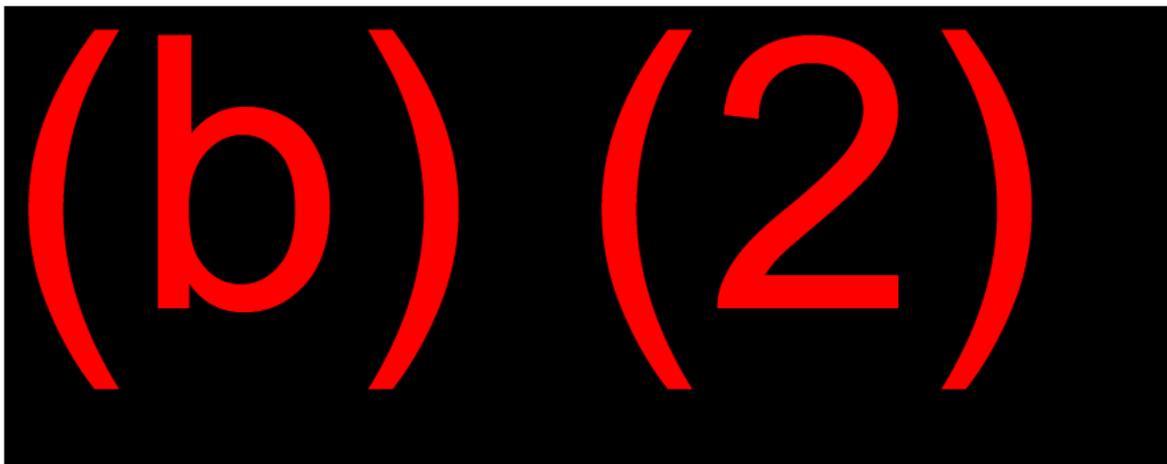
The first screen you will encounter is the Welcome screen. From here, select Integrated View from the buttons on the left side of the screen.



Querying TCIS Records

On the Integrated View, the most common way to query a record is by selecting the Payee Query tab at the top of the screen.

On the Payee Query screen, enter the Payee ID and a date range of no more than one year. **NOTE:** "Payee" in this system refers to the Number Holder's SSN. Then select the Submit button.

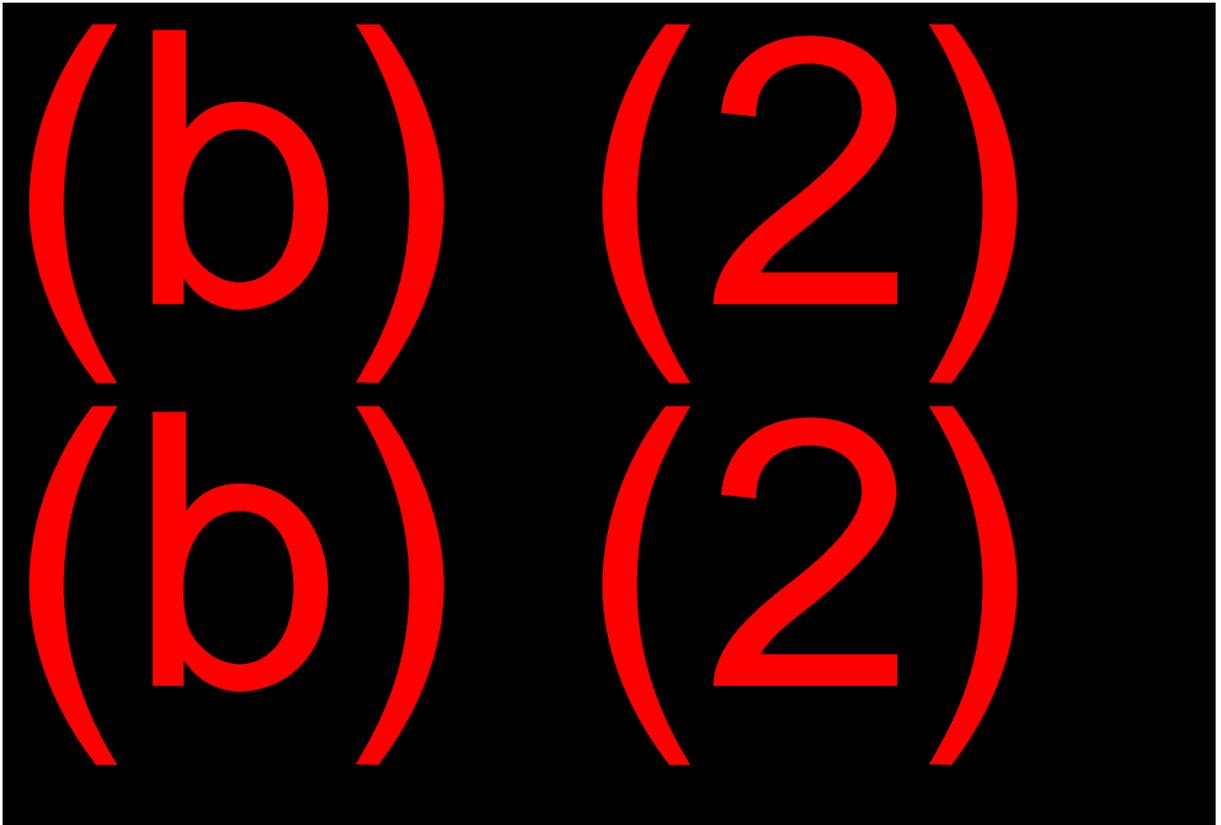


Payment Listing

The next screen shows a list of all payments made on the record for the date range listed. The Checks section will show any paper checks sent. The ACH section lists all payments made via electronic methods.

The Payee ID lists the NH's SSN and the appropriate BIC for each payment.

The Trace Number is a number identifying the date the payment was sent, the Regional Financial Center information, and a trace sequence.



If you select the Trace Number, it is a link to the Payment Details, Payment History, and Claim Details pages. These tabs provide additional details on where the payment was sent, to whom it was sent, and why the payment was returned, if applicable.

Use the Help Button on the left side of the screen to get additional information about the fields on the screens.

Court Order Garnishment (COGS)

Definitions

The Court Order Garnishment System (COGS) is a national system used to automate garnishment payments.

FO Responsibilities

Field Offices (FOs) have primary responsibility for processing garnishment orders for Child Support and Alimony.

The Court Order Garnishment System (COGS) adjusts Title II benefits, issues payments to the appropriate payee as shown on the garnishment order, and issues the appropriate notices to the garnished beneficiary and Court/Agency. COGS automatically applies the appropriate state laws.

PC Responsibilities

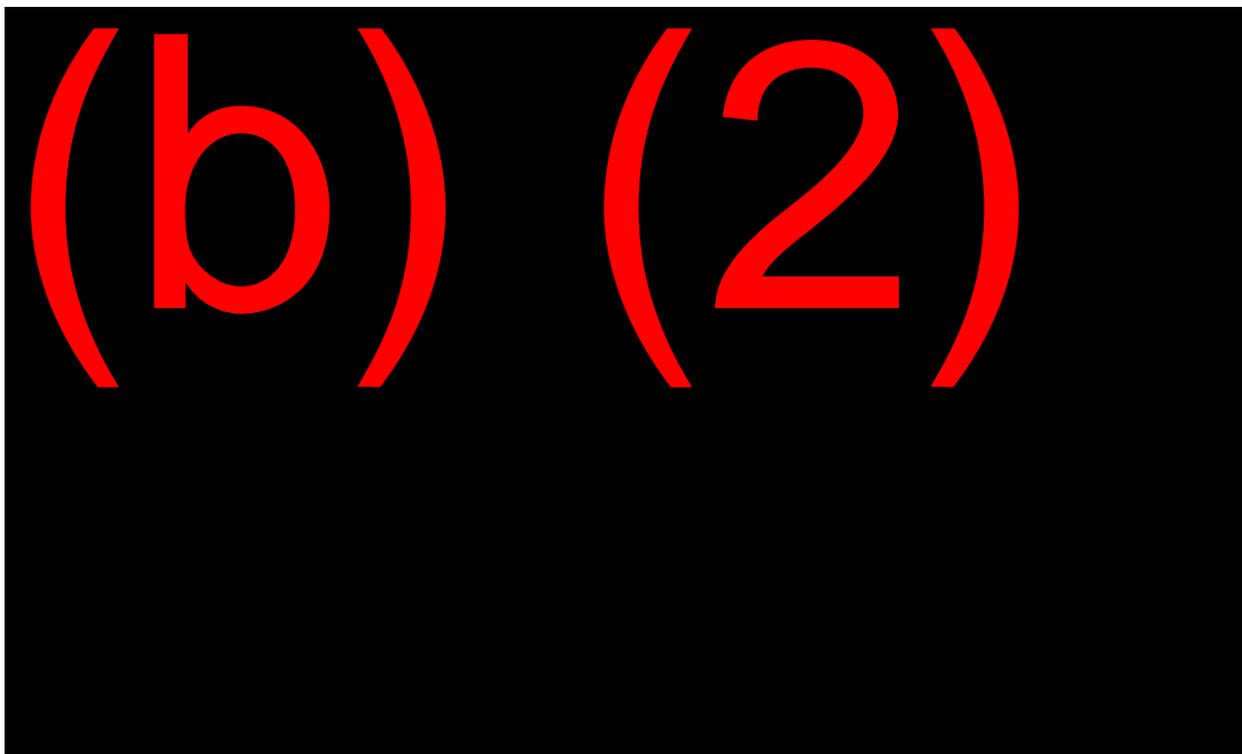
Processing Centers (PCs) continue to process orders served directly to them as well as COGS-related alerts/exceptions. Both PCs and FOs use the COGS to initiate, update, terminate, and query garnishment actions. The PCs handle manual adjustments to COGS (e.g., payment is made outside the system and garnishment is withheld, dual entitlement is involved, and higher benefits will now be paid on the other account).

Access COGS

[SM 00832.100](#); [MS 05703.002](#)

To access COGS:

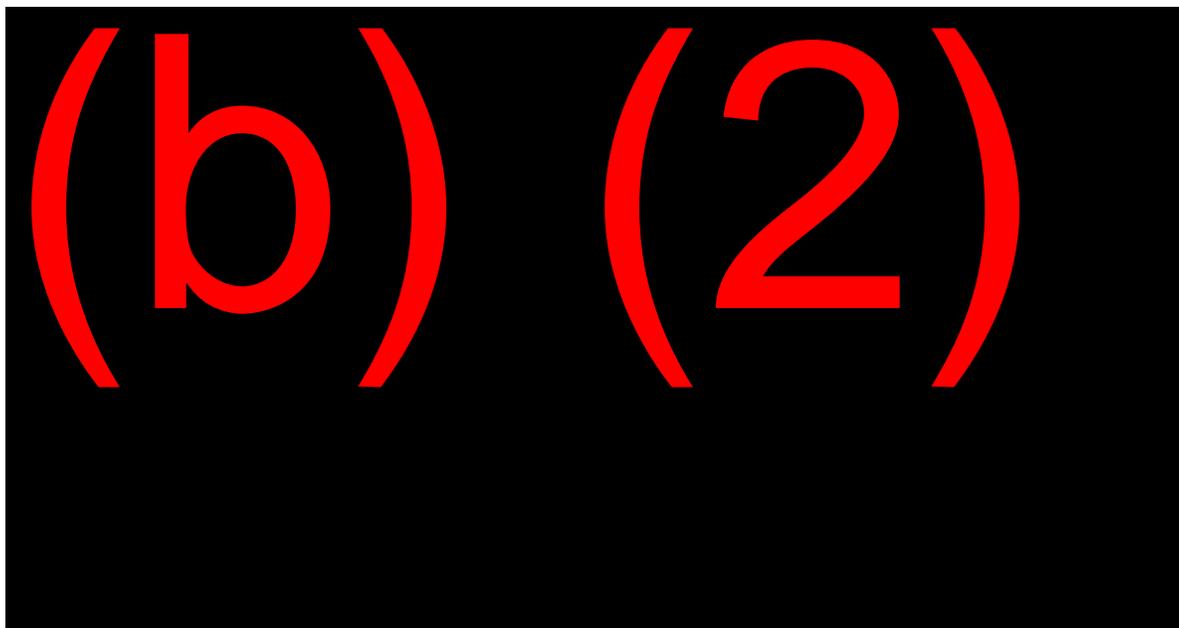
Select #27 (Payment Outside Title II System) on the SSA MAIN menu:



Enter #3 (GARNISHMENTS) on the POTS (Payments Outside Title II System) screen. The next screen displayed is the Garnishment System Menu (OGSM).



The FUNCTION you select on the Garnishment System Menu (OGSM) screen determines the next screens to come into the path.



HELP (PF1) is available on all COGS screens.

Processing Garnishment Orders

Review the Garnishment Order

Review the garnishment order carefully before making the COGS input, verifying it was served properly and is a valid order according to the instructions in [GN 02410.210](#). A state, court, or third party must send the garnishment orders to SSA per [GN 02410.205](#). Court orders received directly from the person whose payments are garnished, or the person receiving the garnishment payments, are not considered properly served.

Determine MBR Payment Status

Once you carefully review the garnishment order, you must determine the payment status using the MBR. If no MBR is present for the beneficiary, and there is no claim or appeal pending, the FO returns the order using the notice in [NL 00703.724](#). If an MBR exists in any LAF status (current, terminated, deferred, suspense, etc.), or if there is a claim or appeal pending, process it as if the person receives benefits and perform the input to COGS. COGS controls the pending order. If the individual goes from non-payment into current pay, COGS takes action to process the order and begins garnishment, if appropriate, or

refers the order to the PC for review and recontact with the court if the order is more than one year old. [GN 02410.210A.3](#)

Verify the BOAN, CAN/BIC, and Case Number

Verify the garnishment order establishes on the correct BOAN and CAN/BIC. Always ensure you garnish the correct beneficiary. For example, the NH and a child may have the same name and both may receive benefits on the same SSN. Be sure to establish the COGS record for the beneficiary shown on the court order. If it is not clear who the correct beneficiary is, contact the issuing entity (court or state).

Verify the correct case number/docket number before input.

Check all Addresses

Carefully check the payment address and notice address on all COGS inputs because often they are not the same. It is very important the notice address is different from the payment address in COGS when the payment goes to an individual (i.e., LEGEND 1 on the OGNA payment address screen is for an individual). For example, alimony garnishment payments usually issue to an ex-spouse or attorney address. The notice address in COGS must be the court or State Disbursement Unit (SDU), which issued the order. See [MS 05703.007](#) for details on the Notice Address screen in COGS.

Electronic Fund Transfer

Only code an Electronic Fund Transfer (EFT) or bank data, such as routing and transit, check digit code, direct deposit code, or bank account number, if the payment goes to an individual. Do not code an EFT to a Support Collection Unit or SDU.

SSA has agreements with most states to use EFT. If you select one of these states, COGS automatically establishes payment for EFT. Systems automatically convert the COGS records to allow EFT with additional state agreements. Eventually all states will receive garnishment payments via EFT.

Lump Sum Payment Requests

Code lump sum payment requests as a “Y” in the PMA Withholding field on the OGPD screen, and code the lump sum amount in the Garnishment PMA Withholding (OGPW) screen. [MS 05703.009](#); [MS 05703.010](#) Accept lump sum payment orders and input to COGS even when an ongoing monthly withholding exists in the system with the same case number. Do not place PMA amounts in the Current Child Support Amount field or change it unless you receive an amended order. The PC removes the lump sum information from COGS when they release the lump sum payment, if the payment totally satisfies the requested lump sum amount. [SM 00832.900](#)

Coding Lump Sum Only Orders

Code lump sum only orders (no monthly amount requested or already in COGS) as follows on the OGPD screen:

- WEEK/MONTH (W/M): M
- PMA WITHHOLDING (Y/N): Y
- TOTAL WITHHOLDING ON ORDER: 0.00

The zero amounts coded apply to the month/week amount, not the lump sum amount. After you enter this data, COGS takes you to the PMA withholding screen (OGPW) for completion of the Lump Sum withholding amount. COGS does not impose monthly withholding.

Coding Ongoing Withholding Amounts

Code ongoing withholding amounts in the Current Child Support Amount field or Past Due Amount field as indicated on the court order to the OGPD screen. [MS 05703.009](#) Inputs in the wrong fields, such as the PMA withholding field, result in incorrect withholding amounts. [GN 02410.215](#)

Use the REMARKS screen in COGS to document your actions, especially if the action is not routine or may result in an inquiry. [MS 05703.019](#)

Reinstating/Correcting Terminated Garnishment Orders

If you attempt to reinstate a terminated order in COGS or receive a new order with the same case number as a terminated order, change the case number on the terminated order by using function #9 = CORRECT CASE NUMBER on the OGKC screen. Change the number by adding a "T" to the end of the case number on COGS. This allows you to enter the new order with the same case number (without the "T"). [MS 05703.020](#)

Notices

[GN 02410.210 A.4](#)

Notices issued by COGS

COGS automatically sends the appropriate garnishment notices to the beneficiary/payee and the Court/Agency when garnishment actions are taken through the system.

The advance notice previously sent to SSA beneficiaries is no longer required. Since COGS processes the garnishment action and sends a notice to the beneficiary within 15 days, this fulfills our regulatory requirement.

Manual letters [NL 00703.710](#); [NL 00703.711](#) must be released by the FO for garnishment orders input into COGS for beneficiaries in LAF E (paid by RRB). These notices are in DPS's National Notices Tab and General Notices. COGS does not release letters on RRB cases, but generates garnishment alert OG02 to PC. The PC contacts RRB to verify the adjustment action takes place before paying the garnishment amount and releasing a notice to the garnishment recipient. [SM 00832.900](#)

Routing Procedures

After entering the garnishment order into COGS, fax the order (initial, amended, or termination) to eView or NDRed as appropriate. Fax each order separately and use the payment SSN on auxiliary/survivor cases, not the BOAN.

Also, fax in any documentation material even if it is a write-up of a phone contact with the court or state, after the COGS input. Once the order of garnishment has been faxed and viewed electronically in either an eDIB claim filing record or through NDRED by using CFUI, the original document can be destroyed. Do not send the original order to the PC.

OBJECTIVE 5:

**Identify types of checks issued,
describe procedures for
endorsement and negotiation;
Identify and process critical case
situations**

Types of Checks

[GN 02401.001](#)

Certification of Title II Checks

Field Offices (FO) and Payment Centers (PC) certify Social Security payments and the Department of the Treasury (Treasury) issues them. The types of checks certified are:

- **RCMA** – RECURRING payments are regular monthly payments issued according to the assigned payment cycling date.
- **CMA** – Current Month Accrual – A CMA payment represents payment for the current month. These payments are dated and delivered on the payment cycle date of the month following the month for which they are due.
- **PMA** – Prior Month Accrual – A PMA payment represents payment for months prior to the "current operating month" in which a transaction is processed. These payments represent a partial or full monthly payment, or payment for several months in a single check. PMA checks may arrive at any time during the month.
- **Single Payment System (SPS)** – SPS payments are automated fee payments made directly to appointed representatives. SPS payments arrive at any time and will appear on the PHUS after payment authorization.
- **Critical Payment System (CPS)** – CPS payments can arrive at any time during a month. A CPS payment represents payment to a

beneficiary for a due benefit AND the beneficiary is in dire need of the payment.

Limited Payability

[GN 02401.901](#) – [GN 02401.903](#)

A Department of the Treasury (DT) check has a life of only one year from its date of issue. After 12 months, checks are non-negotiable, which means these payments have "limited payability." If a check is not cashed within 12 months after issue, it does not mean the beneficiary has lost their right to the funds. SSA can recertify and issue a new payment.

Critical Cases

[RS 02801.001](#)

SSA's goal is to pay all benefits due on time. Usually this goal is met through routine processing. However, if a beneficiary is adversely affected because payment is not made timely, then our goal is to make payment as soon as possible. Some of these cases, where benefits are not paid timely, are considered critical cases. Processing critical cases has priority over any other workloads.

The FO is responsible for identifying and processing critical cases using the Critical Payment System (CPS). If a case is identified as critical, CPS is used to quickly issue due payments to the beneficiary.

There are two methods of replacing payments for a beneficiary using CPS:

- Critical Payment – the payment is sent via direct deposit or Direct Express if an account is available. The beneficiary should receive the payment within 3-4 business days. If an electronic payment option is not available, a check is issued and received by the individual in 5-7 mailing days.
- Immediate Payment (IP) – a check is issued immediately in the field office because of a dire need situation.

Definition

A critical case is:

- A case identified as a terminal illness (TERI) case, or
- A case in which the beneficiary has not received a due payment **and** they are either in dire need of the payment **or** there is a public relations problem, **or** both.

Examples of situations that, if payment is delayed, result in critical cases and require priority handling are:

- The case involves an initial claim for retirement, survivors, or disability benefits and all factors of entitlement are met;
- The case involves reinstatement of payment when payments have been suspended for a known reason which no longer applies;
- The case involves a delayed or interrupted payment stopped due to a processing error and the beneficiary had been regularly receiving payment;
- The case involves an appeal of a prior adverse determination and the determination has been reversed;
- The case involves a non-receipt of issued payment and there is a dire need.

Critical Case Exclusions

See [RS 02801.001B](#) and below for exclusions from the Critical Case Procedure:

4. Medicare problems – No Title II payment problem is involved.
NOTE: CPS may be used to refund Medicare premiums due to State Buy-In [HI 00930.001ff](#);
5. SSN problems [RM 10220.000](#);
6. Earnings discrepancy [RM 03844.006ff](#);
7. Request for explanation of benefit or overpayment amounts;

8. Request for recomputations, recalculations, and/or Delayed Retirement Credits (DRCs) and only the amount of a payment is in question [RS 00605.401](#);
9. Non-receipt of a missing payment representing only a retroactive cost-of-living increase payable to all beneficiaries, a LSDP, or an underpayment due a deceased beneficiary;
10. A conditionally adjudicated or unadjudicated claim; the claim was forwarded to the PC for final adjudication because necessary evidence was submitted with a prior claim and the claimant has not received a payment or award letter. However, if the required evidence is submitted, forward it to the PC via Transmittal of Critical Case Material (SSA-1671-U2);
11. The family maximum has been paid to a single family unit living in the same household and the beneficiary requesting payment is living in the same household as part of the same single family unit (i.e., no payment over the maximum will be paid) [GN 02603.090](#);
12. Tax Refund Offset (TRO) Refunds [GN 02201.030](#).

NOTE: [SM 00635.001E.3](#) contains additional instances when CPS is not permitted.

Immediate Payment Records

[RS 02801.010](#)

Process

Immediate payment (IP) may apply by utilizing the field office third party draft system in certain extremely critical/sensitive cases. The beneficiary must meet the criteria for a critical case and have an **immediate** need for payment (e.g., a need for food, shelter, medical treatment, etc.) which cannot be met through other resources available in the community.

In cases in which a beneficiary receives both Title II and Title XVI benefits, the IP generally pays under the title that can pay the full amount of the IP. If both can pay the full amount, the IP pays from Title II benefits due. If neither can pay the full amount, partial payments come from both titles.

Payment Amount

An IP may be the lesser of \$999 or the amount of benefits due the beneficiary.

Procedures:

[RS 02801.010 D](#)

1. Read queries to determine the status of payments and identify problems on the record;
2. Explain possibility of duplicate payment;
3. Complete CPS screens;
4. Obtain second PIN approval;
5. At input approval, CPS sends a record to the TPPS if Title II IP is involved;
6. The cashier retrieves the information by entering the TPPS Main Menu;
7. The cashier prepares the draft to the individual or representative payee.

The CSR/CS or higher initials all copies of the TPD to indicate its receipt and delivers the check to the beneficiary or representative payee and obtains the necessary signature on a specially worded SSA-795.

Time Frame for Receiving an Immediate Payment

Generally, the issuance of an IP removes the financial emergency and the person receives payment under the normal procedures. However, the FO occasionally needs to input a second IP. These situations should be extremely rare. When doing a second IP is needed within a 30-day period, all requirements must be met for each IP paid. For examples of when a second IP applies, see [RS 02801.010 B.3](#).

SSA 795/Receipt

The SSA-795 generates through the Critical Payment System when the IP is initiated. The SSA 795 should contain the following:

TPD# (Third Party Draft number): _____

"I _____ (print full name of individual or representative payee) Claim Number _____ acknowledge receipt of a Title II Immediate Payment in the amount of \$ _____. I understand that I may receive duplicate payments based on this current request for payment. I agree to repay any overpayment which may result from receiving duplicate payments."

Award the payment to the beneficiary after they sign the SSA-795. Photocopy the SSA-795 for cashier's file and file the original. Give a copy of the SSA-795 to the individual or representative payee as a receipt. Only fax, e-mail, or mail a copy of the completed SSA-795 to the appropriate PC if the PC processes the CP. Use DOORS to find the correct mailing addresses and fax numbers for the various PSCs.

Critical Case Processing Methods**[MS 07901.001](#)****CPS Input**

Always review queries to determine the status of payment before issuing payment using CPS or IP. Review the MBR, PHUS, and payment worksheet queries to determine if payment is due, the date it is due, and the correct amount of payment.

Once establishing the need for a critical payment, take action to input the CPS. For direct input instructions, see **[MS 07901ff](#)**.

Access CPS by selecting "CPS – TII Critical Payment System" on I-Main.

Help is available throughout the system by clicking on the four-letter screen name and linking to MSOM or by clicking on the various info buttons for each field.

CPHP

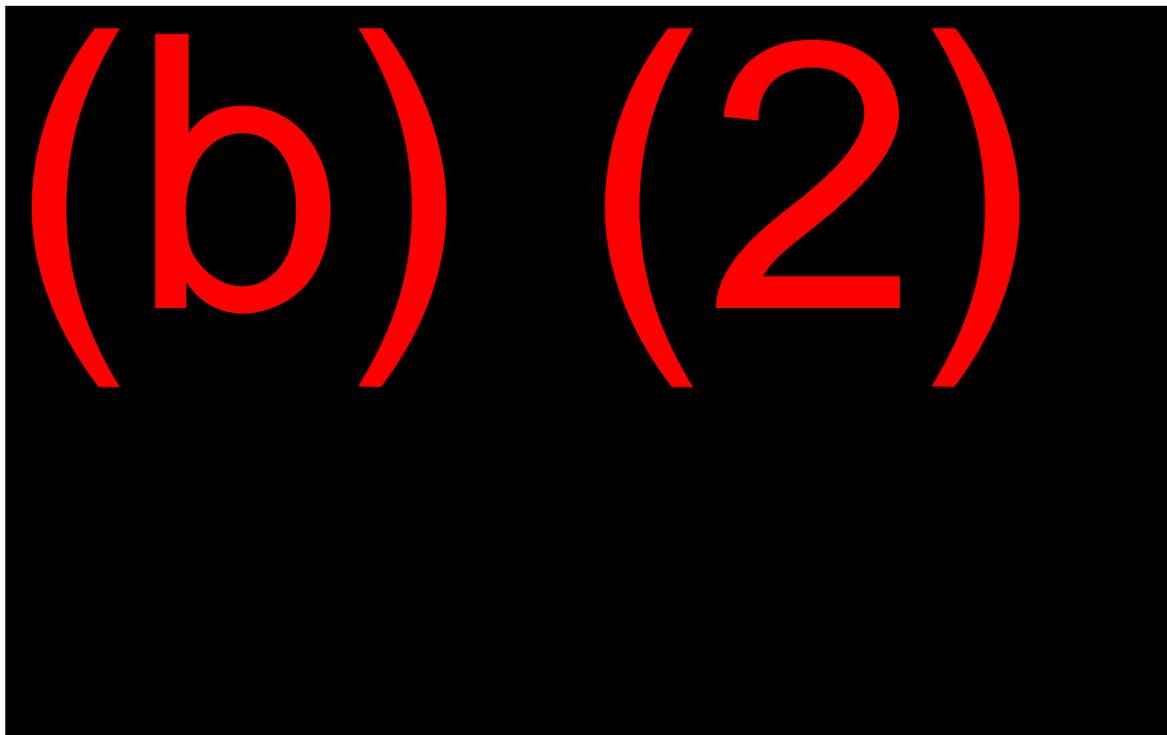
[MS 07901.002](#)

After entering your unit code, you will be taken to the Critical Pay Home Page, CPHP. Enter the beneficiary's SSN. If the Beneficiary is receiving this payment from another record, enter the NH's SSN and the beneficiary's BIC. Select Search and the Search Results will appear on the screen. Verify the information is correct, and select Initiate Payment.



CRSN

[MS 07901.004](#)



The Critical Payment Details (CRSN) web page:

- Identifies the payment reason,
- Indicates required special processing (ex: dual entitlement),
- Provides the payment Trust Fund (ex: Retirement) information,
- Explains the authorization reason,
- Provides the payment issue type (ex: non receipt of check),
- Indicates if a non-receipt and/or an overpayment is applicable, and
- Allows the user to enter pertinent instructions to the Processing Center (PC).

Based on your answers to the questions on this screen you will see one of the following screens in the path.

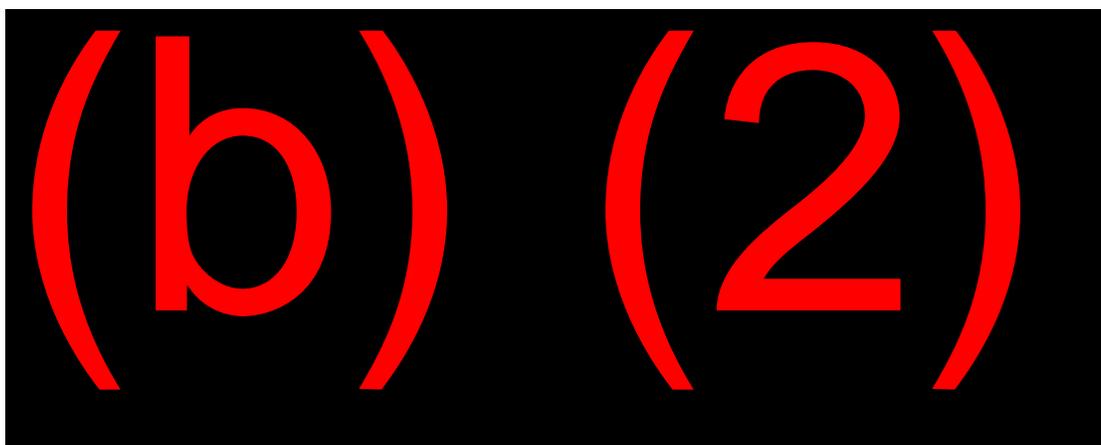
- CPNR – Critical Payment Amount Non-Receipt
- CPLS – Critical Payment Amount Lump Sum Death Payment

- CPOT – Critical Payment Amount Other Critical Payment

CPPS

[MS 07901.008](#)

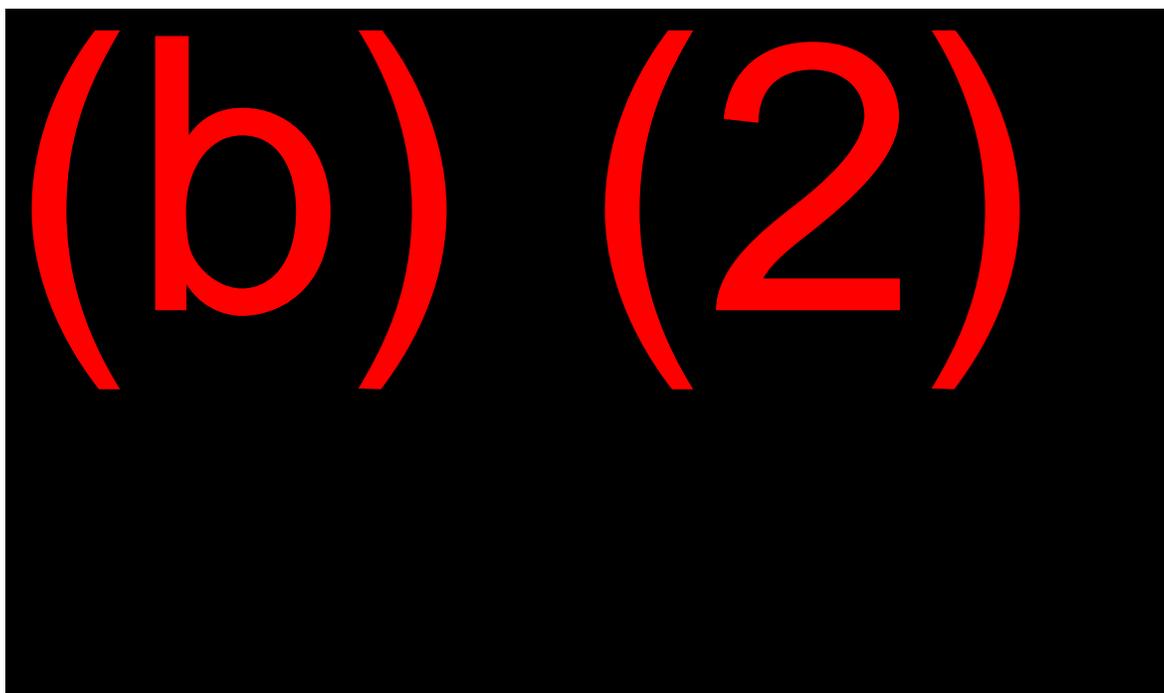
After completing one or more of the above input screens, you will be taken to the Critical Payment Schedule (CPPS) screen. This screen allows you to see the total payments that are scheduled for payment and/or override the default Immediate Payment (IP) amount.



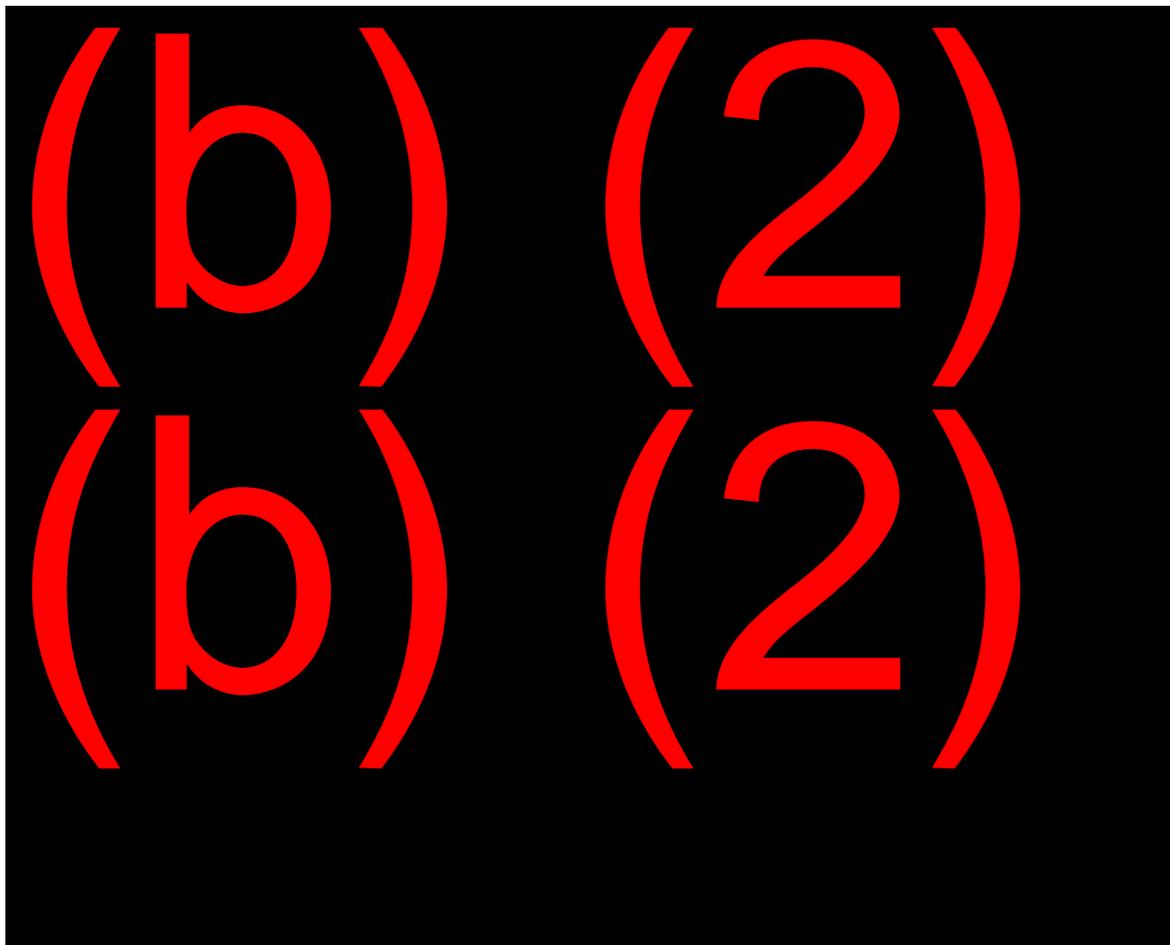
CPYE

[MS 07901.009](#)

The Critical Payment Whom to Pay (CPYE) screen will appear next in the path and gathers information on the person receiving the CPS payment, (the beneficiary or the representative payee), the payment method (Direct Deposit, Check, or Direct Express), and the Processing Center handling the CPS payment.

**CSUM****[MS 07901.011](#)**

The Critical Payment Payment Summary (CSUM) screen appears next in the path. This screen permits the user to review all pertinent data regarding the pending critical payment action. Depending on your role in the CPS process, i.e. initiator or approver, and the type of action, i.e. Critical Payment or Immediate Payment, your options on the screen will change.



CONF

[MS 07901.012](#)

The final screen in the establishment of the Critical Payment action is the Critical Payment Confirmation (CONF) screen.



Other Screens

Depending on the type of action and your role in the Critical Payment process, you may see other screens or options. For example, if you are issuing an Immediate Payment, you will receive the Critical Payment Statement of Claimant (CPSC) screen to prepare the mandatory SSA-795 for these situations.

The individual approving an Immediate Payment action will receive the Critical Payment Third Party Payment (CTPP) screen. The CTPP allows the approver to either issue a check and annotate the record or annotate the record only.

Review the appropriate MSOM references for assistance in completing these and any other screens you may encounter.

CPS Record Information

MBR Query

The STATUS line of the MBR shows whether CPS is or was involved for anyone on that record.

```

-----
STATUS MBR YES LOU-01/10 DATA FILES YES LOU-01/10
SSACCS NO CPS-YES
-----
    
```

CPS Record

The end of the MBR contains additional CPS information, either the CPS record or an informational remark.

The CPS record is established by SSN and divides into sections that show:

- Beneficiary information (BENEFICIARY);

- The current status of the CPS payment(s) (STATUS);
- Payment history (PAY HIST);
- Taxable/nontaxable payment data (TAX DATA);
- Payee name and address (PNA DATA); and
- A history of all processed transactions (TRANS).

Non-receipt of CPS Payments

If MBR/PHUS shows a CPS payment, allow seven mailing days from the system run date before inputting a non-receipt action using POS. Also, if the CPS record shows RTN/DAN information, ensure the MBR reflects the correct RTN/DAN.

NOTE: If a beneficiary alleges dire need, do not input a non-receipt through POS of the missing CPS payment. Issue an immediate payment (IP) instead. If there is no dire need for the payment, see [GN 02406.201](#) for step-by-step instructions on processing a non-receipt of a CPS payment.

OBJECTIVE 6:

Determine if proper use, improper use, or misuse of benefits is involved

Background

Representative Payee

Most of our beneficiaries are capable of managing their own financial affairs. There are some people who, because of a mental or physical impairment or because they are very young, are unable to make sound judgment about how their benefits should be used. When we determine an individual is unable to manage their own financial affairs, our policies are designed to select the most qualified person, or in some cases, institution, to act on their behalf. Once we have made our selection, the individual, or institution is referred to as the "representative payee" or "payee." The type of payment received by this payee is called "representative payment."

The decision to make payment through a representative payee is a serious one since it removes the beneficiary from direct control over their finances and may affect their manner of living.

Beginning 11/19/05, changes were made to the Representative Payee System (RPS) to allow the expansion of signature proxy on representative payee applications. Representative payee applications that can't be processed through eRPS will still require completion of a signed paper SSA-11.

Payee Responsibility

[GN 00502.114](#)

The representative payee is required to use the benefits in the beneficiary's best interest. When filing as representative payee, the individual/ institution is agreeing to perform payee duties in compliance with Social Security Administration regulations. Regulations require a

payee disburse benefits for the use and benefit of the beneficiary. The payee must know how all benefits received are used.

Payee Accounting

[GN 00605.001](#)

Policy

To ensure a payee's compliance with these regulations, a payee accounting is obtained every year. This accounting report will show whether the payee is managing the funds correctly. When a payee misuses the funds, a change of payee usually is required. A change of payee may also be needed if custody changes, a change of address of either payee or beneficiary occurs, or if the payee dies, becomes incapable, or no longer wishes to serve as the beneficiary's payee.

Online reporting is available only to those payees who receive an accounting form in the mail. Information from the paper accounting form must be entered during the online reporting process. Payees should NOT complete both an online and a paper report.

Occasionally a payee brings or mails the accounting form to the field office. If you are reviewing or completing an accounting form, be alert to any issues requiring additional development.

Exemptions to Payee Accounting

Public Law 115-165 amended the Social Security Act to exempt certain payees from the accounting requirement. Effective 06/22/18, SSA will no longer mail accounting forms to these payees:

- A natural/adoptive parent of a minor child who primarily resides in the same household as the beneficiary;
- A legal guardian of a minor child who primarily resides in the same household as the beneficiary;
- A natural/adoptive parent of a disabled individual who primarily resides in the same household as the beneficiary; or

- The spouse of an individual entitled to Title II benefits and/or eligible for Title XVI payments. [EM 18023 REV 2](#)

Note: The spouse of the beneficiary does not need to primarily reside in the same household to be exempt from the accounting requirement. For example, the beneficiary may reside in a nursing facility while the payee spouse resides at a different address.

Final Accounting

[GN 00605.245](#); [GN 00605.250](#)

When Required

When a payee's appointment terminates, it is the FO's responsibility to obtain a final accounting if the payee served for 11 months or fewer. Use Form SSA-623-F3 and tell the payee to return any conserved funds with the final accounting. [GN 00605.250](#)

When Not Required

No final accounting is required if the DOS (Date of Selection) field on the MBR is 12 months or more from the month of input of payee change. However, the FO should ask the former payee if there are conserved funds. If there are, the FO notifies PC of the appropriate notice to send to the former payee requesting the return of conserved funds. The PC is responsible for releasing the notice and preparing a diary for the return of any conserved funds.

Payees exempt from annual accounting based on certain relationship criteria (above) are also exempt from final accounting procedures. [EM 18023 REV 2](#)

Proper Use of Benefits

[GN 00602.001](#); [GN 00603.000ff](#)

Social Security benefits should be used for current needs such as food, clothing, shelter, medical care, and personal comfort items, or reasonable foreseeable needs. If the benefits are not needed for these purposes, they may be used for the support of the beneficiary's legally dependent spouse, child, and/or parent(s) (Title II only).

The benefits must be used, conserved, or invested, at minimal risk, on behalf of the beneficiary (e.g. U.S. Savings Bonds).

Benefits should be held in properly titled accounts, not mixed with the payee's own money. [GN 00603.001](#)

Improper Use of Benefits

[GN 00602.130](#)

Improper use of benefits occurs when a representative payee uses the benefits for the beneficiary, but not in the best interest of the beneficiary.

Example 1:

The representative payee buys a television for the beneficiary rather than paying the beneficiary's rent.

Example 2:

The representative payee buys a large amount of clothing for a sick beneficiary but then has no funds to purchase medicine.

Discuss the applicable regulations with the payee. If the payee is unable or unwilling to change practices, develop for a new payee. If the payee agrees to correct their practices, follow up twice at 3-month intervals to be sure proper use continues. Do not request restitution.

Misuse of Benefits

[GN 00604.001](#)

Misuse of benefits occurs when the payee does not use benefits for current or foreseeable needs of the beneficiary nor conserves remaining

benefits for the future needs of the beneficiary. **Take every allegation of misuse of benefits seriously** and investigate, develop, document, and make a determination whether misuse occurred.

Agency Responsibility

SSA fully investigates and develops every allegation of misuse. We document all relevant information about misuse allegations in the Electronic Representative Payee System (eRPS) Misuse system.

Electronic Representative Payee System-Misuse (eRPS Misuse)

[MS 07403.001 –.002](#)

Use the web-based Electronic Representative Payee misuse system (eRPS) for cases involving misuse. The eRPS provides a means to create, develop, track, and store misuse allegations beginning with the first report up to recovery activities. Access the eRPS misuse system via IMAIN by selecting the link “Electronic Rep Payee System (eRPS)”.

Field Office Responsibility

A claims specialist (CS) or higher makes all formal misuse determinations documenting the facts of each case and the decision whether benefits were misused ([GN 00501.015 A.1](#)). A second CS or higher reviews and approves every formal misuse determination as outlined in [GN 00604.035](#).

When you find a payee misused benefits, refer the case to OIG for possible investigation, criminal prosecution, and/or civil monetary penalties.

For Title II only cases, the FO requests the PSC to reissue/repay the beneficiary and recover the misused benefits from the payee, if applicable. [GN 00604.062](#)

For more information on component responsibilities, refer to [GN 00604.010](#).

Misuse Process Overview [GN 00604.005](#)

- Investigate and develop misuse case [GN 00604.020](#);

- Prepare misuse determination [GN 00604.030](#);
- Take corrective actions [GN 00604.045](#); and
- Send notices [GN 00604.005 B.4](#).

Procedure for investigating and developing misuse allegations [GN 00604.020 C](#)

Allegations or information raising a suspicion of misuse may take various forms and come from many sources, including: the beneficiary, the current representative payee applicant, a third party, information discovered by SSA, adverse media reports, and even an anonymous tip. SSA's thorough and timely action on suspected misuse cases minimizes losses and increases the likelihood of full recovery of misused funds.

In the eRPS Misuse system, immediately document what initiated the allegation and all available information about the reporter, the beneficiary, and the representative payee. Provide as many details as possible on the allegation including: the type of complaint, the period of the misuse, the amount of funds and the number of beneficiaries involved. To properly investigate the allegation:

1. **Contact the complainant** - find out why he or she believes the payee misused the benefits.
 - Fully develop the details and scope
 - Obtain any evidence
 - Do not release information about the misuse case to the complainant without obtaining proper consent per [GN 03305.001](#).
 - Document the results in the eRPS Misuse system using the Report of Contact screen in [MS 07405.016](#).
2. **Review representative payee information** - e.g., documentation in eRPS, the payee application, annual accounting reports, redeterminations (if SSI is involved), and amount of benefits paid during the period of alleged misuse.
3. **Contact the payee** - by phone to discuss the misuse allegation(s) and SSA's responsibility to ensure the payee is properly using benefits.
CAUTION: do not reveal the complainant's identity to the payee.

4. **Contact others** - If evidence is not conclusive, contact other individuals or agencies who may be able to furnish information.
5. **Payee Whereabouts Unknown** - If the former payee no longer resides at the last known address, use the usual channels (post office, financial institution verification, relatives, employer, etc.) to try to locate a better address. See skiptracing in [GN 02210.213](#).

If you cannot locate the former payee and:

- **Evidence is inconclusive**, document your development on a SSA-553 (Special Determination) using the “Create 553” screen in the eRPS Misuse system by following the instructions in [MS 07405.014](#). Fax the SSA-553 into the appropriate electronic folder per [GN 00604.035C](#). Refer the case to OIG.
- **Evidence is conclusive**, prepare and process a misuse determination on the “Create 553” screen in the eRPS Misuse system as described in [MS 07405.014](#). Follow the instructions in Preparing a Misuse Determination [GN 00604.030](#) or Processing Misuse Determinations [GN 00604.035](#).

Preparing Misuse Determination [GN 00604.030](#)

The determination consists of the following four parts prepared on a SSA-553 in eRPS:

- Identification;
- Narrative (Issues, Facts, Determination);
- Authority;
- Signatures (requires two signatures).

Processing Misuse Determinations [GN 00604.035](#)

Once the decision has been documented on the SSA-553, how you process a misuse determination depends on your findings:

- **If No Misuse is Found** [GN 00604.040](#) - Generally, the only action necessary when SSA determines misuse did not occur is to notify the beneficiary and their payee of our decision.
- **If Misuse is Established** [GN00604.045](#) - If the evidence establishes misuse has occurred, you must immediately refer the case to OIG. You must have a response from OIG before starting recovery efforts or sending any notices.

Referral to OIG [GN 00604.015](#)

A finding of misuse may indicate a criminal violation. You must refer all cases where misuse is found to the Office of Inspector General (OIG) for violations development of the Social Security Act.

Before you send the case to OIG, you must complete:

1. Your misuse development,
2. Your misuse determination using the Create 553 screen in eRPS, and
3. The Misused Funds Worksheet screen documenting the misuse period and the amount of misused funds for all beneficiaries associated with the case.

Once these actions are taken, you will send the referral to OIG by using the eRPS Misuse version of the SSA-8551 on the Refer to OIG screen in eRPS. Instructions for completing this screen are in [GN 00604.015 B](#) and additional information is in [MS 07406.010](#).

In rare situations, you may refer a case to the Office of Inspector General (OIG) before completing all of the steps required for a formal misuse determination, depending on the circumstances. Immediately consult with FO management and contact your regional office (RO) for guidance whenever you encounter a misuse case which involves a large number of beneficiaries or when the payee is uncooperative.

Keep in mind, OIG and Department of Justice (DOJ) may use the facts of the case in a court of law.

Misuse of Benefits Found [GN 00604.045](#)

As previously stated, after you determine misuse occurred, immediately refer the case to OIG. Some of the following steps cannot be taken until you have permission from OIG.

- Change Payee for all beneficiaries the misuser payee serves– no longer suitable to act as payee;
- Develop for additional misuse cases – if payee currently serves or has served other beneficiaries in the past;
- Prepare Negligence determination - when an individual payee serving 14 or fewer beneficiaries misuses benefits, SSA makes a formal negligence determination. An individual who was not previously involved in any payee aspect of the case must make this determination. [GN 00604.050](#)

IMPORTANT: Do not send the negligence notice until OIG notifies you it is appropriate to do so and the 15-day protest period has expired.

- Send notices when misuse occurred – to both the former payee and the new payee (and/or beneficiary);

IMPORTANT: Do not send any notices until you are notified by OIG it is appropriate to do so.

- Establish 15-day diary to control for possible repayment or proof that benefits were not misused;
- Input misuse data to RPS (RMIS screen);

NOTE: this action should happen automatically based on your actions in eRPS, but you can manually code the information as well.

- Establish misused funds/overpayment on Title II cases;
- Send the overpayment notice following the instructions in [GN 00604.045 B.13](#);
- Send the negligence determination notice;

- Reissue and repay misused funds to the beneficiary following the instructions in [GN 00604.062 - .063](#).

Preparing a Negligence Determination [GN 00604.051](#)

Prepare this determination on a separate SSA-553, Special Determination, using the “Create 553” tab from the Misuse Development screen in the eRPS Misuse system. A negligence determination consists of six parts:

- Identification;
- Issue;
- Facts;
- Determination;
- Signature; and
- Signature of second reviewer.

Prepare an individual negligence determination for each affected beneficiary.

Reminder: An individual who was not previously involved in any payee aspect of the case must make this determination. [GN 00604.050](#)

Restitution of Misused Benefits [GN 00604.060](#)

The restitution process depends on whether there is negligence and how many beneficiaries the payee serves. Please see POMS for the process based on your case characteristics.

EXHIBIT 1: MDW DO'S AND DON'TS

FIELD	DOs	DON'Ts
SSN	Enter SSN on which payment is made	Do not enter BOAN unless you must send multiple requests at the same time
UNIT	*Show NEW if sending to another office *Show your UNIT if retaining jurisdiction	Do not leave the old unit information in this field
ID	Enter BIC or SSI ID	
FO	*If sending to another office, over-key with the FO/PC code *If retaining jurisdiction leave your office code	Do not send to a DDS, OHA, RRB, or TSC; never send a REPLY back to a TSC or SPIKE
XREF SSN	Show any cross-reference number involved	
NAME & ADDRESS	An entry must be made in Claimant Name	Do not show "See MBR" or "See SSR"
MISC	Indicate if a reply is needed and show any pertinent information regarding the issue	
ISSUE	Be as descriptive as possible	
CATEGORY	*If sending to PCs, use only 2560, 2560HP, or 2560AT *If sending to FOs, use only ADM *Press F1 or see MS 03901.003 for correct coding if you are retaining jurisdiction	*Do not use any other categories when using the MDW to communicate with another office *Other categories may be used for In-Office Controlled Workloads
REQUEST	Show the current date or leave blank	
F/UP	Check the PCACS for pending actions	Do not use when sending to a PC
TICKLE	ALWAYS show the next day when sending to another FO or PC	

FIELD	DOs	DON'Ts
RECEIVED	When all ISSUES have a received date, the MDW will drop off after 120 days from the latest date. All Xs in this field will cause the MDW to remain open indefinitely. Use this procedure sparingly.	
REMARK	Enter "Y" when you need to complete the REMARKS screen	
DELETE	Use when you create an erroneous MDW	Unless you are the author, never delete unless authorized by management
REMARKS	<ul style="list-style-type: none"> *Always show your name and office/unit information *Show your phone # if you may need to be contacted to resolve the issue *Give as thorough an explanation as possible, and actions needed *If a reply back is needed, you must say so *If changing the FO code, annotate "Return Ownership to FO Code ____" using the old code; Also show the previous UNIT 	<ul style="list-style-type: none"> *Do not use jargon or abbreviations which may not be known to other users (not just the intended recipient) * Do not provide return phone numbers if you are a TSR/SPIKE * Do not be impolite * Never send a REPLY back to a TSC or SPIKE
ENTER	Double check your entries before you press ENTER	
OTHER	*Use PF1 for Help Screens and for step by step instructions	

EXHIBIT 2: THE PHU1 QUERY

PHU1 DTE:12/09/XX SSN:XXX-XX-XXXX DOC:R07 UNIT:EC PG: 001+
 STATUS MBR YES PHUS YES LOU-12/XX DATA FILES NO LOU-12/XX
 SSACCS NO LOU-12/XX

ACCOUNT PCOC-6 NOB-01 BICS-A

PERSON BIC-A NAME-BETHANY R JONES BOAN- XXX-XX-XXXX
 MBR FDS DOC-734 RTN-000000000 BDCD-11/14/XX
 PAYEE- BETHANY R JONES
 ADDRESS- 7777 SUNSHINE DRIVE
 ANYWHERE MO 12345-6789

LAF-C NAME-BETHANY R JONES DOB-XX/XX/19XX DOEC-10/XX
 BENE ENT-START-10/XX ABN-3GKZ DOEI-10/XX SMI START-01/XX
 MBC-\$641.90 PCI-2
 INDCTR RETURN TO MBR-06/XX
 PNAD BETHANY R JONES 7777 SUNSHINE DRIVE
 ANYWHERE MO 12345-6789
 +++BIC-A TY-XX+++
 MBR PMT EVNT-014 RECUR PMT AMT-\$ 523.00 ETD-01/XX THRU 12/XX (12)

PHU1 DTE:12/09/XX SSN: XXX-XX-XXXX DOC:R07 UNIT:EC PG: 002+
 HSA-\$ 96.50
 STM TOT BENEFITS FOR 20XX-\$ 7434.00 (BOX 3)
 ADD: DIRECT PAY-----\$ 6276.00
 MEDICARE PART B-\$ 1158.00
 TOTAL ADDITIONS-\$ 7434.00

BENEFITS REPAID TO SSA IN 20XX-\$ 0.00 (BOX 4)

+++NET BENEFITS FOR 20XX-\$ 7434.00
 +++ (BOX 5=BOX 3 MINUS BOX 4)
 +++BIC-A TY-XX+++
 MBR PMT EVNT-014 RECUR PMT AMT-\$ 523.00 ETD-01/XX THRU 12/XX (12)
 HSA-\$ 96.50
 STM TOT BENEFITS FOR 20XX-\$ 7434.00 (BOX 3)
 ADD: DIRECT PAY-----\$ 6276.00
 MEDICARE PART B-\$ 1158.00
 TOTAL ADDITIONS-\$ 7434.00

BENEFITS REPAID TO SSA IN 20XX-\$ 0.00 (BOX 4)

+++NET BENEFITS FOR 20XX-\$ 7434.00

OFF-AIR ACTIVITIES

1. Check with the CSRs in the office to see if there are any PE actions, which the student may be unfamiliar with, to input. Actions such as requests for address change, direct deposit, request for Medicare cards, etc.
2. If unfamiliar with the CSR position, have the student sit with a CSR to observe post-entitlement interviews in the office and by phone. When the student is ready, have them conduct some interviews and do any necessary inputs.
3. The student should review the intranet website available on SFNet, which discusses checks, non-receipts, and check-related post-entitlement issues. The page is located at: (b) (2)(b) (2)(b) (2)(b) (2)(b) (2)
4. The student should sit in on several interviews involving CPS and/or IP payment situations. Have the student, with assistance from the mentor, do the systems input.
5. Under the guidance of the mentor, work the tickle lists for several MDW and/or PCACS items.
6. View the VODs for eRPS and CPS on the Lesson Information page.
7. Review a pending misuse case in eRPS and assist the CS assigned to the case with pending development issues.

EXERCISE #1

OBJECTIVE: Apply the concept of due process and determine the proper action necessary after receipt of a report.

Determine if the following are first party or third party reports. Remember an incomplete first party report processes as if it was a third party report.

1. Report #1

Dear Sirs,

My 17-year old stepson ran away last year. I just heard from his girlfriend's mother they got married on March 10 this year. I thought I'd better let you know since I heard he shouldn't get any more checks if he's married. Please let me know if there's anything else I can do for you.

Yours Truly,

Martha N. Parker

P.S.

Does this mean my kids and I get more money?

2. Report #2

To Whom It May Concern,

Jack Adams has been working for me for 10 months now. Someone recently told me he's getting disability checks. I don't want to get into trouble with the government for hiring somebody who is getting disability. Could you please check and let me know? His Social Security number is xxx-xx-xxxx and he lives at 222 Oak Street.

Thank You,

Joe Small

3. Report #3

Dear Social Security,

Hello, my name is Susan Green. My husband is at work and unable to call. He asked me to write to you with our new address. His name is Richard Green, and his Social Security number is 555-55-5555 and his date of birth is 5/19/xx. I also receive benefits on his record. Our new address is 123 Sycamore Street. Our new phone number is (206) 123-4567.

Sincerely,

Susan Green

Richard Green

4. Report #4

Dear Social Security,

My mother, Emma White, is receiving widow's benefits on my father's Social Security. His name is Bill White and his Social Security number is 999-99-9999. Mother got married on the 10th of this month to George Meyers. George's number is 888-88-8888, and he receives Social Security, too. Mother's number is 777-77-7777. Mother asked me to let you know since she'll be on her honeymoon for a few months. Their new address is 455 3rd St. Telephone number is: (555) 765-4321.

Sincerely Yours,

Jane Anderson

SSN: 666-66-6666

Address: 222 1st Street

Phone: (555) 123-4567

5. Report #5

Dear Sirs,

Tom Johnson is working and getting Social Security checks at the same time. He works at Phil's gas station at the junction of Rt. 15 and TT Hwy. He's been bragging about how he's getting disability, working, and getting all this money and I think you should put a stop to it.

I can't give you my name because I'm afraid he'll try to get back at me if he finds out I told you. He lives at 509 N. Main Street in Junction City in those apartments over the drugstore, but I bet he won't admit it if you ask him about the job. He's usually at the gas station in the afternoons. You should send somebody out there to catch him in the act. He gets paid in cash so Social Security won't know he's working.

It's not right that he should get away with this. It's like stealing. Please check this out and stop his checks.

Sincerely,

A Taxpayer

EXERCISE #2

OBJECTIVE: Identify acceptable requests for direct deposit and Direct Express; Determine when a PE action will affect payment and how to make Title II PE direct inputs

1. John Smith, payee for his three children who live at home, requests direct deposit for the payments to be sent to a checking account entitled "John Smith." He uses all of the benefits each month. Will you process his request? Explain your answer.
2. Wendy Rodriguez receives her benefits on payment cycle 3. She called on 09/10/18 to report she has a new bank account. What will you tell Wendy regarding her upcoming payment(s)?
3. Jack Vlastic receives his benefits on payment cycle 2. Today is 08/28/18. He has an overpayment on his record and called today to request partial withholding of \$350 per month. When will the withholding begin?

EXERCISE #3

OBJECTIVE: Identify and properly process critical case situations.

1. Mike Jimenez comes to the FO on January 18. He is in dire need because he never received the January 3rd payment, which was input as missing on May 8th, and he cannot purchase his medication. Review of the MBR and PHUS shows the report posted, but no replacement check has been issued. What action can the FO take? Explain your answer.
2. Evelyn Phuong comes to the FO on February 19th stating she never received her payment on February 13th. Which queries will you review to determine if you need to do a non-receipt input, process a critical case action, or take no action?

EXERCISE #4

OBJECTIVE: Determine if proper use, improper use, or misuse of benefits is involved.

Label the following situations: proper use, improper use, or misuse.

1. Mr. Smythe is payee for his aged mother. He keeps detailed records of her finances. Since SSA requires periodic accounting, Mr. Smythe pays himself \$10 per month from his mother's SSA benefits as a service fee.
2. The beneficiary is confined in a nursing home. His basic needs such as his care and maintenance expenses are paid. The payee uses SSA funds to purchase a television for the beneficiary.
3. Edward Booker is Daniel Tran's payee. Mr. Booker deposits his paycheck and Daniel's SSA check in the same checking account. The account title reads Edward Booker.
4. Mr. Wilcox is payee for his nephew. He uses some of his nephew's SSA benefits to purchase a bicycle for his own son.
5. You believe Mr. Wilcox (from the previous question) is likely misusing his nephew's benefits. List some additional evidence you may need to gather before you can make a determination on misuse.
6. Based on the evidence gathered, you determine Mr. Wilcox did misuse the benefits for his nephew. Complete an SSA-553 documenting your determination. You can make up the facts of the case. Because there is no eRPS Training Region, you will need to use a paper SSA-553 for your determination.

EXERCISE ANSWERS

Exercise #1

1. Third party report: there is no indication Martha is acting on her stepson's behalf and there is not enough information for us to process an action.
2. Third party report: there is no indication Joe is reporting on Jack's behalf. We would want to verify that Jack Adams is receiving disability benefits. If so, then we would want to see if work has been reported.
3. Acceptable first party report: Susan is a relative reporting at the request of the beneficiary and has supplied enough information about him and herself for us to take immediate action. This is a situation where you should use your best judgment to determine whether or not to change the address. If you are uncertain of whether or not to make the change, err on the side of caution.
4. Third party report: Jane is a relative reporting enough information about Emma and herself for us to identify them but we do not know that Jane is reporting on Emma's behalf. In this situation, use your best judgment in determining whether to change the address. If you are uncertain of whether to make the change, err on the side of caution. Tell Jane that Emma can call the 1-800 telephone number between the hours of 7 a.m. and 7 p.m. to make the change or change the address through her *my* Social Security account at any time.
5. Third party report: the taxpayer is not acting on behalf of the beneficiary and has not supplied us with enough information to take action. We would refer this information to OIG for further investigation.

Exercise #2

1. Yes. The account does not need to show beneficiary's ownership if all the conditions for the exception apply. [GN 02402.055](#)
2. Wendy's report is too late to make the cutoff for the payment she will receive on 09/12/18. Tell Wendy we will make the change, but she should keep her old bank account open until she receives her first payment in the new bank account. She should expect to receive payment in the new bank account in October. [GN 02407.010](#)

3. Withholding will begin with the September benefit, the payment Jack receives in October 2018. He called to request partial withholding after the end of the August COM (08/23/18). Therefore, even though his report is prior to the cutoff date for the Cycle 2 inputs, the partial withholding will not begin until the payment for September received in October. Inputs made during the window period cannot change the payment amount for the prior COM. [GN 02407.010 B.3.b](#)

Exercise #3

1. If in the judgment of FO management, Mr. Jimenez is in fact, in dire need, the critical case criteria are met. Management might authorize:
 - a. Replacing the missing check through the critical payment system (CPS),

OR

 - b. Issue an immediate payment (IP) through the third party draft system if the need is especially severe with any remaining amount due issued by CPS. Mr. Jimenez should be cautioned about the possibility of an overpayment if he receives and cashes duplicate payments.
2. Take the following steps to determine the action to take on Ms. Phuong's record.
 - You should review the MBR to determine if a payment was due and where it was sent (e.g. mailed paper check, Direct Deposit, or Direct Express).
 - Then look at the PHUS (or QRSL) to determine if our records show a payment was actually issued.
 - If the above records indicate a payment should have been made, then you can review the Treasury Check Information System (TCIS) to determine when and where Treasury sent the payment.
 - If the payment was sent via Direct Deposit or Direct Express, verify with the financial institution (FI) the payment was received in the correct account.
 - If the FI states they did not receive the payment or the payment was returned, then take action to input a non-receipt or process a critical case if the requirements are met.

Exercise #4

1. Improper use [GN 00602.130](#); [GN 00602.110](#)
2. Proper use of funds [GN 00602.010](#)
3. Improper use of funds [GN 00602.130](#)
4. Misuse of funds [GN 00604.010](#)
5. The following is a list of documentation you may need to obtain before making a misuse determination. This list is not necessarily all-inclusive:
 - Contact the complainant to find out why they believe the payee misused the benefits and the period involved.
 - Review representative payee information, e.g. eRPS, the payee application, annual accounting reports, and amount of benefits paid during the period.
 - Contact the payee to discuss the misuse allegation and obtain an accounting report or other signed statement regarding how the benefits were used. Also, request supporting evidence (e.g. receipts, cancelled checks, financial records, bank statements, etc.) for all benefits paid and used.
 - Contact other individuals if the evidence previously gathered is not conclusive.
6. Follow [GN 00604.030](#) for instructions on completing the SSA-553.

AS WE REDESIGN ENTRY-LEVEL TRAINING, WE ARE ELIMINATING THE NEED FOR PAPER COURSE MATERIALS. THE MATERIAL PREVIOUSLY TAUGHT FOR THIS MODULE HAS BEEN CONVERTED TO ONLINE CONTENT. ALL NECESSARY INFORMATION IS EMBEDDED WITHIN THE ONLINE OBJECTIVES. THEREFORE, THERE ARE NO CORRESPONDING PAPER MATERIALS. PLEASE VISIT THE [\(b\) \(2\)\(b\) \(2\)\(b\) \(2\)\(b\) \(2\)\(b\) \(2\)\(b\) \(2\)\(b\) \(2\)](#) TO FIND MORE INFORMATION CONCERNING THIS TOPIC.

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LESSON PLAN

Chapter Objectives

At the completion of this chapter, the students will be able to:

1. Determine what is an overpayment, how overpayments are computed, and the proper actions to minimize overpayments.
2. Determine who is liable for recovery of an overpayment.
3. Determine the appropriate actions regarding overpayment notices.
4. Determine the proper method of recovery of an overpayment.
5. Determine the proper actions when a claimant disagrees with the overpayment.
6. Read and interpret the overpayment queries and Debt Management System-DMS.
7. Determine if an underpayment exists, who should receive an underpayment, and the proper disposal of an underpayment.

Length of Chapter

14 hours

Local Supply

SSA-409, Post-adjudicative Routing

SSA-561-U2, Request for Reconsideration

SSA-632-BK, Request for Waiver of Overpayment Recovery

SSA-632-SUP, Recovery Interview Supplement

SSA-635, Waiver Determination

SSA-1724-F4, Claim for Amounts Due in the Case of a Deceased Beneficiary

AACT showing a ROAR

Original O/P letters received by beneficiaries or letters readable online via ORS and corresponding MBR AND PHUS

Pamphlets:

“How Work Affects Your Benefits” (05-10069)

“Retirement Benefits” (05-10035)

“What You Need to Know When You Get Retirement or Survivor Benefits”(05-10077)

“Disability Benefits” (05-10029)

“What You Need To Know When You Get Social Security Disability Benefits” (05-10153)

BACKGROUND AND RATIONALE

Overpayments/Underpayments

An overpayment is the total amount an individual receives for any period that exceeds the amount which should be paid. An underpayment is an unpaid benefit amount for which no payment has been made or an un-negotiated check(s) due a deceased individual.

One of SSA's basic policies is to pay beneficiaries their correct benefits promptly. Prevention of overpayments and underpayments is one of our agency's primary goals. When overpayments and underpayments cannot be prevented, the next steps are detection and resolution.

Prevention

Debt prevention is an important factor in overpayments. Beneficiaries do not want to be overpaid. Repayment of the overpayment is often required at a time when the beneficiary can least afford it. Some overpayments may be impossible to prevent, but most can at least be minimized.

Detection

When an overpayment occurs, identify and resolve it as quickly as possible. Overpayment detection is largely a function of the program service center (PSC). Once an overpayment is discovered, a notice is sent to the person(s) with liability for the overpayment.

Resolution

Overpayments must be resolved in accordance with laws, regulations, and procedures. They are to be collected through compromise, waiver, or administrative write-off. Overpayment resolution should be efficient, timely, and persistent. Collection efforts should correspond to the circumstances of the debtor and the amount of the debt. The emphasis of SSA's responsibilities in debt management is on recovery after offering the beneficiary legally mandatory due process. Due process gives the beneficiary the opportunity to protest recovery of the overpayment. Overpayments represent improper expenditures of

trust fund or tax monies. Recover these whenever appropriate and possible. However, if the liable individual is without fault in causing the overpayment AND recovery of the overpaid amount would cause financial hardship or be inequitable, repayment may be waived.

Underpayments

It is important to determine who to pay the underpayment. Frequently, the beneficiary is deceased before it is recognized that an underpayment exists. Because of this, there is a prescribed order of priority to determine who should receive these underpayments.

Your Responsibility

Overpayments and underpayments are post-entitlement issues. A large part of the SSA employee's job is to explain why an individual is overpaid and how the individual can protest the recovery of or repay the overpayment. It is very important for the individual to know why the overpayment occurred and you have the responsibility of providing an understandable and comprehensive explanation. Keeping this in mind, the purpose of this module is to:

- Provide you with the skills necessary to prevent or minimize overpayments and underpayments
- Determine how overpayments occur
- Identify the individual(s) liable for recovery action or the individual eligible to be paid, and
- Take the appropriate action in each case

SSA employees also have responsibility for interacting with the processing service centers (PSC), to resolve RECOOP (Recovery and Collection of Overpayment Process) problems, and to respond to PC requests.

OBJECTIVE 1:

Determine what is an overpayment, how overpayments are computed, and the proper actions to minimize overpayments.

Overpayments

[GN 02201.001](#)

Definition

SSA defines an overpayment as the amount of benefits an individual receives, for any period, which exceeds the total amount that should be paid for the particular period. The overpaid amount is a legal debt owed to the United States Government.

Overpayment Causes

The majority of Title II overpayments occur when beneficiaries do not report events that cause suspension or termination of benefits. For this reason, you should always explain and give a copy of the reporting responsibilities to each claimant.

Overpayments occur when beneficiaries do not report:

- Earnings in excess of the annual earnings test,
- Termination of full-time school attendance (students),
- Marriage or divorce causing termination,
- Receipt of, or changes in, workers' compensation payments,
- Mother or father no longer has a child-in-care,

- Return to work.

Other causes of overpayments occur within the agency, and they include:

- Incorrect computations, and
- Untimely processing of DIB cessation cases.

Your Role

You must understand the procedures involved in the overpayment process so you can explain the overpayment to the beneficiary and/or identify errors in the process.

The Program Service Center (PSC) is primarily responsible of determining the existence of a Title II overpayment, the amount of the overpayment, and the person(s) who is liable for repayment of the overpayment.

Overpayment Example

Many overpayments occur when a beneficiary's earnings are higher than he/she estimated. See the example below of an overpayment resulting from under-estimated earnings.

EXAMPLE:

Benny Fishary was 63 years old in January of 2018 and this was his MOE. He estimated he would earn \$33,720 in 2018. The MBA is \$1,000 a month. The earnings limit in 2018 for beneficiaries under FRA was \$17,040. Based on the estimate, we withheld all checks for January through September and he was due full benefits for October through December.

When this beneficiary filed an annual report in March 2019, he reported earnings of \$36,720 (\$3,000 more than estimated).

Estimate

\$33,720	2018 estimate
<u>-17,040</u>	2018 allowable amount
\$16,680 divided by 2 = \$8,340 excess earnings	

\$ 8,340/\$1,000 = 8.34 benefit checks withheld.

We do not pay partial checks based on estimates. Once the actual earnings are known at the end of the year, a partial monthly benefit will be paid, if due.
([RS 02501.110](#))

We withheld 9 checks and we paid 3 checks (3 x \$1,000) = \$3,000

Actual

\$ 36,720	2018 earnings
<u>- 17,040</u>	2018 allowable amount
	19,680 divided by 2 = \$9,840 excess earnings

\$ 12,000	potentially payable in 2018; (\$1000 (MBA) X 12 Months)
<u>-\$9,840</u>	excess earnings
	\$2,160 actually payable

NH was paid	\$3,000
NH was due	<u>\$2,160</u>
Overpayment	\$840

NOTE: Any suspension or termination event not timely reported or processed can also create an overpayment.

Examples of what is considered an O/P

Listed below are examples of what is an overpayment.

EXAMPLE 1:

Sam Jenkins passes away on September 15th. His brother, Gary, is his representative payee. On October 3rd, Gary receives Sam's SSA Retirement check for the month of September and uses it to pay for funeral expenses. Even though he uses the monies on Sam's behalf, we consider the check an overpayment because Sam is not alive throughout the month of September. Therefore, the check is not due. See [GN 02201.001D](#) for examples of what SSA considers overpayments.

EXAMPLE 2:

Mr. Drummond reports non-receipt of the June check. A duplicate check is issued and cashed. In August, he finds and cashes the original June check. The check amount is an overpayment subject to recovery. See [GN](#)

[02250.024B.2](#) for an explanation of at fault criteria when a person receives a Courtesy Disbursement or Substitute Check.

Examples of what is not considered an O/P

Incorrect payments are different from overpayments. We provide individuals with an overpayment, the right to a waiver or an appeal, while individuals with incorrect payments, do not receive the same rights. See below for examples along with [GN 02201.001F](#) for a list of incorrect payment situations.

Forgery Example

Jerome's July Social Security check is stolen from his mailbox. Jerome reports he has not received the check. Daniel steals the check, forges Jerome's signature, and cashes the check. This check is not an overpayment to Jerome, but rather an incorrect payment, subject to Treasury Department reclamation.

Current year work estimate Example

Humberto receives Retirement benefits. In April, he reports he returned to work and estimates earnings above the annual earnings limit. Based on his estimate, we should not have paid him benefits for January or February. However, we consider this an incorrect payment because we are able to recover the incorrect payment before the end of the year. If we are unable, then it may become an overpayment when the annual report is filed the following year.

Benefits issued for the month of death Example

Mrs. Larsen dies on August 28th. On September 3rd, the August benefit deposits to her bank account. Mrs. Larsen is not alive throughout August and therefore is not due a check for the month. The payment is considered an incorrect payment and recovered via Treasury Department reclamation process. Treasury deducts the monies paid in error to Mrs. Larsen from her bank account.

Joint Bank Account Example

Bill and Vandy Simmons have a joint bank account. Bill's check arrives as a direct deposit on May 3rd. However, Bill passed away on April 30th. Vandy is NOT entitled on Bill's record for the month before the month of death. Even if Vandy were receiving benefits on another record, this is not considered an overpayment. It is an incorrect payment recovered via Treasury Department reclamation.

If Vandy were entitled to benefits on Bill's record the month before the month of death, it would be an overpayment and she would have appeal and/or waiver rights. See [GN 02201.007F](#) for how a joint account owner entitled on the same record can be overpaid once the NH passes away.

O/P and Family MAX

[GN 02201.003C](#)

When the family maximum is involved and all beneficiaries are in the same household, there may not be an overpayment. As we know, one person's retroactive suspension, termination or entitlement may cause an overpayment to other beneficiaries in the same household. In this situation, we calculate the overpayment as the difference between the total monthly amount already paid to the household and the monthly amount payable after the retroactive event to other beneficiaries in the household.

Total Amount Monthly Paid – Total Amount Monthly payable = Overpayment

When the amount paid to the household exceeds the amount payable or there is a protest to the withholding of retroactive benefits from a beneficiary in the same household, we take normal recovery action against the overpaid person.

When the correct family benefits are paid and there is no protest to the withholding of any retroactive benefits to others in the household, there is no overpayment. This means when benefits payable to the family as a whole are the same before and after the entitlement of a new beneficiary there will be no overpayment to those who were entitled before the change.

EXAMPLE:

The Aguila's family of four receives \$1,600 per month as the family maximum. (Each is receiving \$400.00). Another child, who still lives in the same home as the other beneficiaries, files for benefits as a disabled adult child. The family maximum when she is entitled is still \$1,600, with each child now entitled to \$320 per month. The four original beneficiaries are overpaid \$80 each for 1 month of the new disabled child's entitlement period. This one month the new disabled adult child was due \$320 and the other 4 children \$320 also. SSA considers the \$1,600 family maximum shared within the family unit and no overpayment is assessed against the original four beneficiaries.

However, if the newly entitled beneficiary protests the withholding of any of her retroactive benefits, those benefits must be paid, and O/P notice(s) sent to the other members of the household.

Debt Prevention

Debt Prevention Strategy

Debt prevention is an important part of every SSA employee's work. Consequently, SSA has taken action to prevent overpayments through:

- Ongoing public information campaigns to increase public awareness of the importance of accurate and timely reporting of earnings.
- A direct follow-up mailing in July and August each year to get updated estimates from working beneficiaries and high-risk non-reporters.

Role of the CS Interviewer in Debt Prevention

A good explanation at the initial claims interview or during a PE interview can prevent overpayments. The explanation includes the person's reporting responsibilities for events causing nonpayment, suspension and termination of benefits. Keep in mind prevention is a lot easier for both the claimant and SSA than repayment.

Your role in debt prevention involves a counseling approach and careful interviewing, especially if the beneficiary is working.

Interviewing Working Claimants

When you are interviewing a claimant who is working, ask the following specific questions:

- How often are you paid?
- How many hours per week do you average?
- What is your hourly rate?

- Do you expect a raise or change in pay?
- Do you have any other jobs?

Most people receive a cost of living increase in their wages each year. If the claimant's estimate is lower than or equal to the amount earned in past years, ask questions to determine why it is lower.

During the interview, you should stress:

- The need to report changes shortly after the event occurs.
- The consequences of under reporting;
- The advantage of having benefits offset while working when there are wages coming into the household, rather than having SSA benefits interrupted because of an overpayment when the claimant is no longer working and Social Security may be the only source of income.

Pamphlets Containing Reporters' Responsibilities

In addition to telling beneficiaries about their reporting responsibilities, interviewers should provide written information and tell the claimants about SSA's online services at www.socialsecurity.gov.

The following publications discuss reporting responsibilities:

- "How Work Affects Your Benefits" for retirement beneficiaries;
- "Retirement Benefits";
- "What You Need to Know When You Get Retirement Or Survivor Benefits";
- "Disability Benefits";
- "What You Need to Know When You Get Social Security Disability Benefits".

Advantages of Debt Prevention

The advantages of debt prevention are:

- Less time spent processing overpayments,
- Less inconvenience to beneficiaries,
- Accurate benefit payments,
- Increase in public confidence in the Agency,
- Good service.

OBJECTIVE 2:

Determine who is liable for recovery of an overpayment.

Liability for Repayment**Primary Liability Priority****[GN 02205.003](#)**

The person who receives an overpayment is primarily (directly) responsible for repaying the overpayment; however, others may be primarily liable as well. If the person who receives the overpayment is the only person with primary liability, the person is solely liable.

Contingent Liability Priority Process**[GN 02205.005](#)**

Contingent liability is imposing the responsibility for repayment of an overpayment on another person entitled on the same record when we are unable to recover from the primarily liable person(s). If we are unable to recover an overpayment from the overpaid person(s), we will propose adjustment of the benefit payable to any other person receiving benefits on the same earnings record. This person is contingently liable for recovery of the overpayment. It does not matter if the person lives in the same or a different household as the overpaid person.

A contingently liable individual is responsible for the overpayment to the extent it is recoverable from any benefits they are eligible to receive on the particular overpaid individual's account.

Contingent Liability Example

Carol Curtis receives a total of \$1,035 monthly. She is dually entitled to a retirement benefit of \$405 and a widow's benefit of \$630. It is determined Mrs. Curtis' deceased husband was overpaid \$1,960 because of his earnings from work. There is no estate. Because Mrs. Curtis receives benefits from her

husband's record, she is contingently liable for repayment, to the extent of the benefit she receives on the record. SSA will propose withholding the \$630 widow's benefit until the full overpayment of \$1,960 is recovered. Mrs. Curtis would continue to receive her \$405 retirement benefit.

Joint Liability and Several Liability

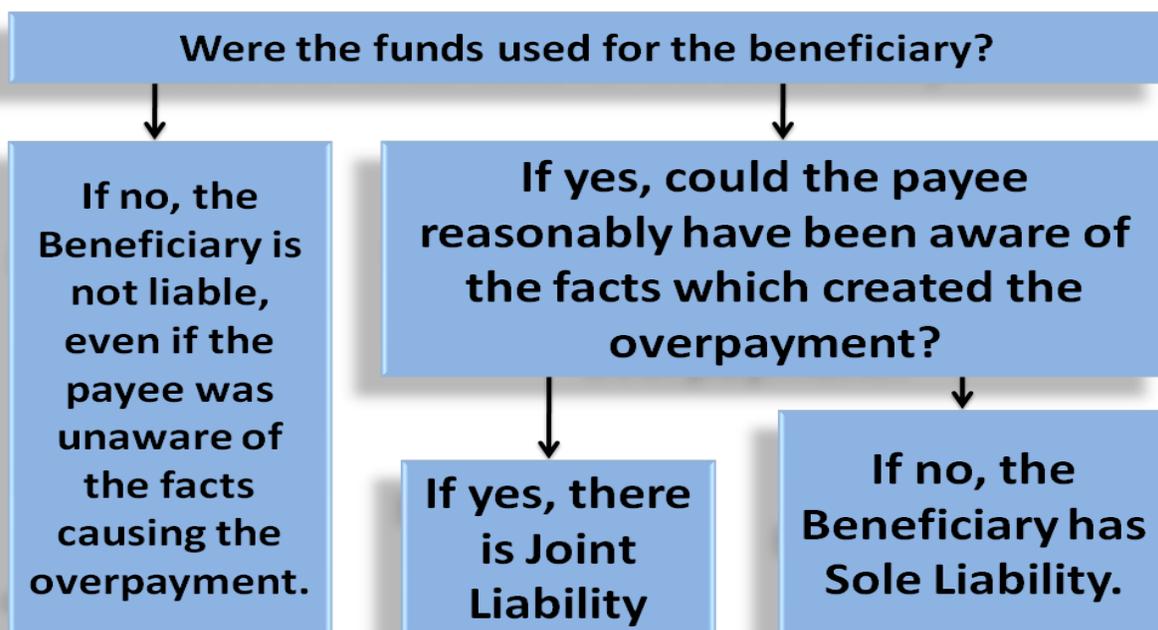
[GN 02205.007](#)

Joint and several liability occurs when two or more people share equal responsibility for repayment of an overpayment. Each person also has to be independently primarily liable for the overpayment. If two or more people are jointly liable for an overpayment, then each person has full responsibility for the overpayment. This situation may arise when we pay a beneficiary's payments to a representative payee.

However, there may be cases where either the payee or the beneficiary protests liability and SSA has to make a determination concerning individual liability.

- The beneficiary is liable only to the extent payments were used for his or her benefit.
- The payee is liable only to the extent the benefits were not used for the beneficiary or the payee is not without fault in causing the overpayment.

Determining Joint Liability



Joint Liability Example

Barbara Burnham is representative payee for her disabled adult son Bob. She receives \$142.00 monthly for him. In June, we receive a report Bob married Susie, who does not receive SSA benefits. Bob and Susie were married earlier in the year, in March. This means Bob was not due benefits for March, April, and May.

SSA presumes Mrs. Burnham and Bob jointly liable for repayment of the \$426.00 overpayment. We establish joint liability if Mrs. Burnham knew Bob married and never reported it. If Bob secretly married and Mrs. Burnham had no knowledge of the event and used the money for him, Mrs. Burnham would not be liable for repayment of the debt.

If Bob did not receive the proceeds of the benefits, Bob would not be liable for repayment of the debt.

Regulations also permit SSA to hold a representative payee solely liable for the repayment of an overpayment caused by payments made after the month a

recipient died. The criteria for finding a representative payee solely liable for repayment of the overpayment are:

- Payment(s) were made for month(s) after the month of the recipient's death.
- The payment(s) were made on behalf of the recipient to his or her representative payee.
- The payments were either directly deposited in to the representative payee's financial institution or cashed by the representative payee.

This policy applies to overpayments occurring on or after 12/04/2008.

Priority Order of Recovery Actions

Overpaid Person Alive

1. **If the overpaid person is alive and currently receiving benefits**, SSA first requests full refund unless the overpayment can be recovered from the next monthly benefit. Propose 100% adjustment unless we receive a refund within 30 days. Adjust benefits payable on any earnings record of the overpaid person.
2. **If the overpaid person is not currently receiving benefits, but has a payee who is**, attempt recovery from the currently entitled representative. If there is no joint liability or no entitled representative payee, SSA requests the overpaid person to refund the overpaid amount within 30 days.
3. **If the overpaid person serves as representative payee for other beneficiaries on the same earnings record**, the overpayment notice should simultaneously request refund from the overpaid individual and propose full withholding of the benefit (for which individual is representative payee) to recover the overpayment.
4. It may not be possible to recover the overpayment from the individual who is primarily liable if the overpaid person is not receiving benefits. In this case, refer to the priority order of recovery action found in [GN 02205.007](#). [EXHIBIT 1: Priority of Recovery Action](#) contains the list of recovery actions to use with individuals both alive and deceased.
5. If these recovery efforts are not successful, propose adjustment against beneficiaries who are entitled on the account. It does not matter if the

person lives in the same or a different household as the overpaid person. Refer to [GN 02210.015](#).

6. If this is not possible, SSA considers referral for civil suit when the case meets the criteria in [GN 02215.150](#). If the case does not meet these criteria, we discontinue collection action.

When proposing adjustment against anyone other than the overpaid individual, SSA provides a thorough explanation along with appeal rights. Take note that at any point in the recovery process, recovery action resumes against the overpaid person if the overpaid person re-establishes eligibility.

Overpaid Person Deceased

[GN 02210.016B](#)

If the overpaid person is deceased, the priority of recovery is to:

1. Withhold any benefits due the deceased. ([GN 02301.065](#))
2. Withhold any LSDP payable on the same earnings record.
3. Propose adjustment against beneficiaries entitled on the same earnings record who were living in the same household with the overpaid person at the time of the overpayment or helped cause the overpayment.
4. Propose recovery from any estate or its distributees. ([GN 02215.050](#))
5. Propose adjustment against benefits payable on the same earnings record to any person who was living in a separate household from the overpaid person at the time of the overpayment.

If recovery from these beneficiaries is not possible, collection action terminates.

OBJECTIVE 3:

Determine the appropriate actions regarding overpayment notices

O/P Resolution Process

The overpayment resolution process begins when a debt is discovered. We inform the overpaid person as soon as possible of the fact, amount, and liability for repayment of the overpayment.

Proposed Recovery Actions

[GN 02201.009](#)

Overpayment Notice

SSA sends the initial overpayment notice proposing full adjustment of the monthly benefit or full refund of the overpayment to the liable individual(s).

NOTE: SSA does not charge interest on an overpayment.

The notice provides the liable individual due process and 30 days to respond before we enforce recovery of their overpayment. The 30-day timeframe offers the beneficiary a reasonable opportunity to contest an overpayment determination.

The overpayment notice:

- Contains an explanation of the overpayment,
- Requests full refund or adjustment,
- Proposes recovery if no refund in 30 days,
- Explains appeal and waiver rights,
- Encloses a SSA-3105 (Important Information About Your Appeal, Waiver Rights, and Repayment Options)

Despite the information in the initial notice, a beneficiary may contact SSA for a more detailed explanation. These inquiries often include questions like:

- How did SSA arrive at the amount of the overpayment?
- Why am I overpaid?
- What next course of action is available to me?

If the overpaid individual elects to repay the overpayment by credit/debit card, money order and check follow the procedure in [GN 02403.161](#).

If the individual contacts SSA within this 30-day period, either questioning the O/P determination, protesting full withholding, requesting a reconsideration, or requesting a waiver, take prompt action to avoid adjustment of benefits prior to resolution of the issue.

Explanation of O/P

[GN 02201.017](#)

When you interview a beneficiary who is asking about an overpayment notice, tell them the law requires recovery of the overpayment. You should explain the appropriate appeal and waiver rights.

Provide an explanation of the overpayment (O/P) using the following resources:

- Master Beneficiary Record (MBR),
- Online Retrieval System (ORS) for notices sent about the overpayment,
- Payment History Update System query (PHUS),
- Recovery of Overpayments Accounting and Reporting System (ROAR),
- Overpayment Wizard on the personal communications Office of Quality Assurance (OQA) PCOM toolbar,
- Claims File User Interface (CFUI); and
- Paperless

Action after Explanation of O/P

Document the Debt Management System's DMS remarks with a description of the explanation you gave and the person's decision after your discussion. When the FO or teleservice center (TSC) cannot provide a more detailed explanation of the overpayment follow instructions in [GN 02201.017C](#) for instructions on referring to the Overpayment Telephone Inquiry (OPTTEL) at the PSC and transferring the DMS record to suspend collections until explanation can be provided. Consequently, after the overpaid person is satisfied with the explanation the next action depends on what the beneficiary decides to do. The person may request:

- to repay the O/P by partial adjustment or installment payments, follow instructions in [GN 02210.030](#);
- a Waiver, follow [GN 02201.021](#); and
- a Reconsideration, follow [GN 02201.025](#)

EXAMPLE: Martin Gonzalez wants an explanation of how we figured his overpayment. You review the PHUS and MBR, but the information reviewed is still not sufficient to explain the overpayment. In this situation, you use OPTTEL to call the PSC to obtain an explanation. If the PSC cannot answer the questions during the call, input a recovery protest asking an Explanation Request in the Debt Management System (DMS) to stop the overpayment recovery action and annotate DMS remarks. Recovery will cease until Mr. Gonzalez receives an explanation. ([GN 02201.017C](#))

SSA-3105

[GN 02201.010](#); [GN 02201.009](#)

The PSC sends the overpayment notice and Form SSA-3105, "Important Information about Your Appeal, Waiver Rights, and Repayment Options." This form gives the beneficiary information about appeal and waiver rights. In order to request a waiver or appeal, the beneficiary can opt to call or complete page 4 of the SSA-3105 and mail it to the local office. When the FO receives page 4 of the SSA-3105, take the action indicated based on the block the overpaid person checked. If the person chose a:

1. **Reconsideration** –

- a. Input protest reason 4 for recon fact/amount via the Protest/Stop Recovery Request - FO - (DRPF) screen in DMS to stop collection activity (if applicable);

- b. Mail form SSA-561-U2 to the overpaid individual with the appropriate cover notice and a return envelope addressed to the PC of jurisdiction;
- c. Document your action(s) on the Remarks screen in DMS; include a remark regarding the good cause determination if applicable. For example, "Received SSA-3105 dated 05/05/18 from Jessica James HA requesting reconsideration. Mailed form SSA-561-U2 and notice 05/08/18. –Luke Brown, FO AAA;"
- d. Transfer jurisdiction to the appropriate PC via the WMS Debt Management Function Selection (DMFS) screen in DMS (see [MS 01202.003](#)); and
- e. Fax the SSA-3105 to the servicing PC via Paperless fax.

For more information regarding processing the overpayment reconsideration request, see [GN 02201.025B](#).

2. **Waiver** – If the overpayment is \$1,000 or less and the request meets the requirements in [GN 02250.350](#), take the following actions:

- a. Input protest reason 2 for informal waiver via the Protest/Stop Recovery Request - FO – (DRPF) screen in DMS (if applicable);
- b. Process the request under the \$1,000 administrative waiver tolerance provision via [GN 02250.350](#); and
- c. Fax the SSA-3105 and any additional documentation into NDRed.

If the overpayment amount is over \$1,000, take the following actions:

- a. Input protest reason 2 for informal waiver via the Protest/Stop Recovery Request - FO – (DRPF) screen in DMS to stop collection activity (if applicable) (see [GN 02201.021](#));
- b. Mail forms SSA-632-BK, SSA-4641, and a waiver cover notice with a return envelope addressed to the FO of jurisdiction to the overpaid individual;
- c. Document your action(s) on the Remarks screen in DMS. For example, "Received SSA-3105 dated 05/05/18 from Jessica James HA

requesting waiver. Mailed forms SSA-632-BK and SSA-4641 with a waiver cover notice 05/08/18. –Luke Brown, FO AAA;”

- d. Allow 30 days for receipt of the above forms and follow the instructions in [GN 02201.021](#); and
- e. Fax the SSA-3105 and any additional documentation into NDRed.

3. Combined Waiver and Reconsideration –

- a. Input protest reason 5 for waiver and recon fact/amount via the Protest/Stop Recovery Request - FO - (DRPF) screen in the DMS to stop collection activity (if applicable);
- b. Mail forms SSA-561-U2, SSA-632-BK, and SSA-4641 to the overpaid individual with the appropriate cover notice and return envelope addressed to the PC of jurisdiction;
- c. Document your action(s) on the Remarks screen in DMS; include a remark regarding the good cause determination if applicable. For example, “Received SSA-3105 dated 05/05/18 from Jessica James HA requesting reconsideration and waiver. Mailed forms SSA-561-U2, SSA-632-BK, SSA-4641, and notice 05/08/18. –Luke Brown, FO AAA;” and
- d. Fax the SSA-3105 to the servicing PC via Paperless fax.

NOTE: The PC must process the reconsideration request prior to the FO processing the waiver request.

4. Partial Withholding – If we can recover the overpayment within 12 months based on the requested withholding amount, take the following actions:

- a. Input the request via the Establish Offset (Debtor) (DROA) screen in DMS (see [MS 01106.015](#)) following the guidelines in [GN 02210.030B](#); and
- b. Fax the SSA-3105 into NDRED.
- c. If recovery would take longer than 12 months, take the following actions:

- d. Contact the overpaid individual to conduct financial development following guidelines in [GN 02210.030B](#); and
- e. Fax the SSA-3105 into NDRED.

If the overpaid individual did not provide a partial withholding amount, take the following actions:

- a. Call him or her to establish a rate of recovery following the guidelines in [GN 02210.030B](#).
- b. Send a direct contact notice in the mail requesting the necessary information, if you are unable to contact the overpaid individual;
- c. Resume normal collection activity effective with the Current Operating Month (COM), if you do not receive a response;
- d. Document your actions and rationale via DMS Remarks; and
- e. Fax the SSA-3105 into NDRed.

5. **Monthly Installment** – Input the requested installment amount on the Record Installment Agreement (DRIN) screen in DMS (see [MS 01106.014](#)). For more information regarding installment payments, see [GN 02210.180](#).

If the overpaid individual did not provide an installment amount, or he or she did not submit a payment with the request, take the following actions:

- a. Contact him or her to establish an installment amount;
- b. Follow the guidelines in [GN 02210.180](#); and
- c. Fax the SSA-3105 into NDRed.

If direct contact is unsuccessful, take the following actions:

- a. Resume collection activity (if applicable) effective COM via the applicable Record Installment Agreement (DRIN) screen or Establish Offset (Debtor) (DROA) screen in DMS;
- b. Send a dictated notice explaining that we received form SSA-3105 but we were unsuccessful contacting him or her regarding the incomplete request;

- c. Document your action(s) on the Remarks screen in DMS. For example, "Received SSA-3105 installment payment request dated 06/07/16 for Jessica James HA, the installment amount is missing on the form, and payment not included. Attempted to contact Ms. James but was unsuccessful. Resumed collection activity 07/10/16 and sent a notice to Ms. James. – Luke Brown, FO AAA;" and
- d. Fax the SSA-3105 into NDRed.

6. Explanation –

- a. Input protest reason 1 for explanation via the Protest/Stop Recovery Request - FO – (DRPF) screen in DMS to stop collection activity (if applicable);
- b. Follow the guidelines in [GN 02201.017B](#); and
- c. Fax the SSA-3105 into NDRed

7. Full Refund –

If the overpaid individual encloses a remittance with the SSA-3105, process the request following the guidelines in [GN 02403.006](#) and fax the SSA-3105 into NDRed.

If the overpaid individual does not enclose a remittance with the SSA-3105, take the following actions:

- a. Review the ROAR record to see if it shows that a full refund already closed out the debt (i.e. the overpayment balance is now \$0.00). If so, take no action on the record and fax the SSA-3105 into NDRed; or
- b. See if the ROAR shows a remittance exception.
 - i. If so, check Paperless Read Only Query System (Paperless ROQS) to see if an action is pending with the type of event levels (TOEL) of OPMT REMIT. If an action is pending, take no further action and fax the SSA-3105 into NDRed.
 - ii. If no action is pending, contact the servicing PC via Modernized Development Worksheet (MDW), request that they take the

necessary actions to credit the remittance to the appropriate overpayment and fax the SSA-3105 into NDRed.

If there is no evidence of a remittance, take the following actions:

- a. Resume collection activity (if applicable) effective COM via the applicable Record Installment Agreement (DRIN) or the Establish Offset –Debtor- (DROA) screen in DMS;
 - b. Send a dictated notice stating that, since we did not receive a refund with their SSA-3105, we are starting recovery of the overpayment;
 - c. Document your action(s) on the Remarks screen in DMS. For example, “Received SSA-3105 refund request dated 06/07/16 for Jessica James HA and payment not included. Resumed collection activity 07/10/16 and sent a notice to Ms. James. – Luke Brown, FO AAA;” and
 - d. Fax the SSA-3105 into NDRed.
8. **Other** – If the overpaid individual checked this box and provided an explanation on a separate sheet of paper, process accordingly, and fax the SSA-3105 with documentation into NDRed

If an overpaid individual did not enclose an explanation, take the following actions:

- a. Call the overpaid individual and ask what he or she is requesting;
- b. Process the request accordingly;
- c. Document your action(s) on the Remarks screen in DMS. For example, “Received SSA-3105 dated 06/07/18 for Jessica James HA, “other” box was checked. Called Ms. James and she requested partial withholding of \$50 for 12 months. Action taken 06/10/18 and sent a notice to Ms. James. – Luke Brown, FO AAA;” and
- d. Fax the SSA-3105 into NDRed.

If direct contact is unsuccessful, take the following actions:

- a. Resume collection activity (if applicable) effective COM via the applicable Record Installment Agreement (DRIN) or the Establish Offset –Debtor- (DROA) screen in DMS;

- b. Send a dictated notice explaining that we received form SSA-3105 but we were unsuccessful contacting him or her regarding the incomplete request;
 - c. Document your action(s) on the Remarks screen in DMS. For example, "Received SSA-3105 "other" request dated 06/07/18 for Jessica James HA and an explanation was not included. Attempted to contact Ms. James but was unsuccessful. Resumed collection activity 07/10/18 and sent a notice to Ms. James. – Luke Brown, FO AAA;" and
 - d. Fax the SSA-3105 into NDRed.
9. **Multiple Blocks Checked** – Contact the overpaid person as to what action he or she is requesting and process accordingly. If contact is unsuccessful, process in the following order:
 - a. Partial recovery
 - b. Explanation
 - c. Reconsideration
 - d. Waiver
10. **No Blocked Checked** – Process as though it is a request for explanation, following the instructions in #6 above.

OBJECTIVE 4:

Determine the proper method of recovery of an Overpayment

Methods of Recovery

When the 30-day notice expires and the individual does not request an appeal or waiver, initiate recovery.

The methods of recovery used include:

- Full refund
- Adjustment, installment
- Compromise
- Administrative wage garnishment
- Tax refund offset
- Credit bureau reporting
- Non-entitled debtor (NED)
- Cross program recovery (CPR)

Recovery by Adjustment

When the overpaid individual is **currently receiving benefits**, recovery by adjustment of benefits is the standard method used. Recovery will begin on the date stated in the O/P notice as long as the beneficiary does not protest recovery.

Rate of Adjustment

[GN 02210.030](#)

When a person requests a different rate of adjustment, you need to consider the following:

- If a waiver request was made,
- If SSI is involved,
- If the debtor is with or without fault.

If the debtor is not requesting a waiver, consider a different rate of withholding only at the debtor's request.

If a debtor files a waiver (no SSI involved) and is **at fault** for the overpayment, consider a different rate of withholding if:

- A partial withholding request was received with the waiver request, or
- A specific request was made after the waiver denial notice was received.

When a person is **without fault** in causing the overpayment, but the waiver is denied because recovery would not cause hardship, full withholding may be inconsistent with the "defeat the purpose" provisions. Withholding cannot be greater than what the "defeat the purpose" finding allows.

Example:

Sandra is without fault in causing a \$4,500 overpayment, but her request for a waiver is denied because she can afford to repay \$65 a month without financial hardship. Adjustment for Sandra is then recovered at \$65 per month.

Establish Rate of Adjustment

Take the following actions to handle partial withholding requests:

- Attempt to negotiate a rate of withholding which would permit full recovery within 12 months.
- Grant, **without financial development**, any request, which is at least \$10 a month and would permit recovery within 12 months. Document this on the remarks screen in DMS.
- If unsuccessful, negotiate for full recovery within 36 months. Grant the request, do not obtain a SSA-632 and annotate the DMS remarks screen with the debtor income/expense/asset information by asking the following questions:
 - What is the amount of your income (i.e., weekly or monthly)?
 - How much are your average monthly expenses? (e.g., rent/mortgage, utilities, etc.)

- Do you have a savings account, CD or IRA? If so, what is the approximate value of each?
- If the rate would not permit recovery within 36 months, complete Section II of an SSA-632-BK to document the debtor's income, expenses and assets and withhold:
 - The amount by which income exceeds expenses **but no less than \$10**; or
 - The rate permitted by income/assets if there are excess assets, **but no less than \$10**;
 - Annotate the DMS REMARKS screen
 - Fax the SSA-632-BK and supporting documents into the certified electronic folder or NDRed, whichever is applicable
 - **Exception:** If a negotiated/requested rate would not permit recovery within 36 months but the debtor has a **100% Medicare Part D subsidy**, grant, **without financial development**, any request that is at least \$10. Annotate the Medicare information to the DMS REMARKS screen.
- If the beneficiary protests, a different rate of adjustment can be considered due to any new financial conditions. If the rate of withholding is denied in whole or in part, send a notice stating:
 - the basis for the denied request, and
 - the manner in which the overpayment will be recovered.
- Do **not** include a reconsideration paragraph. The decision as to the amount of withholding is an administrative action and not an initial determination.
- **Reminder:** If a debtor requests a greater rate of withholding than would be established under the above rules, withhold at the rate requested.

Effective Date of the Negotiated Rate

Initiate withholding effective with the current operating month (COM) or the specific date requested by the debtor as long as it does not go beyond six months of COM.

When there is outstanding development, full benefits continue pending a decision on the requested rate.

When a claimant makes the request after withholding has begun, the new rate of adjustment is effective for months after the new rate approval unless the debtor proves hardship. The reviewing office will notify the individual in writing of the approval or denial of the request.

NOTE: The decision to withhold a specific amount each month is an administrative action rather than an initial determination and cannot be appealed.

Rate of Overpayment Adjustment – Concurrent Entitlement

[GN 02210.045](#)

When a person receives both Title II benefits and Title XVI payments and is overpaid on the Title II record, we withhold only 10 percent of the Title II monthly benefit credited (the MBC) to recover the Title II overpayment. Verify the SSI entitlement and input 10 percent of the MBC using DMS (if not already established). Do not negotiate a greater withholding. However, we can accept a greater rate at the beneficiary's request.

If the person indicates the 10 percent withholding will create a hardship, accept this, and input a lesser rate. The minimum withholding amount is \$10 a month. You will not need to complete the SSA-632 or SSA-795.

If a debtor is receiving another type of cash public assistance, verify the assistance and withhold at the rate requested **but no less than \$10**. Annotate the DMS remarks screen.

Changes after Adjustment has Begun

[GN 02210.065](#)

Some changes may occur after adjustment has taken effect. The action to continue to collect the overpayment will depend on the type of change and are processed by the Payment Center (PC).

- If entitlement terminates and part of the overpayment is still outstanding, the PC requests refund of the outstanding balance.
- If SSA finds a new overpayment while we adjust benefits to recover a current overpayment, the initial notice about the new overpayment should propose 100 percent adjustment. If then the person requests a

continuance of the current adjustment rate, we grant it without development.

- When a benefit increase occurs, the rate of adjustment remains the same. If the increase is retroactive, SSA withholds the retroactive increase to recover the overpayment.
- When a benefit decrease occurs (for example, a new beneficiary becomes entitled, thus decreasing benefits for those currently entitled), the rate of withholding will remain the same, unless the refigured benefit is less than the established rate of withholding. In this case, the new withholding rate will be 100 percent of the new benefit amount.

Refund by Installments

[GN 02210.180](#), [GN 02210.214](#)

If adjustment is not available because the beneficiary is not in current pay status, SSA requests collection of the O/P through a refund. If the debtor is unable or unwilling to make a full refund in a single payment, then installment payments are acceptable. Following are the Field Office (FO) actions:

- Do not obtain an SSA-632.
- Negotiate an installment amount that allows recovery of the entire debt within 12 months. If this is not possible, negotiate for an amount to repay the overpayment within 36 months.
- If this is still not possible, negotiate a rate, which is as high as the **debtor can manage**. Remember installment amounts should be no less than \$10 per month except for rare situations. For example, a person receiving Aid to Families with Dependent Children (AFDC) may only afford to repay \$5.00 per month.
- Record the results of the conversation to the DMS RMKS screen.
- Input the installment rate into the Debt Management System (DMS) through the Record Installment Agreement screen (DRIN). ([MS 01106.014](#)) ROAR will update overnight. ([SM 00610.735](#))

Refund Acceptance Procedures

[GN 02403.005](#); [GN 02403.161](#)

Refund is made by remittance (e.g. check, money order, credit card, cash and others) or the return of a benefit check(s) when there is eligibility.

If a debtor refunds by check or money order, examine it to make sure of the following using [GN 02003.005 C](#):

- The payee line is completed correctly and readable, Made payable to "Social Security Administration" or "Centers for Medicare and Medicaid Services" or their acronym "SSA" or "CMS".
- The written and number amounts match.
- The check is signed.
- The existence of restrictive language such as "Repayment in Full".
- Record the receipt number on the remittance.

After careful review of the check or money order, enter it into the Social Security Electronic Remittance System (SERS) and issue a receipt to the remitter. [GN 02403.000FF](#) holds the procedures for handling remittances in the field office. SERS will only accept debit/credit cards, money orders, and checks for remittances related to payment/return of the following:

- Benefit Overpayments;
- Conserved Funds; and
- Misused Funds.

Cash Refunds

When a remitter offers a cash refund and refuses to use a check or money order, enter the refund into the Remittance Process of DMS and issue a receipt. In addition, record the cash in the cash log for the field office. Convert cash remittances to a money order or cashier check. Local management determines who purchases the money orders. Note that SSA does not accept cash for non-program standard fees for service. ([GN 02403.009](#), [GN 02403.010](#))

Summary of SSA Actions for O/P

Refer to [Exhibit 2](#), "Summary of Actions Required When Person Responds to Overpayment Notices." This tool will help you determine the proper course of

action when an individual respond to the O/P notice. The forms referred to in the exhibit will be discussed later.

Compromise Settlement

Definition

Another form of refund is the compromise settlement. A compromise settlement occurs when SSA agrees to accept partial payment of an O/P and relieves the debtor of any further liability for the remaining O/P amount. SSA strives to recover at least 80 percent of the debt through this process. Take a look at [GN 02215.100](#).

Normally, the offer of a compromise settlement should come voluntarily from the liable individual or representative. Be alert to fraudulent situations and resolve any questions of fraud before a compromise offer is accepted or rejected.

Overpayment is \$2,000 or less

[GN 02215.115C.1](#)

You have the authority to accept or reject the offer **without further review**.

- Accept an offer of 80 percent of the debt amount (without financial development).
- Accept an offer which is at least 60 percent of the debt if:
 - The full debt cannot be recovered within one year by benefit withholding, and
 - Financial circumstances support the 60 percent offer.
- Accept an offer of less than 60 percent of the debt when financial evidence established the debtor is unable to pay more and the amount offered is reasonable.

Overpayment Exceeds \$2,000 but is not over \$20,000

You, **with the agreement of an operations supervisor** (or higher), have the authority to accept or reject the offer.

- Accept an offer, which is at least 80 percent of the debt amount.
- Accept an offer, which is at least 60 percent of the debt if:
 - The full debt cannot be recovered by the benefit withholding within 3 years, and
 - Financial circumstances support the 60 percent offer.
- Accept an offer of less than 60 percent when:
 - The financial evidence establishes the individual is financially unable to repay more than the amount offered, and
 - The amount offered is reasonable.

Overpayment Exceeds \$20,000

Develop and document financial circumstances on Section II of the SSA-632 and forward the offer to the appropriate PC. In the event the debtor refuses to provide financial information, advise the PC. The PC will prepare all notices in these size of overpayments.

Effectuating the Decision

Notify the person in writing of the decision. If the compromise offer was accepted, include information in the notice about the due date of full payment. Generally, this date would be within 30 days, but extenuating circumstances, such as the maturation of a certificate of deposit in 90 days, could extend the allotted time. Input the decision to DMS via the Record Compromise Decision (DRCD) screen. If SSA obtains financial information, document the DMS REMARKS screen.

External Collection Operation (ECO)

[SM 00610.040](#)

The Debt Collection Improvement Act of 1996 gave the Treasury Department the responsibility of applying administrative offset of Federal payments to recover Federal debts. ECO selects debtors from the ROAR and SSR who meet the criteria for tax refund offset (TRO), Administrative Wage Garnishment (AWG), Treasury Offset Program (TOP), and referral to the credit bureaus. The debtor may or may not have had entitlement (Non-entitled debtor - NED) to Social Security or SSI benefits when the overpayment occurred.

Tax Refund Offset (TRO)

[GN 02201.029](#), [GN 02201.030](#)

Treasury Offset Program (TOP) is a government-wide delinquent debt matching offset system managed by Treasury which enables SSA to collect debt by offsetting any Federal payment due to that individual. SSA has the authority to recover delinquent Title II and Title XVI overpayments from former beneficiaries by offsetting another Federal payment due to them, including through income tax refunds by the Tax Refund Offset (TRO).

SSA selects debts for recovery by TRO each week. The following are the main criteria for TRO selection:

- The debtor is alive;
- The debtor is not entitled to benefits;
- The debtor was 18 years or older when the debt was established on SSA's record;
- The debtor's BOAN is on the MBR;
- The debt is \$25 or more;
- The debtor is not making regular installment payments, or efforts to recover the debt have been terminated;
- The debt is past due, (No pending appeal/waiver) and

- The debt is legally enforceable.

Administrative Wage Garnishment (AWG)

[GN 02201.040-042](#)

AWG is the process where an employer, at the request of a Federal Agency, withholds amounts from an employee's wages and pays those amounts to the agency the employee owes a debt to. The Federal Agency requests this payment by obtaining a court order.

Based on the garnishment order, the debtor's employer withholds up to 15% of the debtor's disposable pay. The employer is required by law to comply with the AWG order.

We advise debtors about our plans to use AWG and wait 60 days before taking action. However, upon garnishment of a paycheck, the debtor may then contact SSA to dispute the overpayment and/or repay the debt. See [GN 02201.041](#) for steps to take when the debtor contacts us after AWG has been proposed or begun.

The AWG process creates a variety of situations requiring interaction between SSA and the debtor's employer. Once all the conditions for AWG are met, SSA sends out the AWG Employer Package providing instructions and procedural forms to the employer. See [GN 02201.040-042](#) for more details on this program.

Credit Bureau Reporting

[GN 02201.032](#)

Credit bureau reporting is the posting of a debt to an individual's credit record. SSA uses credit bureau reporting as a way of influencing a debtor to repay a Title II or Title XVI debt.

SSA sends information about the debt/debtor to the national credit repositories, the largest holders of credit data. The credit repositories then provide the information to the smaller credit bureaus across the country. The SSA debtor could be denied a loan or credit based on the posting of an unrecoverable SSA debt on the credit report.

Non Entitled Debtors (NED)

[GN 02230.035](#), [GN 02230.040](#)

A non-entitled debtor is a person with a debt to the Social Security Administration who is not entitled to Social Security benefits or Supplemental Security Income payments. Such a person does not have an MBR or an SSR so overpayments are controlled automatically by SSA's systems.

At this time, NED initiative controls only payments made to representative payees after the death of a Title II beneficiary, and overpayments made to representative payees prior to the death of the Title II beneficiary for which the payee is responsible. Such payments are legally defined overpayments for which the payee is responsible.

Future releases of NED will include, but are not limited to the following:

- Representative payees of deceased Title XVI beneficiaries,
- Representative payees who have not relinquished conserved funds or have misused Title II or Title XVI benefits,
- Person who owes civil monetary penalties and assessments,
- Person who owes a court ordered penalty or restitution,
- Attorneys and non-attorney representatives who receive excess fees,
- Person who obtains benefits by fraud or error and
- Organizational payees.

The main benefit of NED initiative is it gives SSA the capability to use TOP/ECO debt collection tools to collect overpayments from the payee. SSA's existing overpayment policies and procedures are applicable in responding to inquiries, requests, and protests made by NED payees. If the debtor takes no action in the normal timeframe, we may apply standard collection tools including Tax Refund Offset (TRO), Administrative Wage Garnishment (AWG), and Credit Bureau Reporting.

NED encompasses five related DMS screens described in [MS 01112.001](#)—Non-Entitled Debtor Process. These screens allow the FO to query the NED record and update in the NED database.

To access the NED record, go to the Debt Management Menu (DMMU) screen in DMS entering the rep payee's own SSN or the Claim Account Number and BIC of the deceased beneficiary, and select #13 "Non-Entitled Debtor Menu. This menu choice allows access to query the record or correct the system generated information.

Within the MBR, a ROAR query will display NED data in the EVENT line.

Cross-Program Recovery (CPR)

[GN 02210.008](#), [SI 02220.020](#)

By law, SSA may collect SSI overpayments owed by former recipients from any Title II benefits due them. The agency is not required to obtain written permission from the SSI debtor in order to collect the debt from Title II benefits using CPR.

The general rules for cross program recovery are:

- If the Title II benefit ceases to be payable retroactively, the other program recovery ceases as of the current month. Any amount withheld for crediting to the other program debt constitutes a Title II overpayment.
- Cross-program recovery is invalid when Title II benefits cease. A new cross-program action initiates if Title II eligibility is subsequently re-established.
- Cross-program recovery is used in all states.

Selection of debts for mandatory cross-program recovery is automatically made from the RECOOP system.

RECOOP

RECOOP (Recovery and Collection of Overpayment Process) controls overpayment cases when a beneficiary is in suspense or terminated payment status and adjustment of benefits to recover the overpayment in the same household is not possible. ([SM 00610.015](#))

RECOOP automatically generates monthly installment bills, follows up on delinquency bills, and alerts the Debt Management Section in the PSC to contact the debtor for recovery.

If a debt is under RECOOP jurisdiction, the ROAR shows an event jurisdiction code of 2 PCDCU (Processing Center Debt Collection Unit).

Suspension of Collection

[GN 02215.235](#)

When the debtor is not in current pay, and we are unable to reach them, it is recommended that we discontinue internal collection efforts when the debt is less than \$3,000 per [GN 02210.0217](#). However, termination of the collection action is just a "temporary write-off." The debtor remains liable for payment and efforts to recover via TOP or ECO may still be employed.

New Claim with Prior Overpayment

We must address a prior overpayment on a record when an individual applies for benefits. Discuss the overpayment with the claimant using the existing overpayment notice(s) and billing statements. The notices and statements will help explain the prior overpayment if the claimant states they never received the overpayment notice.

When explaining the overpayment, advise the beneficiary of the overpayment balance and explain repayment options, including:

- A full refund;
- A full withholding from monthly benefits;
- A partial withholding if the claimant is unable to meet necessary living expenses ([GN 02210.030](#)); and
- A waiver, which the claimant can request at any time (Waivers are covered in more detail in [Objective 5](#))

If the overpayment is not addressed, the system will automatically start an immediate full withholding of the claimant's benefits to recover the overpayment.

Fraud

When it appears fraud (as described in [GN 04105.005](#)) may have contributed to the creation of or the amount of an overpayment, consider whether to curtail or continue development per [GN 04110.010](#).

When developing the case, and the evidence and information, either directly or circumstantially, establishes a potential violation may have been committed, forward the allegation to the Office of Inspector General (OIG), Office of Investigations Field Division (OIFD) for consideration of criminal investigation using the procedures in [GN 04111.000](#).

FO employees report potential programmatic fraud cases via the e8551. ([GN 02201.050](#))

OBJECTIVE 5:

Determine the proper actions when a claimant disagrees with the overpayment

Overpayment Waiver

[GN 02250.000](#)

Waiver Requests

If the beneficiary protests the O/P and/or requests a waiver, make an input to DMS to stop the recovery action until the protest issue is resolved.

An overpaid individual may request waiver of recovery of an overpayment at any time. Refer to [Exhibit 3](#) for the appropriate timeframes in which an appeal or protest can be filed.

You **should not** suggest an individual file for waiver just because he/she wishes to protest an overpayment. The individual should initiate the request for waiver.

- A request for waiver may be oral or written.
- Waiver requests can be made at any time.
- The request may be explicit (I want to file a waiver of recovery of my overpayment) or implied (I can't afford to pay this money back).

Relief from repayment (waiver of recovery) may be granted if:

- The individual is without fault in causing the O/P; **and**
- Recovery would either "defeat the purpose of Title II" or "be against equity and good conscience."
- **BOTH CONDITIONS MUST BE MET.** [GN 02250.001](#)

Not without Fault

Find a person "not without fault" when the overpayment resulted from:

- An incorrect statement he/she knew or should have known was false; or
- Failure to give information the person knew or should have known was material to entitlement or the benefit amount, or
- Acceptance of a payment the individual knew or should have known was incorrect.

Without Fault

An individual is without fault when he/she **could not reasonably have been expected** to understand the payment was incorrect. [GN 02250.005](#)

Defeat the Purpose**[GN 02250.100](#)**

"Defeat the purpose of Title II," means recovery of the overpayment would deprive the individual of income or resources necessary to meet ordinary living expenses. In other words, the individual cannot afford to pay back the overpayment.

Verification of income and expenses is required even when the amounts alleged are not questionable. [GN 02250.250](#) When the individual receives some form of cash public assistance, "defeat the purpose" is deemed and only the receipt of the assistance needs to be verified. [GN 02250.110](#) Recovery will also defeat the purpose of title II if the person needs all current income to pay for living expenses and recovery would reduce assets below:

- \$3000 for a person without dependents, or
- \$5000 for a person with one dependent, plus \$600 for each additional dependent. [GN 02250.0115](#)

Against Equity and Good Conscience

[GN 02250.150](#)

Recovery is against equity and good conscience when:

- A beneficiary, relying on benefit payments or notice such payments would be made, relinquished a valuable right or changed his/her position for the worse; or
- A contingently liable beneficiary was living in a separate household from the overpaid person at the time of the overpayment and did not receive the overpayment; or

Against equity and good conscience will also be **deemed** in without fault cases in which there was:

- A misunderstanding about allowable wage earnings; ([GN 02250.060](#)) or
- A reliance on misinformation from an official source; ([GN 02250.061](#)) or
- Earnings prior to the first month of entitlement ([GN 02250.064](#))

You do not need to gather financial information for an “against equity and good conscience” finding. ([GN 02250.240](#))

O/P Less Than \$1,000

[GN 02250.350](#), [GN 02201.013D](#)

An administrative tolerance applies when a person requests waiver of an O/P of \$1,000 or less, and there is no indication the person was at fault in causing the O/P. Waive recovery because it impedes the efficient administration of the Act.

Application of the administrative tolerance depends on the total amount of a person’s liability. A person who is liable for several overpayments, which total over \$1,000, even if each is under \$1,000, cannot be considered for waiver under this tolerance. The tolerance does not apply for an overpayment of more than \$1,000, which has been reduced to \$1,000 or less by repayment or collection.

Consideration of waiver under the administrative tolerance is also dependent on overpayments to other members of the same household. In single-family situations where one request for waiver can be used for all household members, the largest liability any person has will determine if the tolerance applies. For example, if one household member has liability for an overpayment of \$1,200,

waiver under the tolerance cannot be considered for any other member of the household, even though their own individual liabilities are under \$1,000.

Where there is an indication the person was at fault in causing the overpayment, the administrative tolerance cannot be used and full waiver development is necessary. A common example is when the person requesting waiver is overpaid for the second time because of earnings from work. Since this is the second overpayment for the same reason, there is an indication the person was at fault.

If receipt of duplicate payments caused the overpayment and it has been proven the person received both payments, this also indicates the person may be at fault. Full waiver development must be done. This does not mean “without fault” cannot be found, only that full waiver development is necessary. The **(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)** allows you to determine when it is appropriate to process a waiver request under the administrative tolerance.

When a reconsideration is requested on the amount of an overpayment, which is \$1,000 or less, the reconsideration can be treated as a request for waiver, after the processing center (PC) makes a formal reconsideration determination or dismissal.

Full development and completion of a SSA-632-BK is not required under the administrative tolerance provision. However, you must verify the amount of the overpayment before processing the waiver under the administrative tolerance.

If the requirements are met,

- Input the waiver request to the system per [MS 01106.002](#) (DRWD).
- Then annotate the DMS Remarks screen as follows:

“Waiver approval; overpayment is \$1,000 or less; Waiver approval notice sent (MM/DD/YY)”

- Use DPS to send the waiver approval notice.

The DMS systems inputs for an Administrative waiver are:

- Waiver Disposition (DRWD) when processing waivers under \$1,000. ([MS 01106.004](#))
- Use code 77 (Dollar-Down Rounding) for the Decision Reason. ([MS 01106.018](#), [MS 01106.006](#))

NOTE: Continue to use Waiver Approval Under \$500 (Primary) DRWP and Waiver Approval Under \$500 (Contingent) DRWC for waivers under \$500. ([MS 01106.006](#), [MS 01106.007](#))

Request for waiver – O/P above \$1000

[GN 02201.021](#)

An implied request for waiver often results from SSA's receipt of a completed SSA-3105. We provide the debtor with the SSA-632 and SSA-4641 for completion, a "Request for Waiver Cover Letter", a "Waiver Notice for Requesting Authorization to Access Financial Information", and set a diary for 30 days. If the diary expires without receipt of the completed documents and supporting evidence, attempt to contact the debtor by phone. If no response, send a closeout notice requesting the document and evidence with another 30-day diary. At the end of this 30-day period, reinstate recovery actions and annotate DMS with your actions.

SSA-632-BK (Request for Waiver and Recovery Questionnaire)

[GN 02250.230 - .240](#)

The overpaid individual completes the SSA-632-BK, "Request for Waiver of Overpayment Recovery or Change in Repayment Rate," as the formal waiver request. This form establishes whether the person meets the requirements for waiver, but any written statement with the same information will suffice. The SSA-632-BK is preferred because proper completion assures we obtain the required information. There are two parts to the SSA-632.

Part I

SSA-632, Part I, "Information about Receiving the Overpayment" is the "without fault" portion designed to find out why the person believes he/she is without fault in causing the overpayment and should not have to repay the overpayment.

- If a person alleges he/she was misinformed, obtain the name of the person who gave him/her the wrong information, the approximate date(s) received, and was it through personal contact or by telephone, etc.

- Record the information in the individual's own words. You should write down what the beneficiary thought the expected consequences of their action or inaction would be.

Part II

SSA-632, Part II, "Your Financial Statement," asks for a detailed description of the person's income and assets from all sources and the expenses of his/her household. We use Part II information to determine the ability to repay, develop for compromise or relief under Federal Collection Standards, or report the overpayment to the Department of Justice.

If the SSA-632-BK is completed for a reason other than to request waiver, complete only section II.

Verification

[GN 02250.250](#)

Unless a person is receiving cash public assistance, he/she must submit verification of all allegations of income and liquid assets and certain expenses when he/she:

- Requests a waiver; or
- Requests an amount of withholding less than \$10 a month, or
- Requests an amount of withholding which will not permit recovery prior to the expected termination of benefits or within 36 months.

The person requesting the waiver is responsible for furnishing the needed proofs, which should be submitted within 30 days after the completed SSA-632. Listed below are the types of verification, which need to be submitted with the completed SSA-632-BK.

- Verification of Income. Acceptable verification includes, but is not limited to:
 - Pay stubs,
 - Workers' compensation award letters,
 - VA award letters,

- RRB award letters.
- Verification of Expenses:
 - Rent/mortgage—current rent receipts, mortgage payment book, cancelled checks, money order receipts.
 - Utilities (gas, electric, fuel, telephone, water, sewage)—two or three utility bills, cancelled checks, money order receipts, statement from utility company.
 - All insurance—bills, cancelled checks, money order receipts.
 - Any disproportionately large expenses or those, which are above normal for the area—any evidence that will support the allegation(s).

Expenses not requiring proof are food and miscellaneous household expenses unless they seem unusually large. An explanation may suffice as verification for some types of expenditures, (e.g., "food expenses are high because a special diet is medically necessary"), or as justification for an otherwise unreasonable expense (e.g., "I have to have full-time domestic help or move into a nursing home").

For any especially large expense, determine whether the amount represents an unusual cost in one month, which should be prorated over 12 months. Examples would be major home repairs, medical expenses, or whether the expense is included twice (e.g., the amount listed for clothing is also included among charged expenses).

Do not confuse the need to verify an allegation with the need to judge whether an expense (verifiable or otherwise) can reasonably be considered ordinary and necessary. Make sure to explain any discrepancies in the file in item 22 or the Remarks section of the form.

To help you decide whether the "defeats the purpose" requirement is met total the income and expenses on the SSA-632 and do a comparison.

If the overpaid individual receives public assistance, he/she needs to provide verification of those benefits. The individual will complete Form SSA-632 through question 13, and sign on the last page. "Defeat the Purpose" is deemed when public assistance is verified.

Waiver Disposition

The field office makes the waiver determination for a Title II RSI and DIB overpayments. ([GN 02250.301](#))

If an overpaid individual decides to abandon their waiver request, meaning they decide to repay the overpayment without having yet received a decision on their request for waiver, follow the guidance in [GN 00250.240B.4](#) and [GN 02250.305](#).

NOTE: This procedure includes obtaining a signed statement from the person stating he/she knows he/she is entitled to a waiver determination, but he/she prefers not to pursue it and can afford to repay the overpaid amount.

SSA-635- Waiver Determination Form

[GN 02250.315](#)

The three possible dispositions for waivers are approval, partial approval and denial. If a waiver request is **fully approved**, this is a final field office decision. Waivers that are only partially approved and/or denied require a personal conference.

Form SSA-635 is used to document the waiver determination. The form must have an explanation of how the O/P occurred and state the facts supporting the waiver decision. The same SSA-635 can be used for more than one person if the same determination applies to everyone.

Completion of Items on SSA-635

[GN 02250.415](#), [GN 02250.420](#)

Items 1-5 – Self-explanatory. **NOTE:** Names listed in #3 should indicate BIC or RP for a representative payee.

Item 6 – Explain fully the cause of the O/P, amounts due and paid for all months, as well as any amount withheld or refunded. If the person has an electronic folder include the date of the notice. If a person has a paper folder, attach the notice to the form.

Item 7 – Include names of all persons liable for repayment (even if they are not being considered for waiver). If more than one person is listed, indicate the amount of liability for each. When there is a representative payee, add the

remark, "see SSA-553 regarding non-liability of (name)". See [GN 02205.000](#) for more information about liability.

Item 8 – Complete only if recovery of all or part of the O/P is being waived; check the box for "does" or "does not" as appropriate.

Item 9 – Complete only if all or part of the waiver is denied. Check the box "Adjustment" or "Refund" as applicable.

If you were only partially approving the waiver of recovery of the overpayment, complete both Items 8 and 9.

Item 10 – "Deduction" is checked when the O/P resulted from failure to impose deductions; "Entitlement" is checked when the cause was an incorrect entitlement factor, computation, etc. Specific codes are listed in GN 02250.315E.10.

Item 11 – Complete parts A and B and the inappropriate section lined out. Fully document all findings for waiver criteria. Should an appeal be filed on your determination, a detailed explanation is critical to the next decision maker.

Item 12 – Complete as appropriate.

Waiver Determinations

[GN 02250.301](#), [GN 02270.003](#)

When the amount for which the person is liable is over \$2,000, a decision to approve or partially approve the waiver must be reviewed by the decision maker's peer (or above) in the FO. This review must be input to DMS before sending a notice to the debtor.

If you determine the waiver should be approved, then:

- Have your determination reviewed, if necessary;
- Complete the SSA-635
- Document Debt Management System (DMS); and
- Sent "Notice of Waiver Approval" via Document Processing System (DPS) ([NL 00703.180](#))

When the waiver cannot be approved, then:

- Document the denial in DMS on the DRWD screen and enter mandatory remarks on the remarks screen;

- Request the folder from the Payment Center (see NOTE below);
- Do not complete the SSA-635.

NOTE: Since 2000, the field office (FO) or program service center (PSC) does not need to request a paper claims folder for documents used to calculate the overpayment. Most of these documents can be found in either PSC Paperless, or the electronic folder (EF). Use the Claims File User Interface (CFUI) to view documents stored in NDRED. Print the pertinent information used to calculate the overpayment so it is available to the debtor for the folder review (e.g. paid vs. payable charts, notices, etc.).

When the waiver cannot be approved and the input is made in the DRWD screen, DMS automatically escalates the case to the personal conference level. A Title II personal conference is conducted by a CS or higher not previously involved in the original decision. It is an independent and thorough examination of all evidence relating to the overpayment and the issues around it. More about the Personal Process will be covered in Advanced Training. You can also look at [GN 02270.000](#).

Waiver vs. Appeal

It is important to understand the difference between a waiver request and an appeal in an overpayment situation.

- In an appeal, the beneficiary is contesting the fact that caused the overpayment and/or the amount of the overpayment; that is, the person is challenging the Agency determination that he/she was overpaid.
- In a waiver situation, the person is not challenging the fact an overpayment exists. Rather, the beneficiary is asking that repayment be waived (i.e., that it does not have to be paid back).

When responding to inquiries regarding a beneficiary's options upon receipt of an overpayment notice, you must be able to explain to the inquirer the difference between a request for waiver and an appeal of the waiver.

EXAMPLE:

If a person calls to contest the facts of an overpayment after receiving a notice of overpayment, a waiver request would not be the appropriate action. On the other hand, if an inquirer acknowledges the fact and amount of overpayment, but says he/she cannot repay the amount, a waiver request may be appropriate.

Reconsideration Requests

GN 02201.025

A request for reconsideration of an O/P must be in writing within 60 days of the date of the initial overpayment notice. Form SSA-561-U2 is the reconsideration request form and is used only when the individual wants to appeal the fact and/or amount of the O/P. The person must also submit any information pertinent to the appeal.

The SSA-561-U2 should not be used if the overpaid individual only wants an explanation or to file a waiver of the overpayment.

The PC makes a formal determination when a beneficiary submits a SSA-561. This includes cases where there is an implied request for waiver or if the waiver is \$1,000 or less. In a situation in which the beneficiary indicates an inability to repay (or similar language), the PC processes the case as if the beneficiary is requesting both a reconsideration and a waiver. Once PC makes a determination on the reconsideration they forward the case to the FO to process the waiver request.

When the PC needs to take an action on an overpayment issue, the FO can use the Paperless Barcoding Application in lieu of the SSA-409 to notify them of a request for reconsideration of the overpayment determination. For additional information, see the (b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)

(b) (2)

OBJECTIVE 6:**Read and interpret the Overpayment
Queries and DMS****Overpayment Queries****O/P Fields on MBR**

[SM 00510.565](#), [SM 00510.569](#)

There are certain fields on the MBR, which supply O/P information. These fields are included on the O/U PAY line, PAR REC line, and the ROAR line. If you need to interpret the data in these fields, you can use Query Master on the OQP Toolbar to translate them.

ROAR (Recovery of Overpayments, Accounting and Reporting) System

[SM 00610.000ff](#), [SM 00535.000ff](#)

The ROAR system tracks and processes recovery and collection activities of Title II, Title XVI and Medicare overpayments, misused and conserved funds and civil monetary penalty funds. The ROAR record is much like the MBR in that it is a master record of recovery efforts on all overpayments.

We initiate overpayment recovery actions via DMS, the Debt Management System, while ROAR processes and maintains a history of these actions. The ROAR system also interfaces with the MBR, SSR, PHUS, eRPS, RECOOP, ECO, and NED systems to document recovery actions. ROAR obtains information by using the Debt Management System (DMS) function entitled, "Pending File Summary."

The ROAR:

- Displays the cause of the overpayment;
- Specifies the original amount of the overpayment and the current balance;

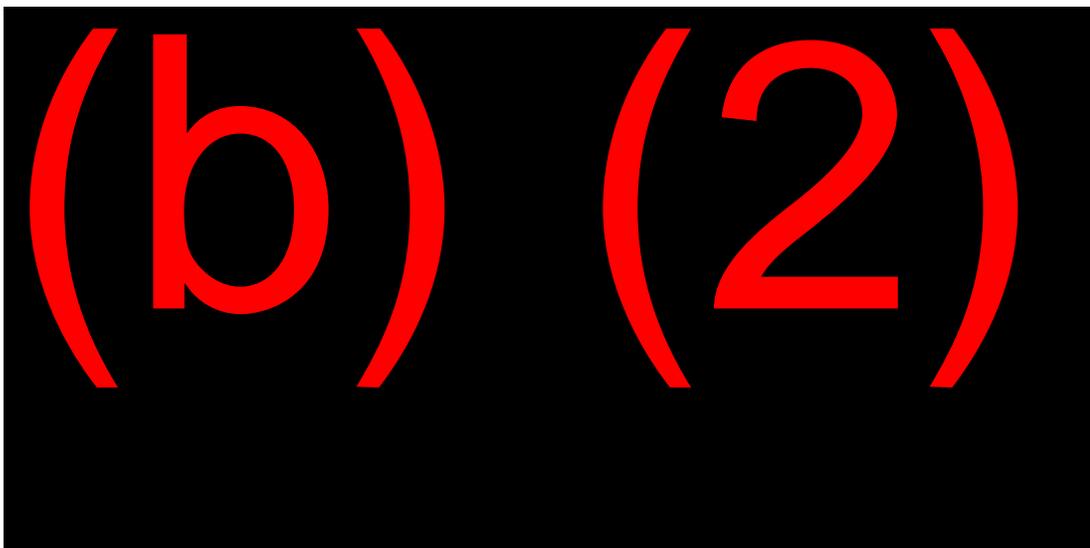
- Provides information about the individual who is liable for the debt;
- Records the actions against the overpayment record;
- Controls the recovery and collection activity of overpayments when refund is requested or adjustment is proposed;
- Indicates the collection status of the overpayment, remittance agreements, waiver and reconsideration information.

There is a limited interface between the ROAR system and the MBR, so there may be cases when the MBR will not show complete ROAR information. The following data passes automatically from ROAR to the MBR:

- Remittances
- Waiver/reconsideration (requests and denial/approval)
- Returned checks
- Accretions
- Diary updates
- Requests for explanations of overpayments

The ROAR system accounts for and controls Title II overpayments recoverable by adjustment and transfers control of the record to RECOOP when recovery by adjustment is not available. RECOOP is responsible for accounting and/or controlling overpayment recovery through methods other than adjustment.

ROAR data is at the end of an MBR as shown below:



The BENEFIT line shows the name of the overpaid individual and the total current balance due for all overpayments for this beneficiary (BBAL) which, in this example is \$1,939.00.

The EVENT field reflects the number of overpayments an individual has had. In this example, the individual has had one overpayment.

- In her overpayment, reflected in the EVENT field as “EI -01”, she incurred an overpayment of \$2,023.00. This was due to a Multiple Entitlement determination (see type of event – TOE). The status of the first overpayment shows Due Process.

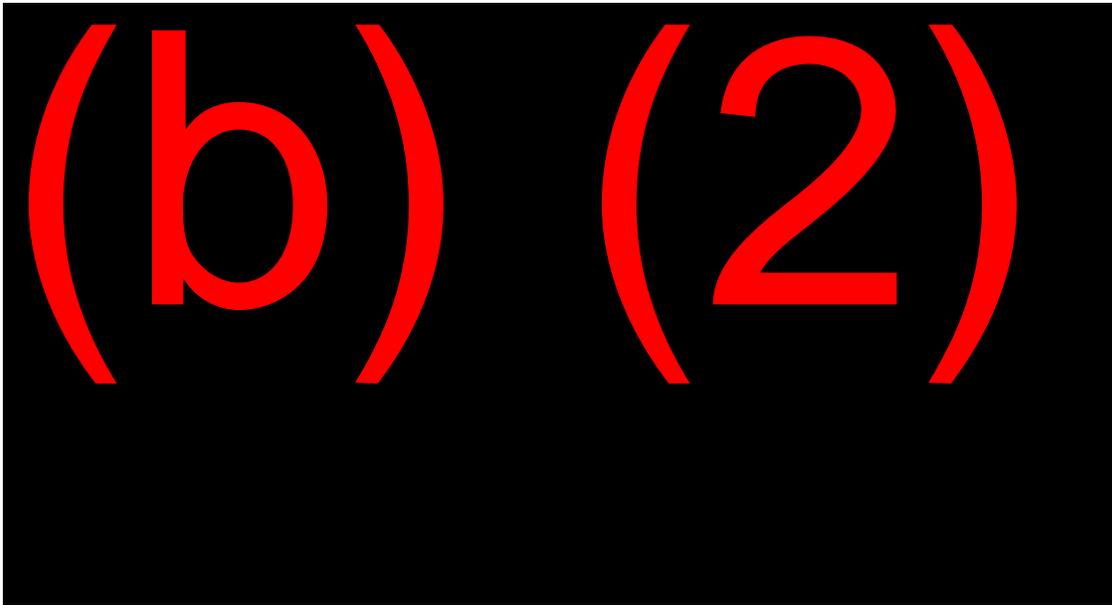
The HISTORY field will show withholdings, reconsideration, waiver, personal conference requests, and PSC actions. Use query readers to interpret the fields in more detail.

Systems Queries

Three online queries are useful in determining the amount of an overpayment. Access all of these through the MFQ System Menu (MFQM). Selection #17 allows you to request the following queries from the Inquiry Response Selection List (QRSL): ([MS 05206.001](#))

- T2 OP (QROP)
- PMTH (Payment History)
- PWST (Payment Worksheet)

The T2 OP (**QROP**) query is selection "D" from the QRSL. It furnishes information regarding the beneficiary's overpayment amount, recovery data and waiver and appeals data. See [MS 05206.024](#) on how to interpret the query.



The Payment History (**PMTH**) query is selection "E" from the QRSL. Use it to answer inquiries about a beneficiary's payment history. See [MS 05206.015](#) on how to interpret the query.

The Payment Worksheet (**PWST**) query is selection "F" from the QRSL. Use it to determine the difference between what a beneficiary was actually paid and what was actually due for a specified period of time. The data propagates from the PHUS and MBR. The system displays a Payment Worksheet Summary (**PWSM**) after the PWST. See [MS 05206.017](#), [MS 05206.016](#) on how to interpret the query.

OPTEL and Modernized Development Worksheet (MDW) 2560 Request

In complex cases, when an automated worksheet is unavailable and a comparison of the PHUS and MBR is insufficient, enlist PSC assistance using the OPTEL procedure. If the issue is too complicated to explain on the phone, use the MDW. The issue of 2560 or 2560HP (high priority) is used on the MDW worksheet and jurisdiction of the MDW is transferred to the PSC. See [GN 01070.235](#).

OPWiz

The OPWiz program, available through the OQP Toolbar, is designed to assist both Title II and Title XVI users in conducting an interview with overpayment issues. By inputting a single SSN, OPWiz searches several query systems and

produces a Summary Sheet showing a variety of information collected in the searches. Systems searched include:

- MBR (including ROAR and Collection query data),
- SSR,
- Modernized Development Worksheet (MDW),
- Debt Management System (DMS), including Recovery and Collection of Overpayment Process System (RECOOP) and DMS Remarks, and
- PCACS for a Title II beneficiary.

The OPWiz program can also:

- Keep track of listings and tickles
- Add issues
- Print and archive notices to ORS
- Create commonly used overpayment forms (e.g. SSA-632, SSA-635, and the SSA-561)
- Update information into DMS (e.g. remarks)
- Record Reports of Contact

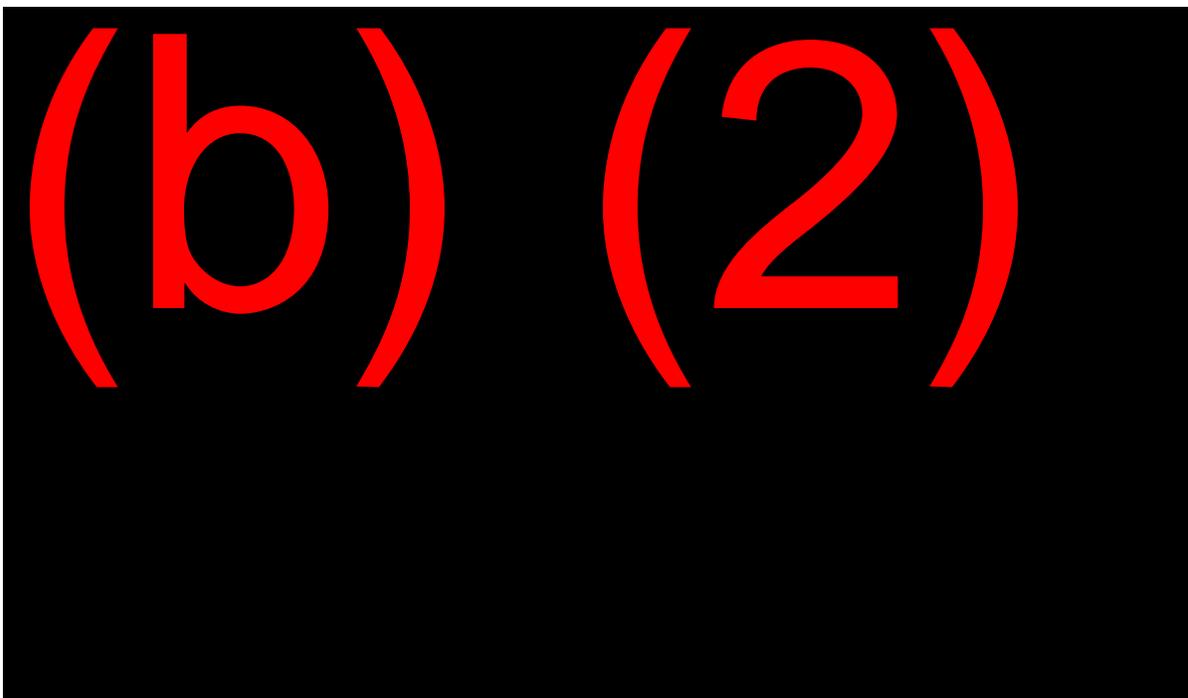
Check out the (b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2) for all the features you can find there.

The Debt Management System (DMS)

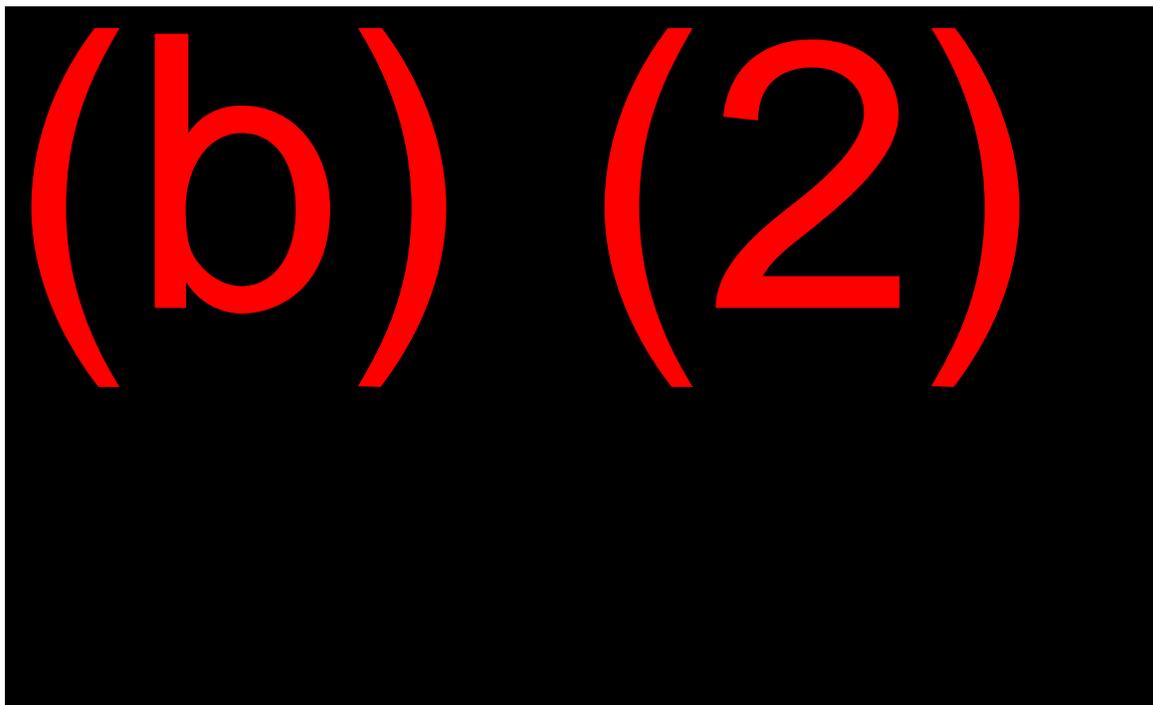
The Debt Management System (DMS, #6 on the SSA MAIN MENU) is the automated, online system that consolidates all of SSA's Title II and some Title XVI debt management data entry activities. Completion of DMS screens allow us to perform the various activities pertinent to debt management.

DMMU

The DMMU (Debt Management Menu) is the first sub-menu screen. Access it by selecting #6 from the SSA Main Menu. ([MS 01101.002](#)) Enter the SSN and BIC and select the desired function.

**DRMU**

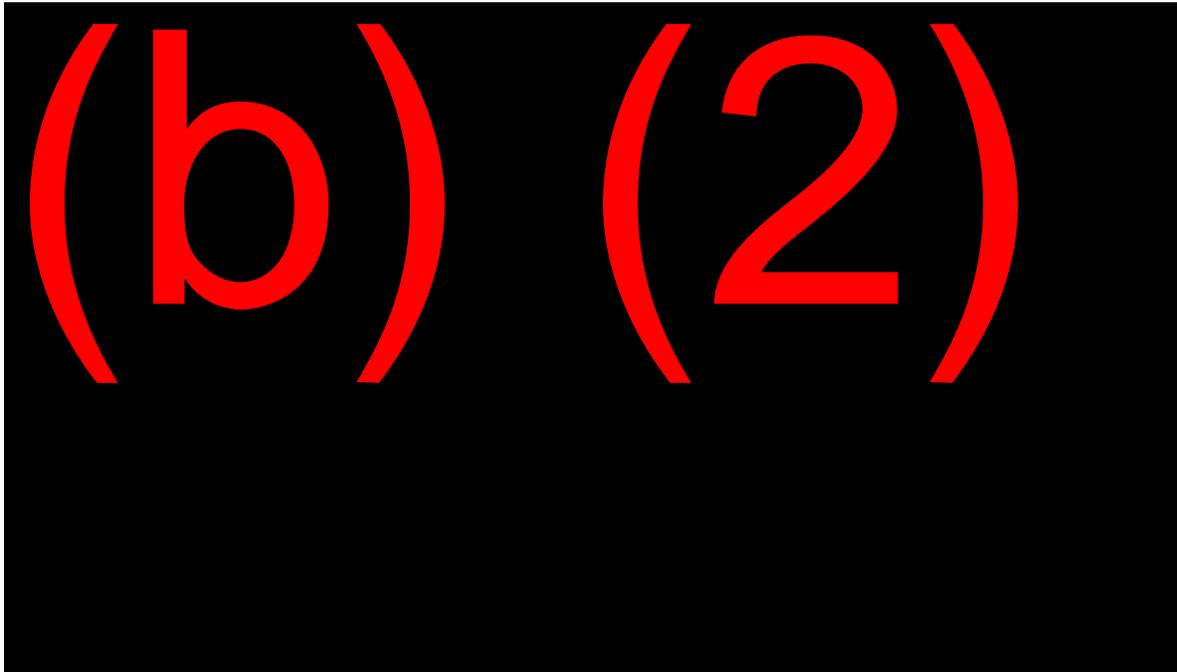
From the DMMU screen, select #2 DEBT RESOLUTION when the overpaid individual wants to protest an overpayment. This brings up the DRMU screen.
[\(MS 01106.002\)](#)



This is a sub-menu screen. First, enter the DEBT NUMBER. This is the event(s) on which action is to be taken. If the claimant is requesting action on multiple open events, enter the debt number of the lowest open event. Here is an example. A claimant has four overpayments (events) posted on the ROAR. If events 1 and 2 are closed and events 3 and 4 are open and the claimant is protesting both open events, we would have to make a decision on more than one event. We would enter a 3 in the DEBT NUMBER field because event #3 is the lowest event still being protested.

DRPF

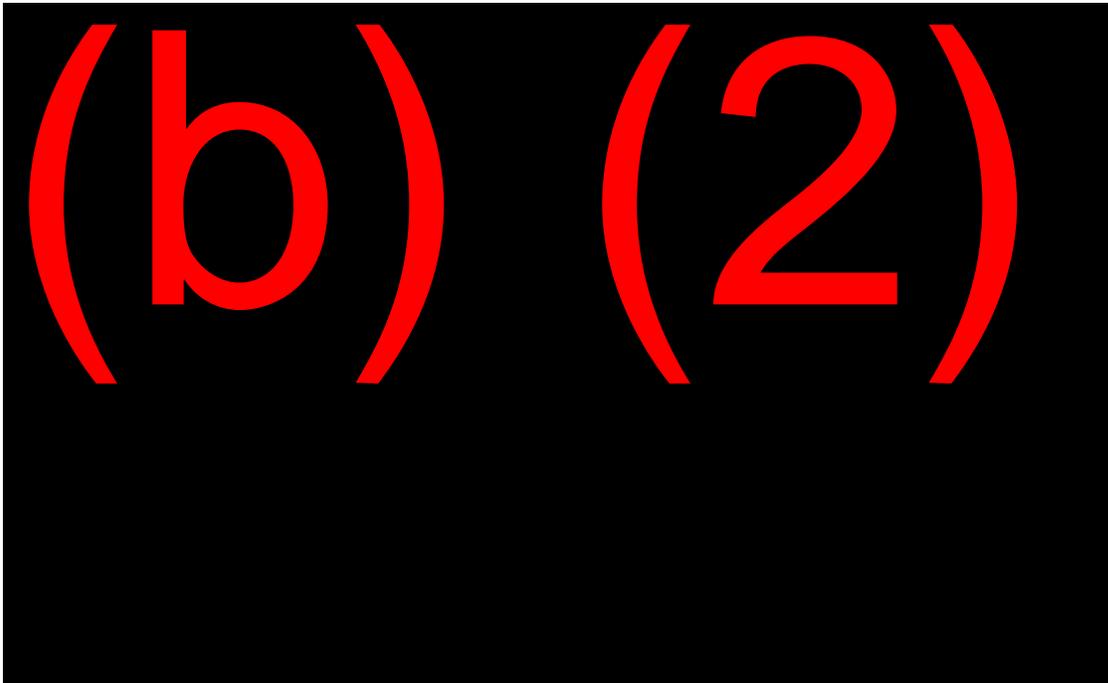
To enter a protest request, a stop recovery action or an ECO protest only, select #1 PROTEST/STOP RECOVERY REQUEST (FO) from the DRMU screen. This brings up the DRPF screen. ([MS 01106.019](#))



Select the request that applies to your case.

DRWD

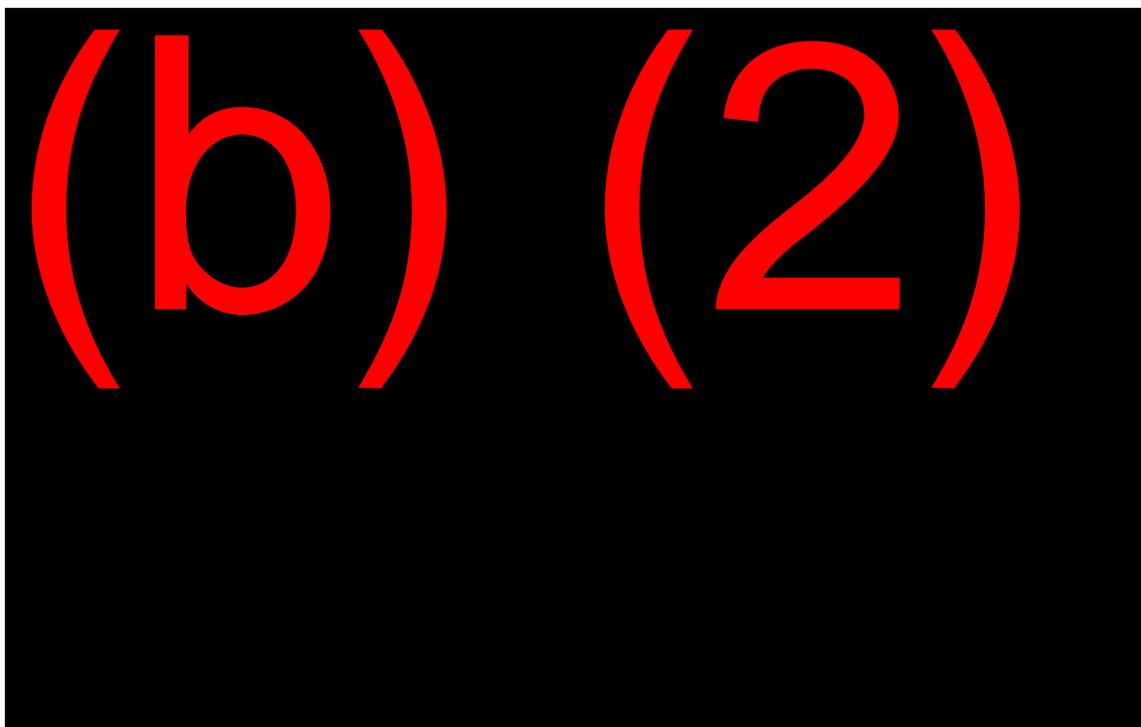
Looking back at the DRMU screen, #4 is used to process the waiver decision. When you select #4 from the DRMU screen, the DRWD or waiver disposition screen will appear.



The DRWD screen shows the debt amount. The decision type can be an approval, a denial or a partial approval. Access the decision reasons to choose from by entering a “Y” in the decision reason codes field. If the waiver is an approval, or is a partial approval, enter the amount waived in the “Approval Amount” field. If the waiver is a denial or a partial denial, enter that amount in the “Denial Amount” field and enter the denial basis - #1. Not Without Fault, or #2 No Hardship or Inequity. Select the appropriate responsibility type - #1 for Primary or #2 for Contingent. If you select #2-Contingent, complete the XREF SSN, BIC and CODE as described in [MS 01106.004](#).

DROA

If the individual is in current pay status and requests to repay the overpayment at a reduced rate, the DROA screen is used to input the amount to be withheld from their check each month. To access the DROA, select #16, Establish Offset (Debtor) from the DRMU screen. ([MS 01106.015](#)).

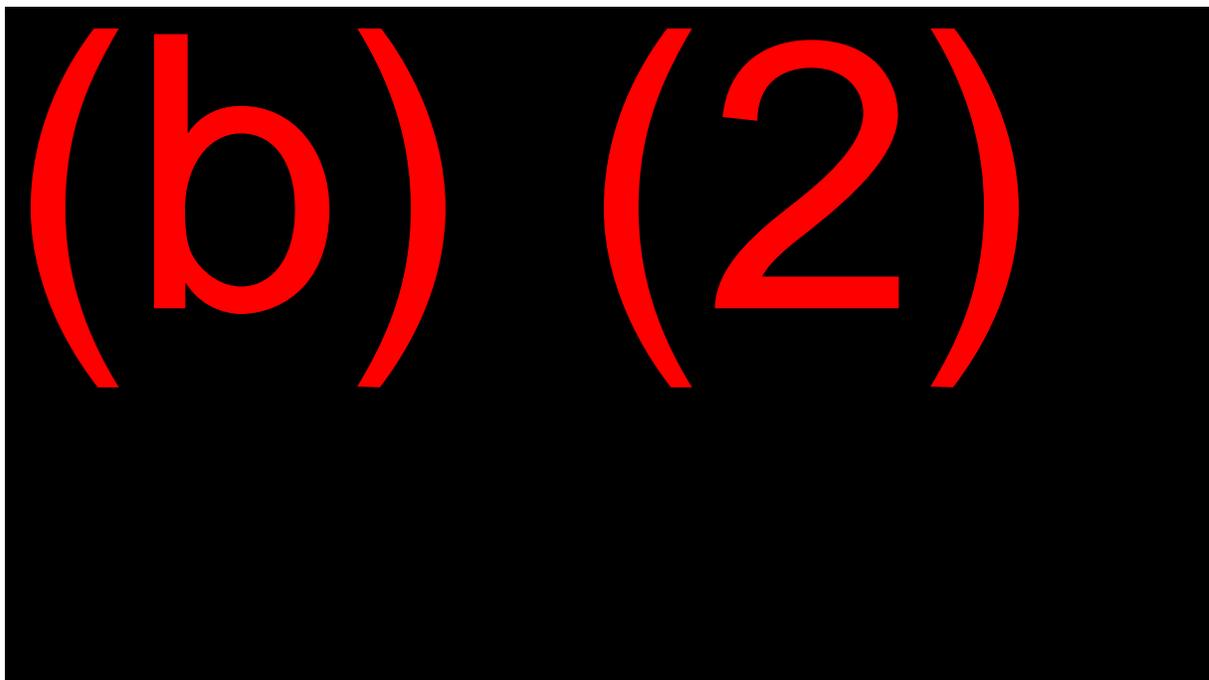


Enter #1 for a full offset or #2 for a partial offset. If you select #2, enter the offset amount. No amount is needed if #1 (full offset) is selected.

When the debt cannot be recovered within 36 months and the claimant meets the financial test guidelines, enter a "Y" in the Financial Test field. Enter a start date for the withholding. The start date cannot be any earlier than COM and no later than six months after COM.

DRIN

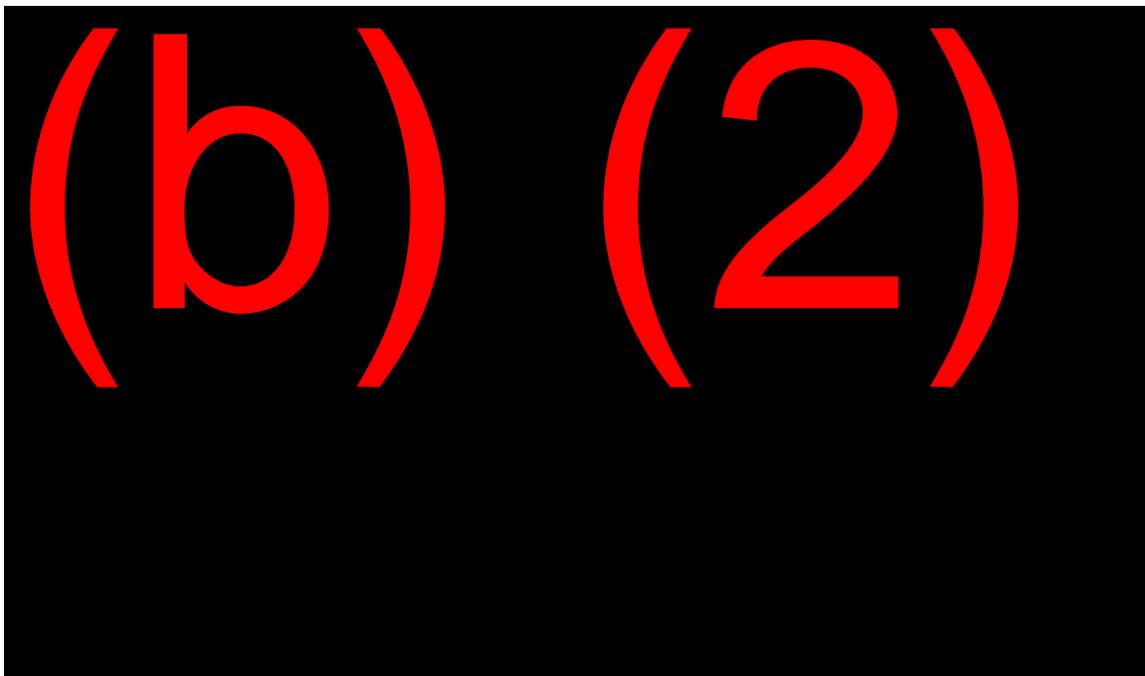
If the overpaid individual is not in current pay and requests repayment by installments, select #15 "Installment" from the DRMU screen. This will bring up the DRIN screen. ([MS 01106.014](#))



Enter the amount the debtor wants to repay in the “New Installment Amount” field and enter the next due date. The debtor will then be billed based on the “Installment Due Date” field.

RMKI

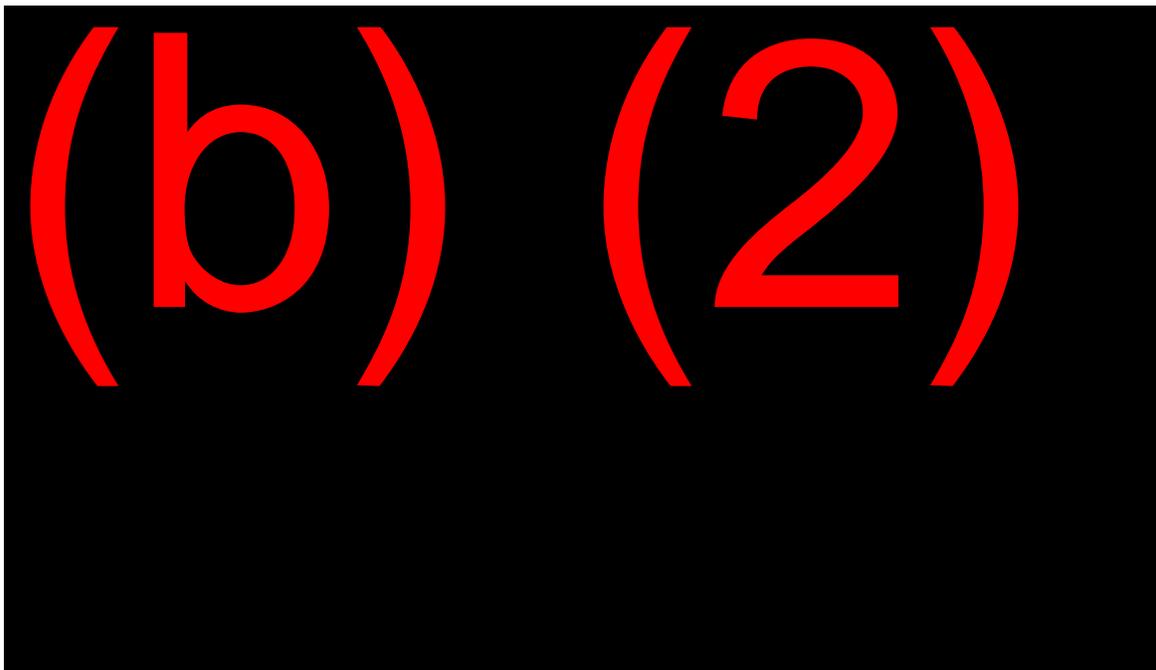
For all requests, including a protest, waiver, adjustment, or installment, the remarks screen will appear in the pathway. You may also access the screen by selecting #6 REMARKS, from the DMMU screen. The first screen in the pathway is the RMKI screen. ([MS 01109.002](#))



To establish remarks, select #1 Establish, then select the appropriate Remark Category for your situation, most often #2 (Conversations/Negotiations) or #3 (Appeals/Explanations). Any other remarks already posted can be viewed by selecting #3 Query and placing an "X" by "All Remarks" or by the specific remark to be viewed.

RMKS

The next screen in the pathway is the RMKS or remarks screen. ([MS 01109.003](#))

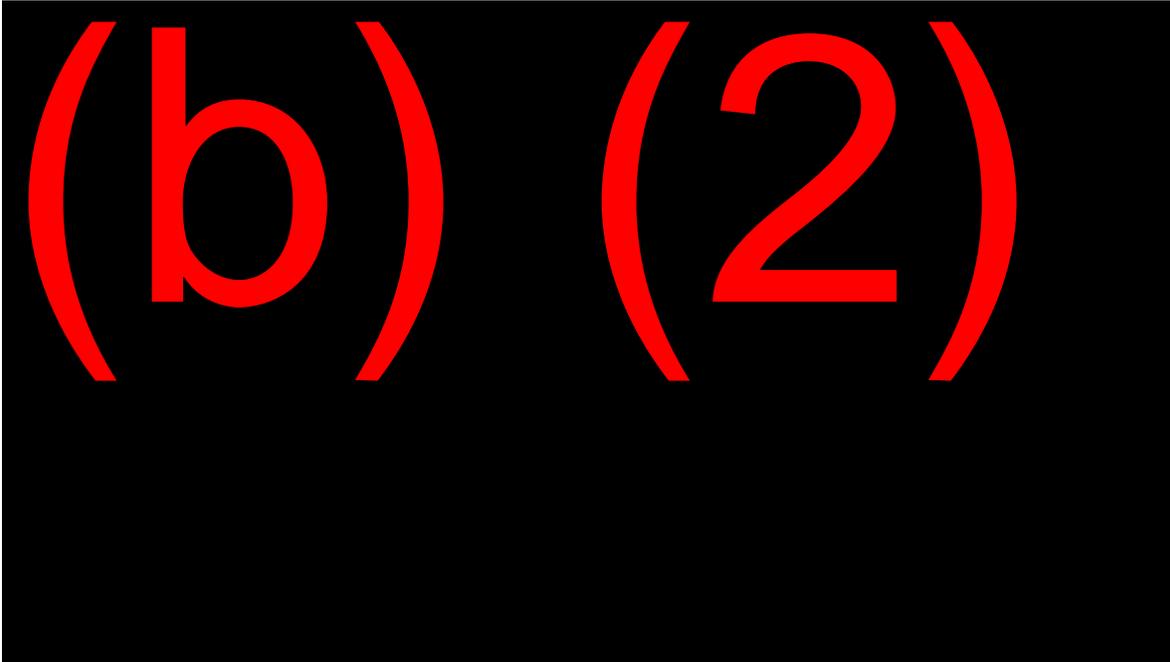


Remarks (RMKS) allows the user to record and/or change account related comments concerning debt collection activity. The data entered is in free-format and there is capability for multiple pages of remarks.

Enter your name, the date, and your office code whenever you establish a remark or add to an existing remark.

DMFS

Use the WMS-Debt Management Function Selection (DMFS) request screen to perform maintenance tasks within WMS-DM. Access this screen by selecting #10 WMS-DM Function Selection from the DMMU screen. ([MS 01202.003](#))



On the Select Function portion, DMS cases can be queried, transferred – with or without documents – receipted in, or assigned/changed to different units with this screen.

NOTE: When an explanation request is input, you must transfer the case to the PSC of jurisdiction. Failure to transfer the case will leave it on your office's listing, and the PSC will not be alerted that an explanation is needed.

OBJECTIVE 7:

**Determine if an underpayment exists,
who should receive an
underpayment, and the proper
disposal of an underpayment**

Definition and Types of Underpayments**[GN 02301.001](#)****Definition**

An underpayment is any monthly benefit amount (or portion of a monthly benefit amount) due a person, which has not been paid.

An underpayment occurs when:

- An accrued benefit was not paid,
- A check(s) representing a correct payment to a deceased person was not negotiated, or
- An issued payment was returned or not received.

Accrued Benefits

An accrued benefit can be a check not yet issued to a beneficiary or a payment amount that is less than the amount to which the beneficiary was entitled.

Identifying a Title II Underpayment

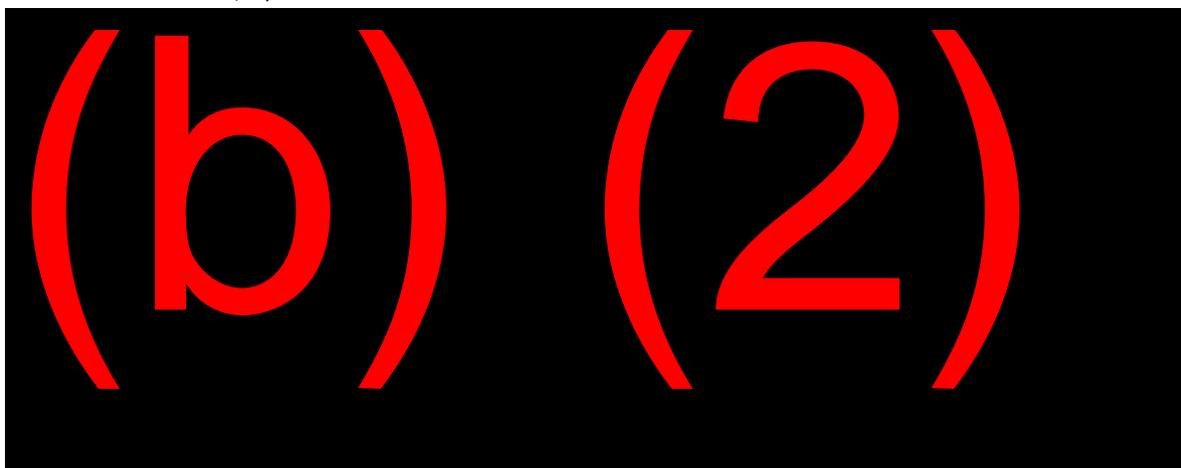
Identification

It is important to determine an underpayment exists before beginning any development. Use The MBR and PHU1 queries to determine if the benefit is due.

MBR

Underpayment data is reflected in the SPECIAL PAYMENT CODE (SPC) field of the SPECIAL PAYMENT (SPC PAY) DATA of the MBR.

The SPECIAL PAYMENT AMOUNT (SPA) represents the amount due. An asterisk will appear immediately following the amount if it is questionable as to whether an adjustment has been made for any health insurance premiums due. The following is a facsimile of the MBR SPC PAY line showing an underpayment amount of \$4,673.00.



PHU1

The MASTER BENEFICIARY RECORD PAYMENT (TRANS) line and the MASTER BENEFICIARY RECORD FIELDS (MBR FDS) line of the PHU1 query contain certain benefit payment related fields direct from the MBR. It is a combination of information taken from several fields on the MBR. A review of the PHUS Transaction lines shows two checks were returned. An underpayment exists.



Possible Underpayment Situations

To identify a possible underpayment, look for the following items:

Accrued Benefits: No Check Issued may result from one of the following circumstances:

- A retroactive payment was not issued in an initial claim situation,
- Failure to receive a payment after a re-computation,
- A payment was not received because of an erroneous report of death,
- A beneficiary was paid less than the amount he/she was due because of an adjudication error,
- Death or other termination in a family maximum situation, or
- A beneficiary's actual yearly earnings are less than the estimated earnings.

Return of Un-Negotiated Check when:

- A beneficiary's change of address was not reported on a timely basis; or
- A beneficiary closed his/her bank account and the bank returned the benefit payment(s).

Not Underpayments

Things that appear to be underpayments, but are not, include:

- An unpaid Lump Sum Death Payment (LSDP) (the exception in [RS 00210.010B.2](#) applies if the LSDP check is received, but not cashed before the recipient dies),
- The payment of excess SMI premiums,
- Unpaid Part A and Part B Medicare Insurance benefits,
- Benefits previously paid to a representative payee, but returned to SSA for recertification, and
- Conserved and misused funds in the case of the death of the beneficiary.

NOTE: If the beneficiary dies before recertification of conserved or misused funds, the money can be paid only to the legal representative of the beneficiary's estate.

Selecting the Proper Person

After an underpayment is recognized, SSA must determine to whom the underpayment should be paid.

Life Case

[GN 02301.020](#)

If the beneficiary is alive, pay the underpayment to him/her or his/her representative payee.

Pay an underpayment due to a living beneficiary only after making an adjustment of any outstanding overpayment for which the underpaid person is liable. ([GN 02210.006](#))

Death Case

If a claimant dies before receiving payment, follow a statutory order of priority to determine who is entitled to the underpayment.

Order of Priority

GN 02301.030

As shown in [Exhibit 6](#), payment must be made in the following order of priority:

- To the surviving spouse who was either living in the same household as the deceased at the time of death or who, for the month of death, was entitled to a monthly benefit on the same record as the deceased beneficiary. (A surviving divorced spouse does not qualify for an underpayment under this provision.)

EXAMPLE:

Anthony and Sherita Johnson were living together when Mr. Johnson died. Mrs. Johnson was first on the priority list for an underpayment on her husband's record.

- To the child who, for the month of death, was entitled to a monthly benefit on the same earnings records as the deceased.

EXAMPLE:

Marcie Jones and her two children receive monthly benefits because of her disability. Ms. Jones has no spouse. In the event of her death, any underpayment on her record would be paid to her children.

- To the parent who, for the month of death, was entitled to a monthly benefit on the same earnings record as the deceased.

EXAMPLE:

Juan Flores provided the sole support of his parents when he became entitled to disability benefits. Since his death, his parents receive a monthly benefit on his earnings record. Mr. Flores was divorced and had no children. An underpayment is discovered on his record. It will be equally divided between his parents.

- To the surviving spouse not qualified as above.

EXAMPLE:

Violet Gray, a RIB beneficiary, had been separated, but not divorced, from her husband, George, for 5 years because of marital difficulties. Mrs. Gray died on June 2. Mrs. Gray's children are adults who work full-time.

Her parents have been deceased for years. The underpayment for the May check is paid to George Gray.

- To the child not qualified above.

EXAMPLE:

Henry Barrows, a widower, is survived by five adult children. No children were entitled to benefits on his account. Any underpayment on Mr. Barrows' account will be equally divided among his children.

- To the parent not qualified above.

EXAMPLE:

Franklin Shaw, who received disability benefits, is survived by his father, Lamont Shaw. The elder Mr. Shaw is still working full-time. Franklin Shaw was divorced and had no children. Any underpayment on Franklin Shaw's earnings record will be paid to his father.

- To a legal representative of the deceased person's estate. (See [GN 02301.035](#))

EXAMPLE:

Lucy Schroeder, a retirement beneficiary, was widowed and had no children. Her parents have been dead for years. Her brother, Linus Van Pelt, is the executor of her estate. Pay any underpayment on Mrs. Schroeder's earnings record to Mr. Van Pelt.

Before any underpayment can be made, you must first determine if there is someone higher on the priority list than the individual requesting the underpayment. An underpayment cannot be paid to someone of lower priority if there is a known living person of higher priority, even if the person cannot be located.

EXAMPLE:

Charles Brown's mother died on May 3 before receiving her April check. She and her husband had been separated for many years. (He lives in a neighboring state.) Charles paid for all of his mother's burial expenses. He requests his mother's benefits be reissued to him. As long as his father is alive, however, the benefit owed to Charles Brown's mother cannot be reissued to someone in a lower priority (Charles).

Same Priority Category

Divide the underpayment equally among persons of the same priority.

EXAMPLE:

Patty Simpson, who received widow's benefits, died. Later, SSA found an underpayment of \$275 on her earnings record. Mrs. Simpson has five children. Four of them have been located. The fifth child was last known to be living in Tibet and has not contacted his siblings in years.

The four children who have been located will receive \$55 each (\$275 divided between the five children). The payment due to the son thought to live in Tibet will not be paid to anyone until he is located. ([GN 02301.060](#))

Forms, Evidence and Documentation

[GN 02301.050](#) - [GN 02301.055](#)

Request for Payment

No formal written request is required for payment of an underpayment if the file contains sufficient information to determine the identity and current address of all persons entitled to the underpayment. Otherwise, a written request is required from at least one person entitled to receive a portion of the underpayment.

SSA-1724

No particular form is required for requesting payment of an underpayment; however, the SSA-1724, "Claim for Amounts Due in the Case of a Deceased Beneficiary" is designed for this purpose.

If another individual of an equal order of priority is listed on the SSA-1724, treat the listing as a request for payment from the person.

Information Required

The individual requesting an underpayment must provide information on the SSA-1724 showing:

- The relationship of the deceased to the person seeking the underpayment;
- The number of persons in the highest priority category entitled to receive the underpayment, along with their names and addresses;
- The Social Security Number (SSN) of the applicant(s);
- Whether or not there was a surviving spouse living with the deceased at the time of death; and
- Direct deposit information when available. Direct deposit is not mandatory to issue a death underpayment per [GN 02402.005](#)

Evidence Required

These types of evidence may be required to pay an underpayment:

- Proof of death of the underpaid person,
- Proof of the underpayment requestor's relationship to the deceased,
- Proof of disability,
- Proof of claimant's qualifications as legal representative of the deceased beneficiary's estate.

SSA records such as the MBR may be used to establish proof of death, relationship or disability.

Proof of Death

The following are acceptable as proof of death:

- Death Certificate; or
- Statement from the funeral director (SSA-721); or
- Numident record with death data based upon EDR report.

Proof of Relationship

If the payment is three months' benefit payment or less, accept the allegation of relationship from the surviving spouse, child or parent unless the allegation is questionable. When the total amount of the underpayment exceeds three months' benefit payment, secure proof of relationship for each person entitled to share in the underpayment.

The following would be acceptable proof of relationship:

- Marriage certificate,
- Birth/baptismal certificate, or
- MBR (if it proves relationship).

Proof of Disability

Proof of the disability of either the deceased person or the parent(s) of the grandchild or step-grandchild is required only for a Title II underpayment, which may be due to a grandchild or step-grandchild of the deceased beneficiary.

Since it may take considerable time and expense in establishing a disability, a grandchild or step-grandchild may prefer to take the steps needed to qualify as a legal representative of the estate if no one higher on the priority list exists.

Underpayment to an Estate**[GN 02301.035](#)****Legal Representative**

The Legal Representative is the administrator or executor of the deceased person's estate.

Evidence Required

The evidence required for an estate underpayment claim with a court appointed legal representative is:

- A certified copy of the letter of appointment, or
- A "short" certificate, or
- A certified copy of the order of appointment, or
- Any official document issued by the clerk or proper official of the appointing court.

If the representative appointment had been more than one year before filing, the certification must show the appointment is still in effect.

Small Estate Statute

[GN 02315.000](#)

A person is seeking qualification under the small estates statutes must show evidence the statutory requirements have been met. The rules of the state where the deceased domiciled on the date of his/her death apply.

Disposition of an Underpayment

[GN 01061.020](#) – [GN 01061.050](#)

If you determine an underpayment exists and the amount of the underpayment is correct, you can then issue the underpayment after you have chosen the proper payee. This is done by notifying the appropriate PC to pay the underpayment to the payee you have selected.

No Claim Involved

No claim is required if the underpayment recipient:

- Was awarded the LSDP and is paid the underpayment in the same capacity; or
- Is due the underpayment for a benefit already awarded a deceased beneficiary.

Claim Involved

If the claimant died prior to adjudication of his/her claim and there are accrued benefits, or if an amended award to the deceased beneficiary results in an underpayment, the manual award must be completed.

The instructions for completing the award for an underpayment are in [GN 01061.030 - 050](#). [MS 03514.001](#) also contains helpful information about A101s.

EXHIBIT 1: PRIORITY OF RECOVERY ACTION

GN 02210.015; GN 02205.007

When the individual with primary liability currently receives benefits, full adjustment is the preferred method of recovery.

If adjustment is not possible against the overpaid individual and if there is a jointly liable person (i.e., a representative payee) who is receiving a benefit, request refund and propose adjustment from the jointly liable person.

If adjustment is not available from the overpaid individual (i.e., the overpaid person is alive but not currently eligible), and there is no jointly liable person and the overpaid person is:

Alive	Deceased
Request refund from the overpaid person even if adjustment against others is possible.	Withhold LSDP.
If no refund is received within 30 days, then propose adjustment against beneficiaries on the same account who: <ul style="list-style-type: none"> • Lived in the same household with the overpaid individual at the time of the overpayment, OR • Caused or helped to cause the overpayment. 	Propose adjustment against beneficiaries on the same account if: <ul style="list-style-type: none"> • The overpaid person dies before adjustment, OR • An overpayment is determined to exist for a reason other than death.
If no adjustment available against such beneficiaries, continue recovery efforts against the overpaid person.	Attempt to recover overpayment from deceased's estate (or its distributees) if the overpayment is \$3,000 or more.
Propose adjustment against beneficiaries on the same account who were not living in the same household.	Propose adjustment against beneficiaries on the same account who were not living in the same household.
Refer for civil suit or discontinue collection.	Discontinue collection.

EXHIBIT 2: SUMMARY OF ACTIONS REQUIRED WHEN PERSON RESPONDS TO OVERPAYMENT NOTICE

FO PROCEDURE

Full Refund of Overpayment

Advise the debtor to make a check or money order payable to SSA, and include the full debt account number on the check or money order. If talking to the overpaid person on the telephone, advise him/her to enclose the bill and send the payment in the pre-addressed return envelope. If he/she does not have a pre-addressed envelope, provide the mailing address during the conversation. Follow [GN 02210.205](#) if the debtor wishes to make full refund via credit card.

Request for Waiver (RSI and DI cases)

The decision maker obtains waiver development, including a completed SSA-632-BK or equivalent information, and resolves any liability issue. The decision maker reviews all the material. If you approve the waiver, prepares a SSA-635 and a personalized notice through DPS. Then fax the materials into the CEF or NDRED ([GN02250.315F](#)). Effectuate the decision in DMS and have the determination reviewed, if necessary. If you cannot approve the waiver, and the amount is greater than \$1,000, document your determination with the facts of the overpayment on the remarks screen in DMS and on the form SSA-635. A personal conference is scheduled by another decision maker.

If the overpayment meets the tolerance rules for administrative waiver of overpayments less than \$1,000, the waiver request is approved. ([GN 02250.350](#))

Request for Explanation

Explain the overpayment and the claimant's appeal and waiver rights. Review the overpayment notice. Obtain any queries, if necessary. If you are unable to provide an explanation of the overpayment, use OPTTEL to get additional information from the PC. If you need more information from the PC, input an 'Explanation' protest to DMS ([GN 02201.017](#)) **AND** transfer jurisdiction of the DMS explanation request to the appropriate PC. If the FO can give a full explanation, document the explanation given, the date, the overpaid person's decision, and your name/office code on the DMS remarks screen.

Offer to Pay by Installment

Evaluate the offer and accept any refund. Input the installment rate to DMS. Installment refunds are usually not applicable if adjustment is available.

Request for Reconsideration

Obtain a SSA-561-U2 and any additional evidence pertinent to the appeal. Use DMS to stop recovery and transfer the request to the PC. Fax the SSA-561 and any evidence to the PC. ([GN 02201.025B](#)) If the overpayment is \$1,000 or less, see [GN 02201.025B.4](#) for instances when the reconsideration will be treated as a waiver.

Request for Different Rate of Adjustment

Document the request on a SSA-795 and evaluate the rate of adjustment. Obtain the financial portion of the SSA-632-BK if the requested rate of adjustment would not complete recovery within 36 months, before entitlement ends, or if request is less than \$10 a month and the person is not receiving cash public assistance. If a lesser rate of adjustment is approved, post the amount to DMS. For documentation purposes, enter remarks in DMS regarding the agreed upon amount and fax the SSA-795 into the EF or NDRED. ([GN 02210.030](#))

Cross-Program Adjustment

Obtain a SSA-795 requesting recovery of the overpayment by adjustment of other program benefits. ([GN 02210.008](#); [SM 00616.001](#))

PSC PROCEDURE**Full Refund of Overpayment**

If a full refund is received, cancel any adjustment or follow-up refund request.

Request for Waiver - RSDI

If the FO requests the folder for a personal conference, forward the folder to the FO and post a personal conference request to DMS.

Offer to Pay by Installment

Establish the installment on ROAR if adjustment is not available. ([GN 02210.180](#))

Request for Explanation

Furnish a payment worksheet to the FO if necessary and, if the request is received directly from person, input a SSA-1112 and attempt to resolve the request via direct contact. If unable to do so, then request FO assistance. ([GN 02201.017](#))

Cross-Program Adjustment

Take necessary action to effectuate the adjustment of other benefits.

Request for Reconsideration

Acknowledge in writing any request received directly from claimant and make a DMS input. Information about how to handle the reconsideration of an overpayment determination is in [GN 02201.025](#). This reference also discusses overpayments that are \$1,000 or less and a reconsideration is treated as a waiver.

Request for Different Rate of Adjustment

Decide the rate of adjustment per [GN 02210.030](#) and input to DMS.

EXHIBIT 3: TIMEFRAMES OF O/P APPEALS PROCESS

Request for waiver – may be filed at any point.

Reconsideration – Must be filed 60 days from date of initial overpayment notice or notice of the waiver denial if the person declined a personal conference.

Personal Conference – scheduled automatically if the PC or FO cannot approve a request for waiver. A Claims Specialist (CS) or higher at the FO will contact the claimant to schedule the conference.

Hearing – Must be filed 60 days from date of reconsideration or personal conference denial notice.

Appeals Council Review – Must be filed 60 days from receipt of the notice of the ALJ notice of decision or dismissal.

Civil Litigation Action – Must be filed 60 days from receipt of the notice of the AC's decision or dismissal.

EXHIBIT 4: ADMINISTRATIVE TOLERANCES

[GN 02201.013](#)

Overpayment \$30 or less

If an overpayment cannot be collected through adjustment, the debtor has not responded to the notice, and adjustment is not possible against any other person on same account, discontinue collection.

Reconsideration and/or waiver when overpayment is \$1,000 or less

Reconsideration/waiver is administratively approved. [GN 02201.013E, GN 02250.350](#)

Overpayment more than \$30, but less than \$200

- A. If overpaid person is in non-pay status and there is no response to the initial overpayment notice, propose adjustment against any other person receiving benefits on the same E/R in the same household ([GN 02210.015](#)). If unsuccessful, send a follow-up notice to the debtor.
- B. If within 30 days there is no response to the follow-up notice, make a limited pursuit of the debt (e.g., call-in letters, telephone calls)
- C. Propose adjustment against others on same E/R in different households.
- D. If not possible, discontinue collection efforts.

Overpayment \$200 or more, but less than \$3,000

- A. If overpaid person is in non-pay status and there is no response to initial notice, adjustment proposed against others on same E/R. ([GN 0220.013D](#))
- B. If not possible, follow-up with debtor.
- C. No response in 30 days, refer case to FO for pursuit of overpayment (IBFS exclusions only).
- D. FO attempts to contact by mail or phone.

- E. If unsuccessful, adjustment proposed against others on same E/R in different households.
- F. If not possible, collection efforts discontinued.

Overpayment \$3,000 or more

Same as above except no administrative tolerance, consideration of civil suit is required. FO is required to attempt face-to-face contact at the debtor's home or place of employment.

Note the following tolerances for recovery efforts:

- Recovery from an estate – only considered when overpayment is \$600 or more.
- SSA is subject to contempt citations if collection efforts occur after bankruptcy notification. Consequently, whenever the FO receives notice of a bankruptcy proceeding immediate action will always be taken. See [GN 02215.190](#) for more detailed instructions.
- Civil suit – not considered for debts less than \$3,000

EXHIBIT 5: Practical Tips for Overpayment Interviews

- When earning over the exempt amount, many people attempt to be too precise in estimating their earnings. Remember, any earnings over the estimate can cause an overpayment (O/P). To avoid an O/P, the beneficiary should be encouraged to provide an estimate of the highest amount he/she could realistically earn, including vacation pay. If the actual earnings turn out to be less than the estimate, an underpayment can exist. This underpayment will be issued to the beneficiary when his/her annual report of earnings is processed.
- In many cases, it is not the fact an O/P exists, but the proposed method of recovery that will cause a beneficiary to seek relief through a request for waiver or for a different rate of withholding. Keeping in mind the limits of the 36-month recovery period and payments of at least \$10 per month, explore other options of partial withholding or installment refunding. In most situations, an equitable arrangement for both the beneficiary and SSA can be arranged.
- **NOTE:** If a new overpayment is posted while a repayment agreement is in place for a prior overpayment, a new repayment agreement will need to be secured for the combined overpayment amount. Full withholding will begin if no request is made.
- For a waiver to be approved the individual must be both without fault in causing the O/P and unable to repay the overpayment or recovery would be inequitable. If these conditions are implied, or in fact, exist, the possibility of filing a waiver should be discussed with the beneficiary and an SSA-632-BK completed. A waiver may not be appropriate for some O/P circumstances. Do not routinely solicit from a beneficiary a waiver because he/she is not happy about an overpayment.
- Request for waiver can be filed at any time.
- Any denied waiver request automatically sets up for a CS to conduct a personal conference.
- A reconsideration of an O/P is an appeal of the fact an O/P exists or the amount of the O/P is correct. If a prior reconsideration has been denied, future requests for reconsideration are not appropriate. A Hearing is the next step.
- A waiver does not question the legitimacy or existence of an O/P, but requests the overpaid person be relieved from having to pay it back.
- Subsequent requests for waiver after prior denials, can be made because an individual's financial circumstances can change, thus allowing them to meet the requirements. If a waiver has been denied because the individual could not be found to be without fault, there is no basis for future waiver requests, and Res Judicata may apply. ([GN 02250.303](#)). HOWEVER, if an individual insists on filing an appeal, it is their right, and you cannot refuse the opportunity to file.

EXHIBIT 6: UNDERPAYMENTS DUE DECEASED INDIVIDUAL ORDER OF PRIORITY

GN 02301.030

- Surviving Spouse – Living with at death OR entitled to monthly benefit on same E/R for month of death. **NOTE:** A surviving divorced spouse does not qualify for an underpayment under this provision.
- Child – Entitled to monthly benefit on same E/R for month of death. If more than one entitled child, divide in equal parts to each.
- Parent – Entitled to a monthly benefit on same E/R for month of death. If there is more than one qualified parent, divide the underpayment equally.
- Surviving Spouse – Not living with nor entitled on same E/R.
- Child – Not entitled for month of death.
- Parent – Not entitled for month of death.
- Legal representative estate.

OFF-AIR ACTIVITIES

1. Locate reference guides. First, go to the T2 CS Resource Kit. Once there, find:
 - Under the Program Information section is the “Overpayment Resource Center.”Include this item in your Favorites for future reference.
2. Discuss your office’s workflow regarding overpayment issues with your mentor. Determine who is responsible for which actions regarding overpayments.
3. Locate the form SSA-632 and the close out/cover letter on DPS, sent to beneficiaries when requesting a waiver. Also, locate the following pamphlets on www.socialsecurity.gov/pubs: “How Work Affects Your Benefits,” “Retirement Benefits,” “What You Need to Know When You Get Retirement or Survivor Benefits.”
4. Locate the form SSA-1724 form using (b) (2)
5. Sit in and observe an in-office interview with an overpaid beneficiary, with a CSR/CS/TE conducting the interview.

EXERCISE #1

OBJECTIVE 1: Determine what is an overpayment, how overpayments are computed, and the proper actions to minimize overpayments.

1. What is the major cause of RSDI overpayments?
2. Name at least one way interviewers can elicit the information needed to prevent overpayments.
3. Mary Diaz reports non-receipt of her February check. She receives and cashes the replacement check. In April, she finds the original February check, and cashes it. Is she overpaid or paid incorrectly?
4. Chris Wozniak did not provide an estimate of her current annual income until June. She has received a Social Security check every month of the year, so far. Her estimate indicates she should have two months of benefits withheld. Is she overpaid or incorrectly paid?

EXERCISE #2**OBJECTIVE 2: Determine who is liable for recovery of an overpayment.**

1. For this exercise, determine who has liability for this overpayment and the type of liability (no liability, primary, contingent, or joint). If more than one person is liable, list each individual and the type of liability they have.
 - a. Jonathan is 63 years old. He is still working and drawing his own RIB benefits. He reported he would not exceed the earnings limit last year; however, his earnings were \$5,000 over the limit.
 - b. Joy is the representative payee for her adult son, Miguel, who is entitled to DIB benefits. Miguel lived at a different address and told his mother that he had been working above SGA after his Trial Work Period (TWP) ended. She continued to use the benefits for his household expenses.
 - c. Sam is currently drawing child's benefits on her mother's record. Her brother, Marquan, was drawing student benefits on the same record after age 18 but dropped out of high school three months later. He did not inform SSA he was no longer in full-time attendance. As a result, Marquan is overpaid two months of benefits. SSA is unable to locate Marquan.

EXERCISE #3

OBJECTIVE 3: Determine the appropriate actions regarding overpayment notices.

1. List three reasons why a beneficiary might contact SSA after receiving an overpayment letter.
2. You should use OPTEL to request assistance from the PSC regarding an overpayment. True or False?
3. List the options available to beneficiaries on the SSA-3105.

EXERCISE #4**OBJECTIVE 4: Determine the proper method of recovery of an Overpayment****PART I**

Provide the correct word or phrase for each of the following definitions. If you wish to match the phrase to its definition, we provided a list of words and phrases at the end of this exercise. **NOTE:** Not all of the words or phrases will be used.

1. Posting an SSA debt to an individual's credit record.
2. SSA agrees to accept a partial payment of an overpayment and relieves the debtor of any further liability for the overpayment.
3. SSA collects an overpayment from an individual's current benefits.
4. An employer withholds amounts of Federal agency debt from an employee's wages and pays the amounts to the Federal agency. There is no need for a court order before withholding starts.
5. Collecting a benefit from one SSA program and applying towards the debt of another SSA program.
6. Repaying an SSA overpayment from a beneficiary who is no longer in current pay.
7. An individual who owes a debt to SSA, but is not entitled to Social Security or SSI benefits.
8. Offsetting a Federal income tax refund to collect a delinquent Title II debt.

Word/Phrase List

Recovery by Adjustment	Installment Agreement
Compromise Settlement	Tax Refund Offset
Administrative Wage Garnishment	Credit Bureau Reporting
Non-Entitled Debtors	Cross Program Recovery
Request for Waiver	RECOOP

PART II

Imagine yourself in each of the following situations. What would you do and why? You may refer to your notes or POMS.

9. You have an irate beneficiary at your desk. He just received an overpayment notice. He is certain it is wrong because he says he has never taken anything that was not rightfully his. He tells you he is going to appeal this "all the way to the Supreme Court!" What do you do?

10. A beneficiary is currently subject to withholding at the rate of \$50 per month. He wants to know how much will be withheld when he receives his COLA increase in January. What do you tell him?

11. You have just received a call from an overpaid individual, who is no longer receiving benefits. He does not "feel like" refunding the overpayment and wants to know what happens if he does not. What do you tell him?

12. An overpaid individual is at your desk. She says she accepted the incorrectly paid checks because she needed the money and she still does. She states she cannot afford to have more than \$20 per month withheld from her checks to recover her \$1,200 overpayment. What do you do?

13. Same situation as #12, only the individual is no longer receiving benefits and requests to send in \$20 per month.

EXERCISE #5**OBJECTIVE 5: Determine the proper actions when a claimant disagrees with the Overpayment**

Determine whether the individuals in the following scenarios are asking for a waiver or an appeal (reconsideration).

1. Roopa, who is drawing a reduced RIB benefit, receives a letter stating she is overpaid \$5,000 due to her earnings last year. She comes into the office and states her earnings were below the limit and we must have the wrong amount posted.
2. Alejandro, a DIB beneficiary, receives a notice stating he is overpaid \$2,750 due to his work last year. He comes into the office and states he shouldn't have to pay back the monies since he reported his work to SSA timely. Further, he shows you paystub receipts from his local FO.
3. Colleen, a surviving spouse, receives a notice stating she is overpaid \$1,500 due to government pension offset. She stated it is unfair we are counting her pension and reducing her Social Security benefits. She states she is on a fixed income and cannot afford to repay the overpayment.
4. In the previous case, if Colleen stated the amount of the pension we are counting is wrong, would this change your answer? Why or why not?

EXERCISE #6**OBJECTIVE 6: Read and interpret the Overpayment Queries and DMS**

Using the following AACT and ROAR, answer the questions and list where you found your information (O/U Pay or ROAR or both).

FACT DTE:11/27/17 SSN: XXX-XX-XXXX BIC: DOC:R07 UNIT:SSA PG: 001+
 STATUS MBR YES LOU-02/27 DATA FILES YES LOU-02/27 SSACCS NO LOU-02/26
 CPS NO

ACCOUNT PCOC-7 NOP-05 SEX-F TAC-D LUM-02 LMM-02/13 FLI-M SSI INVOLVED
 PMT CYC CYI-1 PCEFD-07/19/2002 PCCOM-07/02 PCCR-E
 HIST PC HCYI-1 HPCEFD-06/15/1996 HPCCOM-06/96 HPCCR-S
 PRIMARY S A LAST DOB-07/18/1964 LSPA-\$0.00
 INSURED CLAIM TYPE-DISABILITY DATE OF FILING-02/15/1989 DIB QC EARNED-00
 FULL QC REQUIRE-06 FULL QC EARNED-34 CURR QC EARNED-00
 HLTHBEN QC EARN-00 CONVERTED

PIA HIS 12/09 \$1099.30 L K FMAX-\$ 1649.50D ELY-89 IME-\$1267
 01/10 \$1262.20 L 2 FMAX-\$ 1893.90D ELY-89 IME-\$1545
 12/10 \$1262.20 L K FMAX-\$ 1893.90D ELY-89 IME-\$1545
 01/11 \$1496.80 L 2 FMAX-\$ 2245.80D ELY-89 IME-\$1946
 12/11 \$1550.60 L K FMAX-\$ 2326.60D ELY-89 IME-\$1946
 01/12 \$1675.00 L 2 FMAX-\$ 2512.70D ELY-89 IME-\$2272
 12/12 \$1703.40 L K FMAX-\$ 2555.40D ELY-89 IME-\$2272
 12/13 \$1728.90 L K FMAX-\$ 2593.70D ELY-89 IME-\$2272
 12/14 \$1758.20 L K FMAX-\$ 2637.70D ELY-89 IME-\$2272
 12/15 \$1758.20 L K FMAX-\$ 2637.70D ELY-89 IME-\$2272
 12/16 \$1763.40 L K FMAX-\$ 2645.60D ELY-89 IME-\$2272

PAYMENT PIC-A MPA-\$0.00 DOC-769 RD-02/04/13 LAP-2
 TELE NO BTN-316-201-1814 BTC1-H CPND-02/2013
 PAYEE SUSAN A LAST
 PAYEE UPDATED-07/17/2002

ADDRESS 1325 ANYWHERE SOMEWHERE KS 67213
 ADDR UPDATED-02/28/1995
 SCC-17860 ZDPC-259 SOURCE-C

OTRAD OZIP-67210 OTOM-10/89
 BANK RTN-000000000 DAN-C12345 BDCD-05/07/03
 HLD CHK \$1450.00 FOR 11/12 TOH-4 SPM-TAPE RUN DATE-10/26/2012
 BENEFIT BIC-A SUSAN A LAST SB-F DOB-07/18/1964 B DOEI-07/89 DOEC-07/89
 ABN-QTAY LAF-U RFST-DIBCES MBP-\$1598.00 DRD-01/25/13
 HI CONTS PRD-07/1991 SMI CONTS PRD-07/1991
 PART C PREM W/H PART D PREM W/H

HIST TOC TOC-5 START-CONV
 HBAD01 HAP-01 HEDA-05/24/94
 BENE ENT START-07/1989 DATE OF FILING-02/15/1989 APP RECEIPT-00/00/0000
 ID CODE-A CUR ENT CODE-DISABLED FULL RETIRE AGE-07/2031
 ANN EARN FRA-07/2031 TERMINATION-03/2011

DIB DDO-01/22/89 DIG-7140 DIB DOED-07/1989 MEDICARE DOED-07/1989
 ADC-03/08 CDR-E DBC-03/11 EBD-03/08 EMD-03/08

HI-DIB START-07/1991 TERM-12/2015 BASIS-DISABILITY TYPE-FREE

FILING-06/1991 NON COVER RSN-DIB CESS
 SMI-DIB START-07/1991 TERM-12/2015 BASIS-DISABILITY PERIOD-IEP
 FILING-06/1991 NON COVER RSN-DIB CESS
 SMI PREM START-07/1991 PENALTY-000% CURRENT AMT- \$104.90
 VAR SMI START-01/2010 TERM-01/2011 BASERATE-\$96.50
 START-01/2011 TERM-01/2012 BASERATE-\$96.50
 ST EXCH SEWC-170 SECAC-C SEAD-03/89 SEAC-D
 O/U PAY DPO-\$39730.80 DPOT-EXT PERIOD ELIG PRST-WAIVER REQUEST
 DWA-\$9999

DED/ADD	COM MTH	UPDATED	TYPE	SOURCE	AMOUNT	START	STOP	ITEM
	12/2012	11/17/2012	MBP	BRI	\$ 1702.90	12/2012		010
	12/2012	11/17/2012	MBP	BRI	\$ 104.90	12/2012		420
	12/2012	11/17/2012	MBP	BRI	\$ 1598.00			999
	12/2012	11/23/2012	MBP	TATTER	\$ 0.00	12/2012		010
	12/2012	11/23/2012	MBP	TATTER	\$ 0.00			999
	02/2013	01/25/2013	MBP	T2	\$ 0.00	02/2013		010
	02/2013	01/25/2013	MBP	T2	\$ 0.00			999

HISTORY
 01/08 \$1039.10 \$ 96.40 700 01 S \$1038.40
 03/08 \$1039.10 \$ 96.40 700 21 S \$1038.40
 06/08 \$1039.10 \$ 96.40 700 01 S \$1038.40
 09/08 \$1039.10 \$ 96.40 700 721 EPESGA S \$1038.40
 12/08 \$1099.30 \$ 96.40 900 721 EPESGA S \$1098.40
 12/09 \$1099.30 \$ 96.50 800 721 EPESGA S \$1098.50
 04/10 \$1099.30 \$ 96.50 800 01 S \$1098.50
 10/10 \$1099.30 \$ 96.50 800 721 EPESGA S \$1098.50
 01/11 \$1496.80 \$ 96.50 300 721 EPESGA S \$1496.50
 03/11 \$1496.80 \$ 96.50 300 T81 DIBCES S \$1496.50
 12/11 \$1550.60 \$ 99.90 700 T81 DIBCES S \$1549.90
 01/12 \$1675.00 \$ 99.90 100 T81 DIBCES S \$1674.90
 12/12 \$1703.40 \$ 104.90 500 T80 DIBCES S \$1702.90
 12/13 \$1728.90 \$ 104.90 000 T80 DIBCES S \$1728.90
 12/14 \$1758.20 \$ 104.90 300 T80 DIBCES S \$1757.90
 12/15 \$1758.20 \$ 104.90 300 T80 DIBCES S \$1757.90
 12/16 \$1763.40 \$ 110.40 000 T80 DIBCES S \$1763.40

+++ ROAR UPDATED THRU 02/27 +++
 ACCOUNT PCOC-7
 BENEFIT BIC-A NAME-SUSAN A LAST BBAL-\$39730.80
 EVENT EI-01 TF-DI
 TOE-EXTEND PERIOD OF ELIGIBILITY
 JURIS-PCDCU STATUS-CLOSED BEN ADJ

HISTORY	RUN DATE	TRAN	AMOUNT	SRC
	05/12/11	12	\$19840.70	
	06/24/11	43	\$4394.00	WHLD-1098.50 COM-07/11
				LST WH-10/11 SSC-2
	10/28/11	42	\$3980.00	WHLD-3980.00 COM-11/11
				LST WH-11/11 SSC-G
	10/28/11	43	\$1496.50	WHLD-1496.50 COM-11/11
				LST WH-11/11 SSC-G
	11/19/11	43	\$9970.20	WHLD-1549.90 COM-12/11
				LST WH-06/12
	11/23/12	84	\$0.00	1-PSC OLD1--PCMOD NEW2--PCDCU DOC-000
				DY-CLOSED

EVENT EI-02 TF-DI DRYT-PSC ALERT DRYD-04/05/13

TOE-EXTEND PERIOD OF ELIGIBILITY
EBAL-\$39730.80 JURIS-PCDCU STATUS-DUE PROCESS
HISTORY RUN DATE TRAN AMOUNT SRC
11/23/12 12 \$39730.80
02/04/13 23 \$39730.80 3--DO DOC-769
WRI-W--WAIVER REQUEST

1. How many times has Susan been overpaid?
2. Event 1 is still active. True or False.
3. How much is Susan currently overpaid?
4. Why is Susan overpaid?
5. What date did the active overpayment get posted to the ROAR?
6. What action has Susan initiated?
7. What date did the record show the above action in #6?

EXERCISE #7

OBJECTIVE 7: Select the proper payee for an underpayment, determine what forms, evidence and documentation are required, and dispose of the underpayment.

Part 1

Determine if an underpayment exists in the following situations. Circle YES or NO to indicate your answers.

1. SSA owes Lee Tran retroactive benefits, but he died before the payment was issued. He does not have a surviving spouse. YES NO
2. Alberto Tate died in March. The LSDP check was issued, but his wife died before receiving it. YES NO
3. Akilah Bowman paid Medicare premiums for six months. The premiums were also withheld from her benefits. YES NO
4. Anna Brown died on May 28. In June, her husband receives the check for May and returns it. YES NO
5. Sasha Waters did not receive her April benefit because she closed her direct deposit account but forgot to notify Social Security. YES NO
6. Mr. Hamilton estimated his wages to be \$30,000. In April of this year, he was laid off after earning only \$6,500. He did not receive benefits for January, February, and March because he was in work suspense. YES NO

Part 2

Read each scenario and answer the following questions about the underpayment.

7. David, a widower, died on April 3rd. His check for \$510, dated April 10th, was returned by the bank. David is survived by his mother Martha, who is not entitled on

his record, his father Donald, who was entitled to a parent's benefit for the month of death, and his daughter Janet, who is married and not disabled.

- a. To whom should the underpayment be paid?
 - b. How much is the underpayment?
 - c. Is a SSA-1724 needed?
 - d. What proofs are needed?
8. Thelma Rankin filed for retirement benefits at FRA on March 16th. After her death on May 31st, a check for \$945 arrived. It represented 3 months of benefits (March, April and May) at \$315 per month. Her son, Stephen, returned the check to Social Security. He explained his mother was a widow. Stephen has five brothers and sisters. One brother, Jeremiah, left home 5 years ago, and no one knows where he is now.
- a. How much is the underpayment?
 - b. How many (if any) SSA-1724s are needed?
 - c. How much will be paid to each child?
 - d. If Jeremiah Rankin is not located, what will happen to his share of the underpayment?
9. Carolina Fleming was appointed legal guardian of the estate of her fiancé, Max Evans. Mr. Evans died on May 4th. Mr. Evans had filed for disability. His claim had been approved, and he was entitled to disability benefits, \$1260 per month, as of January. After his death, a check arrived for \$5040. Ms. Fleming returned the check. She also submitted proof of her appointment as executor of Mr. Evans' estate. Ms. Fleming explained she paid the funeral expenses because neither Todd nor Jason Evans, the adult sons of her fiancé, could afford to pay. (Mr. Evans' parents died years ago. His divorce was final last year.)
- a. How much is the underpayment?
 - b. Who should receive the underpayment?
 - c. Is the SSA-1724 necessary?

- d. Who should sign it?
- e. What evidence is needed?

EXERCISE ANSWERS

Exercise #1

1. Non-reporting of suspension and termination events are the main causes of Title II overpayments. For this reason, it is important to make sure our claimants are aware of their reporting responsibilities. ([GN 00203.005](#))
2. Questioning and listening carefully.
3. Mary Diaz is overpaid ([GN 02201.001C & D](#))
4. Chris Wozniak is incorrectly paid ([GN 02201.001E & F](#))

Exercise #2

5. 1a. Jonathan has primary liability. He is the overpaid individual and is directly responsible for repaying the overpayment. ([GN 02205.003](#))
6. 1b. Joy and Miguel have joint liability. Joy has joint liability because she knew of the work and earnings limits following the TWP and reasonably should have been aware of Miguel's earnings. In addition, she did not notify SSA of the overpaid event. Miguel has joint liability because the funds were used for his care and support. If Joy had misused the funds, Miguel would not have liability for repayment of the overpayment.
7. However, if it is determined Joy had no knowledge of Miguel's continued work and earnings, then she would have no liability and Miguel would be primarily liable. ([GN 02205.007](#))
8. 1c. Marquan has primary liability. He is the overpaid individual and is directly responsible for repaying the overpayment. Sam has contingent liability because she is receiving benefits on the same earnings record and the overpayment cannot be recovered from the overpaid person (Marquan). ([GN 02205.003](#); [GN 02205.005](#))

Exercise #3

- 1) A beneficiary may contact SSA to:
 - a) Seek information on how and why the overpayment occurred.
 - b) See how SSA arrived at the amount considered an overpayment.
 - c) Find out what they should do next.
- 2) True. The FO can compute and explain an overpayment using the QROP, PMTH, PWST, PWSM, MBR and PHUS or in complicated cases, request a clarification using OPTTEL. If the overpayment issue is too complicated to be explained over the phone, consider using the MDW. [GN 01070.235](#)
- 3) The options on the SSA-3105 include a request for:
 - a) Reconsideration (appeal),
 - b) Waiver,
 - c) Both a reconsideration and waiver,
 - d) Set up partial withholding,
 - e) Set up monthly installments,
 - f) An explanation,
 - g) Submit a full refund, and
 - h) For “other” issues.

Remember, individuals may check multiple boxes. In these instances, further contact will be needed to determine what action the claimant wants to take. [GN 02201.010](#), [OS 15010.725](#)

Exercise #4

- 1) Credit Bureau Reporting ([GN 02201.032](#))
- 2) Compromise Settlement ([GN 02215.100](#), [GN 02215.105](#))

- 3) Recovery by Adjustment ([GN 02210.001](#))
- 4) Administrative Wage Garnishment ([GN 02201.040](#))
- 5) Cross-Program Recovery ([GN 02210.008](#), [SI 02220.020](#))
- 6) Installment Agreement ([GN 02210.180](#))
- 7) Non-Entitled Debtors ([GN 02230.035](#))
- 8) Tax Refund Offset. ([GN 02201.030](#))
- 9) Calmly, make sure he fully understands how the overpayment occurred. If his only reason for appealing the overpayment determination is “it must be wrong,” then he may not understand how he was overpaid or what to appeal. A reconsideration may not be appropriate to take when the person may need an explanation first. ([GN 02201.025](#))
- 10) Even if the benefit amount increases, the \$50 monthly withholding will remain the same. ([GN 02210.065D.1](#))
- 11) Explain that if no refund is received within 30 days, adjustments would be proposed against others who receive benefits on the account, starting with those who live in the same household. ([GN 02210.015](#)) We can also use other External Collection Operation (ECO) efforts to recover the debt, such as Tax Refund Offset (TRO), Administrative Wage Garnishment (AWG), and Credit Bureau Reporting. If the overpayment cannot be withheld from other beneficiaries on the same account, or the other collection avenues, then we may find it necessary to refer the case for possible civil suit. ([GN 02215.150](#))
- 12) At \$20 per month installment, it would take 60 months or 5 years to recover the overpayment. Since recovery would take more than 36 months, obtain a SSA-632-BK to determine what amount may be appropriate based on her income, resources and expenses. ([GN 02210.030](#))
- 13) Explain to her the overpayment should be recovered within 3 years if possible. In her case, an installment of \$35 monthly would permit this. Encourage her to pay the \$35, but if she insists on the \$20 payment, accept it. Do not obtain a SSA-632. Make sure she understands the proper payee legend for a check or money order. ([GN 02210.180](#))

Exercise #5

- 1) Reconsideration - Roopa is stating the facts in the case are wrong. Therefore, the appropriate action is to file a reconsideration and submit proof of the correct wage amounts. ([GN 02201.025](#))
- 2) Waiver - Alejandro is not disputing the facts in this case. He is alleging he is not at fault in causing the overpayment. ([GN 02250.002](#), [GN 02250.005](#))
- 3) Waiver - Colleen in this case is not disputing the facts in this case. She is only talking about "fairness". She is also alleging a hardship to repay. Because the facts of the case are not in dispute, a waiver would be appropriate.
- 4) Reconsideration – In this case, Colleen is disputing the facts in the case. We should accept the appeal and any supporting documentation.

Exercise #6

- 1) Susan has been overpaid 2 times. There are two "events" on her ROAR record.
- 2) False - Event 1 on the ROAR is closed.
- 3) \$39,730.80 - Found on the O/U PAY of the MBR and BENEFIT line of the ROAR data.
- 4) Susan was overpaid due to working SGA in the Extended Period of Eligibility. This is shown in the DPOT field of the O/U PAY line on the MBR and in the TOE field of the Event line of the ROAR data.
- 5) 11/23/2012 - Data found in the ROAR History line.
- 6) Initial Waiver Request - Data found on the ROAR History Line.
- 7) The record shows the Waiver Request was initiated on 02/04/2013. This date found in the ROAR History Line.

Exercise #7**Part 1****[GN 02301.001](#)**

- 1) Yes. This is a benefit that was due, but not paid.
- 2) No. An unpaid LSDP is not an underpayment.
- 3) No. Excess SMI premiums are not underpayments.
- 4) No. A check is not due for the month of death.
- 5) Yes. This is a benefit that was not paid.
- 6) Yes. Mr. Hamilton is due benefits which have not been paid.

Part 2

- 7) a. Donald is highest in priority to receive the underpayment. (**[GN 02301.030](#)**)
 - b. The underpayment is \$510.00, the amount of the returned check.
 - c. The SSA-1724 is not necessary if all the information is listed in the file.
 - d. Only proof of death is needed. No further proof of relationship is needed since the underpayment (\$510) is less than three months' benefits. Further, relationship is already established for Donald since his claim for cash benefits is established on the record. (**[GN 02301.055](#)**)
- 8) a. The underpayment is \$630. Thelma was entitled to a check for March and April. She is not entitled to a check for the month of death.
 - b. Only one SSA-1724 is needed. Since Stephen listed the names and addresses of his brothers and sisters, the SSA-1724 signed by him is considered a request for payment for them.
 - c. There are a total of 6 children (Stephen + 5 siblings), so each child will get \$105.
 - d. The \$105 due Jeremiah will not be paid to anyone else.

- 9) a. The underpayment is \$5040.
- b. The underpayment will be divided between Jason and Todd.
- c. Yes. Since there are relatives who may be entitled to the underpayment, a SSA-1724 must be completed. ([GN 02301.050](#))
- d. The SSA-1724 may be signed by Todd or Jason.
- e. Proof of Max's death and evidence showing the relationship to Todd and Jason to Max, such as birth certificates, are required given the amount of the underpayment. ([GN 02301.055](#))

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LESSON PLAN

Chapter Objectives

At the completion of this chapter, the students will be able to:

1. Request and use the various workload lists and automated programs to properly control their workload.
2. Determine workload priorities and demonstrate an ability to prioritize work assignments.
3. Remain flexible when faced with changing priorities.
4. Apply the principles of time management to work assignments.
5. Apply good organizational techniques for timely and efficient workload processing.

Length of Chapter

10 hours

BACKGROUND AND RATIONALE

Workload Management

A major contributor to stress in the workplace is the sense of feeling “out of control.” Good desk organization and resource management – knowing where to go and what to do – will help you become a successful claims specialist.

This module provides tools, principles, and best practices for field office claims specialists to use in developing a personalized plan for managing daily workloads. The goal is to achieve a balanced approach. These resources will allow you to keep control of your work and provide you with a basis to start each day.

There are a number of time management principles we will discuss in this module to help you manage your workload. We will also discuss resources and tools to will help you accomplish more in less time. Certain time management principles will be valuable to you in some situations and less so in others. In the end, you will have to find and implement the techniques and tools that work for you.

OBJECTIVE 1:

Request and use the various workload lists and automated programs to properly control your workload

The lists discussed in this chapter are the backbone of SSA workload management. They provide not only a picture of what you have, but they also identify potential problem areas. Used on a regular basis, they will help you prioritize your tasks and properly maintain and control your workload.

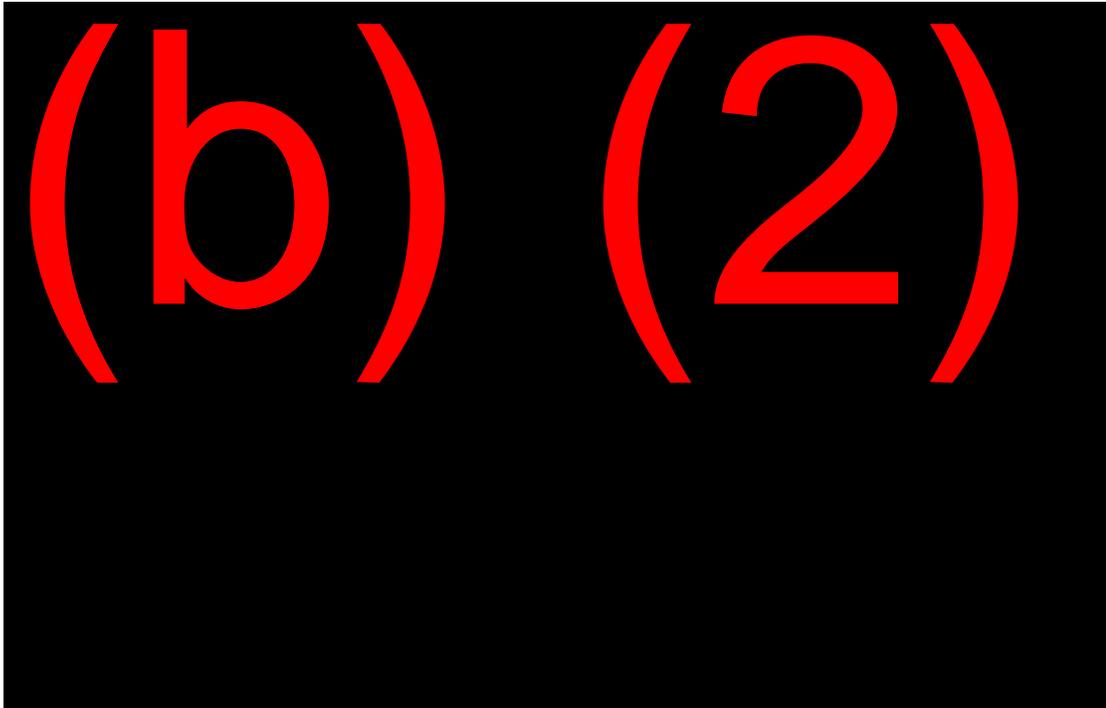
We have an automated program called the Workload Action Center (WAC) to access and manage many of our lists. The first part of this objective will focus on the Workload Management System (WMS). This system is accessed via PCOM and provides WAC with information about agency workloads. We will then discuss all of the lists available in WAC.

WMS/WMI Request

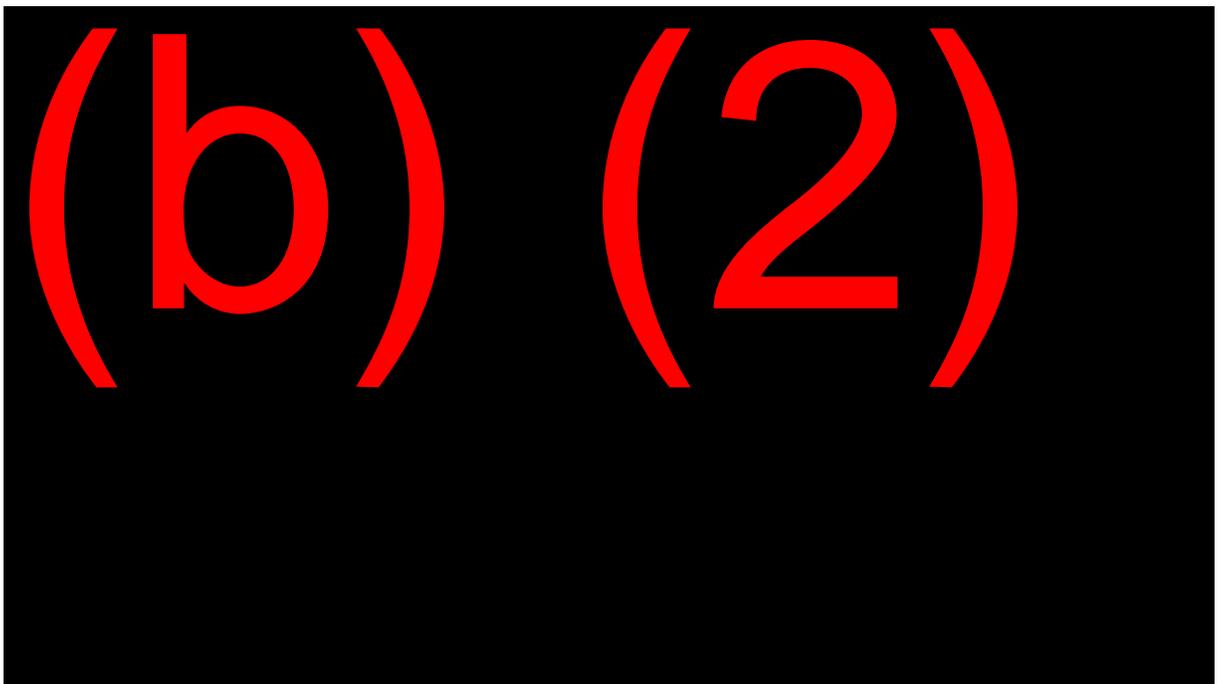
[MS 03701ff](#)

SSA Main Menu option #25 provides access to the WMS/WMI (Workload Management Information) request menu. This menu allows you to request either immediate or automatic Title II WMI DIB/RSHI listings. You may request up to three automatic daily/weekly WMI reports.

Use option #25 to obtain all MCS and non-MCS claims listings (initial through hearing). For each type of listing, subsequent screens will allow you to specify the contents and format of your lists. Each screen has a help screen accessible by pressing the F1 key. The help screens contain explanations of all entries on the requests.



Request lists for Title II initial claims by selecting option #9 (Title II WMI Listings) from the Listing Request Main Menu.



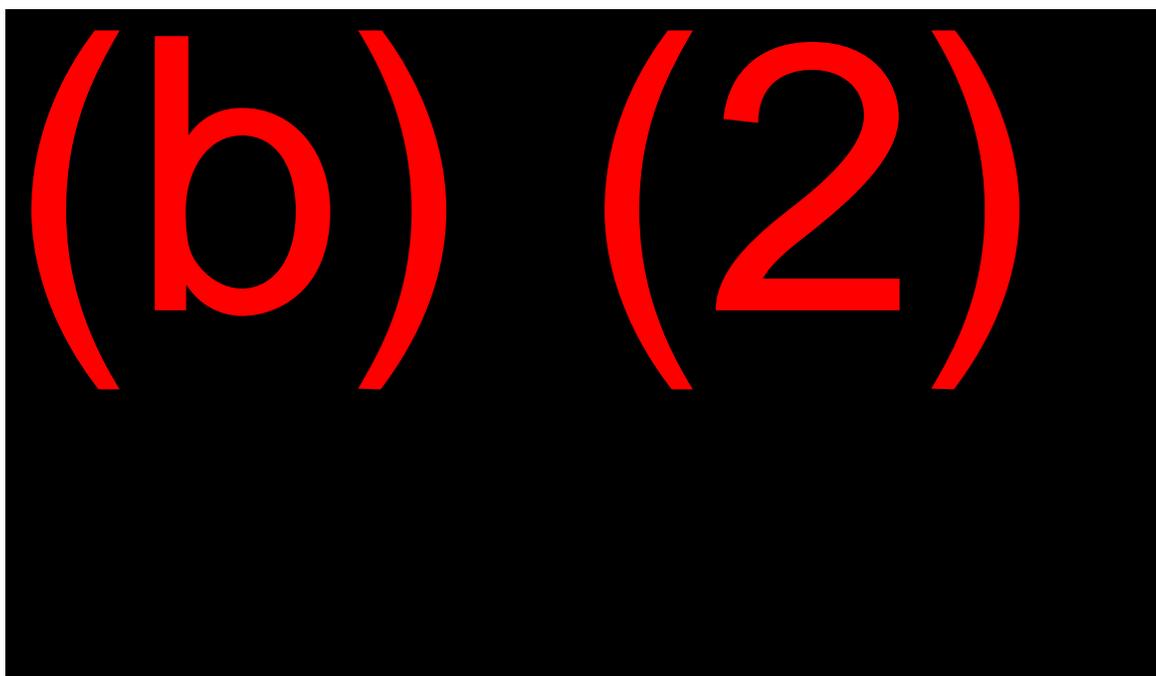
Once on the Title II Initial Claims WMI menu, you have the option to select:

1. Receipts and clearances: All claims received or cleared during the period selected.
2. Pending: Claims pending in the FO, PSC, DDS, DQB, ODAR, or FedRO during the period selected. These are available in WAC.
3. RSHI Action List: Pending RSHI cases likely to need FO attention. Screening conditions may be customized. These are available in WAC.
4. DIB Action List: Same as #3, but for DIB cases. These are available in WAC.
5. Analysis Request: Similar to the Action Lists, but the categories of cases are not as high in priority. This listing will provide the opportunity to analyze problem cases.
6. WMI SSN query: Combined data from MCS, SSACCS, and NDDSS (DDSQ) with the option to key in up to 10 SSNS for individual case queries.
7. Automated Request Maintenance: Used to review your current Automated Requests and to delete any user defined requests you no longer wish to receive. (See "Route Response" options below for setting up these requests.)
8. Internet Applications: Request internet applications by office, terminal digits, or number holder name within the period selected. These are available in WAC.

ROUTE RESPONSE OPTIONS

1. Screen: The listing or query will appear on your screen. Nevertheless, you will still have the option of printing your output.
2. Printer: The listing or query will go directly to the printer, without appearing on the screen. Do not select this option for AUTOMATED REQUEST MAINTENANCE.
3. Automated Daily: Use this option to indicate you are setting up a request for a listing to generate daily after the data updates. You will then complete the regular request screens. If you will only be able to review these listings occasionally, it is suggested you not set up a daily request, due to the processing and paper required.

4. Automated Weekly: This is the same concept as the Automated Daily, but the listing only generates over the weekend.
5. Choose name for automated request: You must choose a name to identify Automated Requests only. You do not have to include your own name since it automatically appears on the cover page of your listings; instead, you may want to use a word which describes the type of request or any other designation you choose. You may not have more than one daily request with the same name, or more than one weekly with the same name. However, you can have a daily list and a weekly list using the same name.



Workload Action Center (WAC)

The Workload Action Center (WAC) program provides you with an extremely efficient way to view and work initial claims pending lists as well as various tickle lists. WAC imports T2 and T16 WMS initial claims pending listings, DIB Action Lists, RSHI Action Lists, Internet Claims and Appeals, the 800# appointment listing, and the following workloads and tickle lists:

- MCS

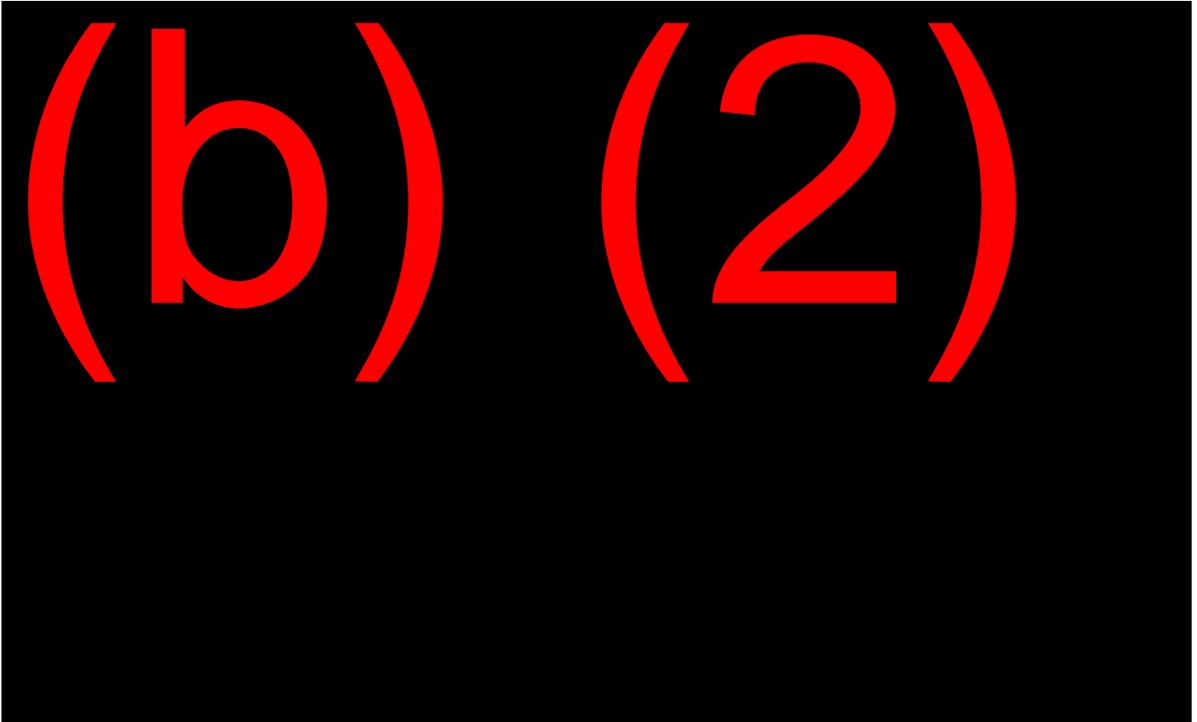
- MSSICS
- RPS
- PCACS
- MDW
- Earnings Modernization 2.8
- EDCS
- DMS
- DCF
- POS (pending)
- SSI PE

WAC significantly decreases the time it takes to request, analyze, and work cases on the WMI and tickle lists. The purpose of WAC is to get you to the information you need as quickly as possible.

For general information, user instructions, or to download the program, go to: (b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)

Pending Claims

To access your pending claims thru WAC, you will need to be logged on to Session A or B of PCOM.



Once this is done, you can access WAC.

- Click on Pending Claims
- Select the appropriate title (T2/T16)
- Enter your unit code
- Click the Request Pending Claims button
- When the list appears, you can open queries, MCS, MSSICS, CPMS, eView, EDCS, DPS, or ORS on each individual case to work and view information on the case



RSHI Action List

The RSHI Action List shows information on RSHI cases requiring action.

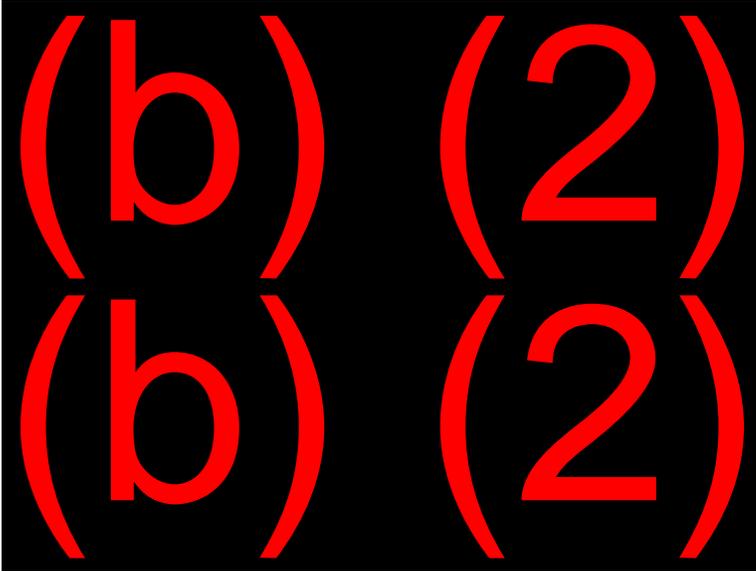


This list should be reviewed a couple of times a week. All of the codes on the list can be deciphered by holding your cursor over the column heading in WAC. This list is one place to review the Service Delivery Objective (SDO) cutoff for RSHI cases.

DIB Action List

The DIB Action List provides information on DIB cases requiring action.





This list needs to be reviewed several times a week. WAC displays all allowances on the DIB Action List in green and all disallowances in red. The DIB Action List also keeps track of claims where a non-medical completion (NMC) input was not done. Remember, a NMC input should be made, unless an exclusion applies, on every claim to quickly and efficiently service your claimants.

Tickle List

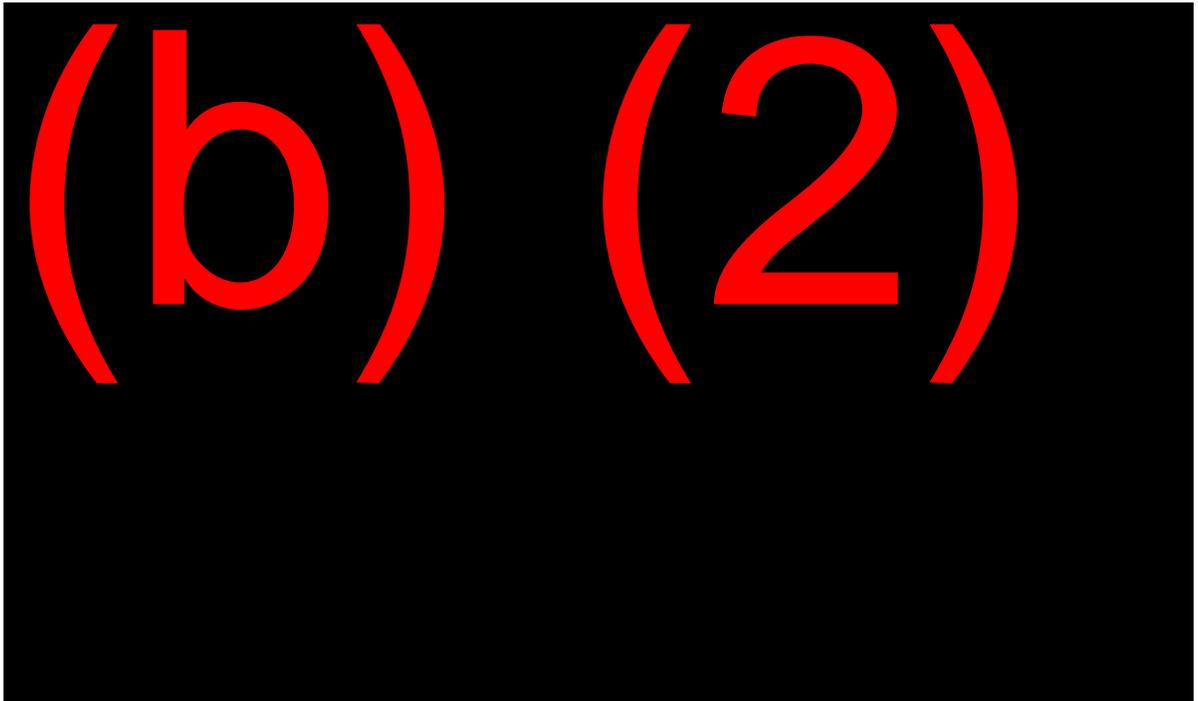
The tickle list provides you a list of your due or overdue MCS and/or MSSICS Tickers (this varies depending on the type of claim you selected under "pending claims.")



Tickle lists are automatically included with your claims request. Tickers are categorized according to the outstanding issue on the DW01. This list should be reviewed daily.

Workloads

The workload listings feature of WAC can be used to import the following workloads: 800#, DCF CDR, DMS, EDCS, EM 2.8, MDW, PCACS, POS, RPS, and SSI PE.



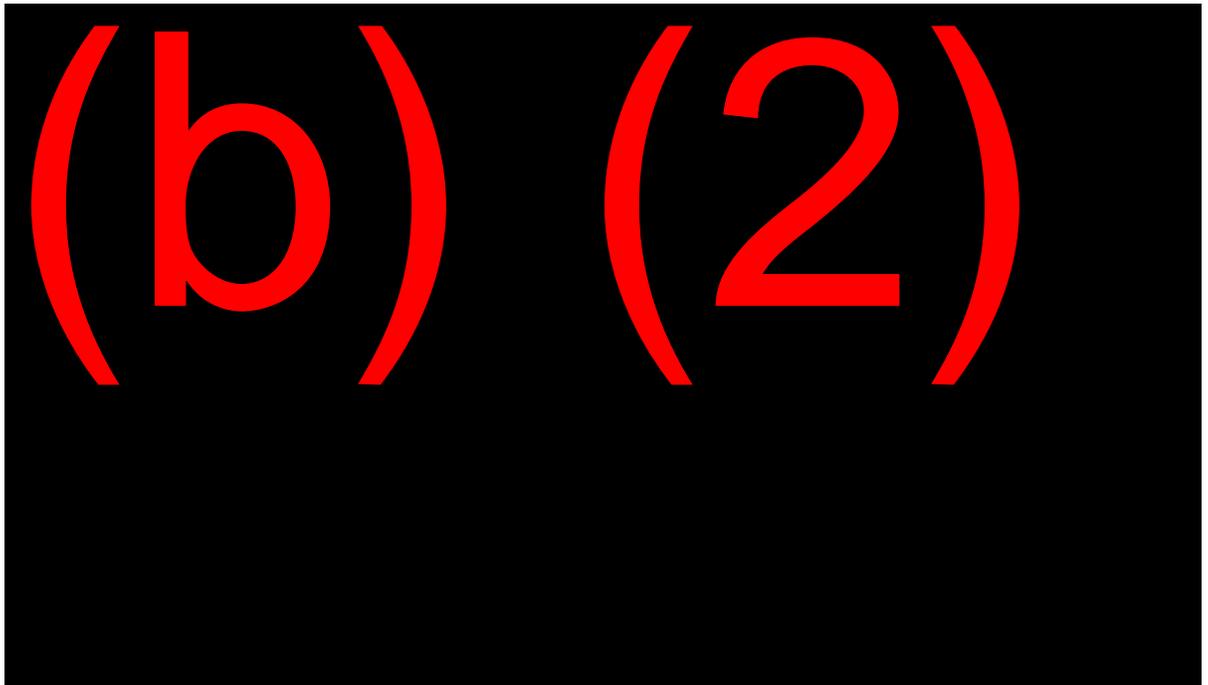
NOTE: All tickles associated with these workloads will also be imported.

To access these workloads, you'll need to log on to Session A or B of PCOM and then open the WAC program.

- Click on Workloads;
- Select the type of workload(s) you would like to request;
- Click on the Request Workloads button;
- When the list appears, from the available lists drop down menu, select the list you want to work on. You will be able to open queries, MCS, MSSICS, CPMS, eView, EDCS, DPS, or ORS to work and view information on the case as well as import the claims directly thru WAC.

Internet Claims

To access the internet claims thru WAC, log on to Session A or B of PCOM and open the WAC program:

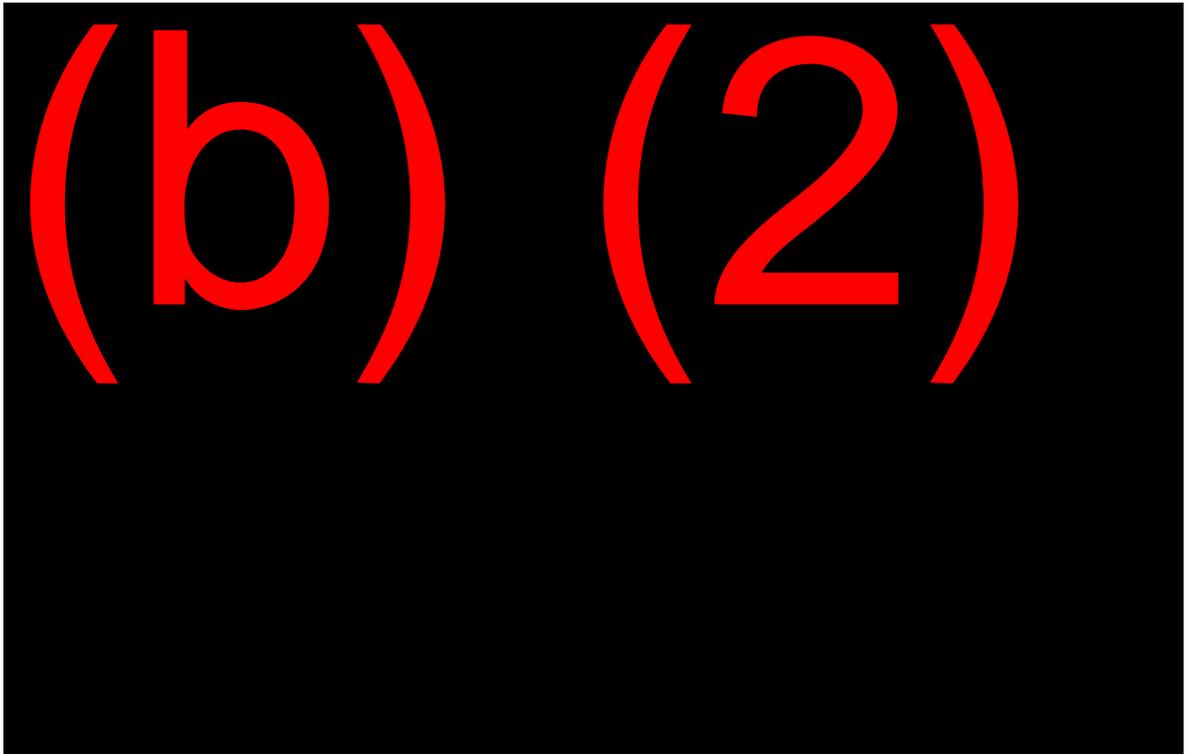


- Click on Internet Claims;
- Select the type of Internet claim you would like to request;
- Click on the Request Internet Claims button;
- When the list appears, you will be able to open queries, MCS, MSSICS, CPMS, eView, EDCS, DPS, or ORS to work and view information on the case as well as import the claims directly thru WAC.

My Lists

My Lists is a tool to integrate workloads which are not part of the listings currently available and to control customized lists created in WAC. My Lists includes Any List, My WACtions and Office WACtions. With My Lists you can:

- Use Any List to import non-WAC workloads and take advantage of all the WAC functionality.
- You can save these lists and access them again the next time you open WAC.
- With WACtions, you can create lists of actions items from workloads already available in WAC. These sub-sets of workload listings can be assigned and controlled in WAC and provide an efficient way to emphasize high priority workloads.
- Office WACtions is used by Managers and WACtion Administrators only.



To access the My Lists thru WAC, you'll need to log on to Session A or B of PCOM and then open the WAC program:

- Click on My Lists;
- Select the type of lists you would like to request; and
- Click on the Request My Lists button.

WorkTrack

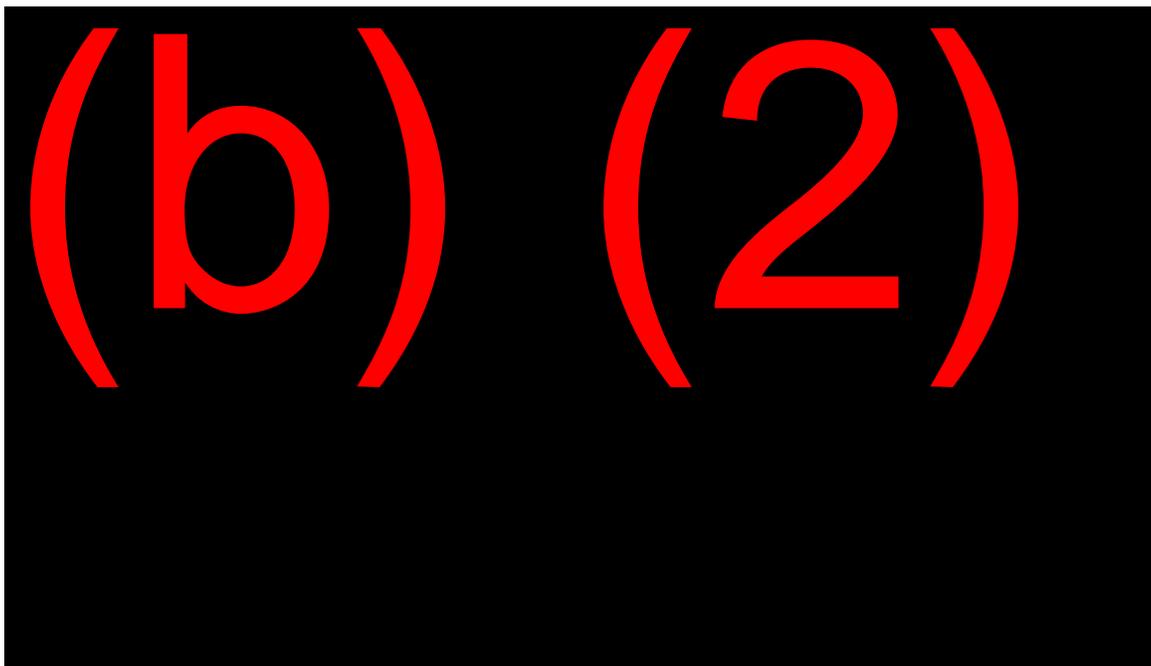
WorkTrack is an internet application designed to strengthen control of paper workloads in the FO. Items received in the FO are scanned into WorkTrack by designated “profilers” in the FO. Once items are scanned into the application, they can be assigned and controlled electronically until a technician makes the appropriate inputs into one of the mainframe or intranet systems such as MCS, MSSICS, or eView.

Items You Must Upload to WorkTrack (in addition to regionally-mandated items)

- Claims Package
- Representative Payee Application
- Appointed Representative Form
- Overpayment Waiver
- Reconsideration (Non-Medical)
- Reconsideration (Medical)
- Hearing Request (Medical)
- Reconsideration DIB Cessation
- Hearing Request (Non-Medical)
- Hearing Decision Appeal (Medical)
- Hearing Decision Appeal (Non-Medical)

Other items may be entered into WorkTrack based on regional instructions.

Access WorkTrack at (b) (2)(b) (2)(b) (2)(b) (2). In the (b) (2)(b) (2) (b) (2)(b) (2) site, you can find user guides and video tutorials about this new system. Opening the application automatically takes you to your pending WorkTrack Queue where you can view all items assigned to you.



“View Item” is hyperlinked, and when clicked, the actual document displays in PDF format. You should review the document and make your PCOM/Intranet systems inputs. Once you have completed your inputs, you can clear the item from your pending queue.

- Check the edit box of the item(s) you want to clear
- Click Edit Cases
- Scroll to the Clear Cases box and select a disposition from the drop down list to tell WorkTrack what you plan to do with the actual document
- Select a Completion Date
- Click Edit/Update Case

Note: The disposition field option does NOT automatically send the document to NDRED or eView. Technicians still need to fax/upload their documents to the proper document repository. You may only shred paper documents when electronic copies of the documents are entered into a permanent document repository.

The cleared item(s) fall off the pending list and display in the “Office Cleared” tab for 7 calendar days. After 7 calendar days, users must view reports or use the “Search by last 6 of the SSN” function to find item information.

OBJECTIVE 2:

Determine workload priorities and demonstrate an ability to prioritize work assignments

Lists

Your lists will help you to determine how to monitor your workload and how to stay on top of it. At any given time, your office may have a particular workload designated as a priority. If so, this workload is also **your** priority.

If you request and work your lists on a regular basis, they will be shorter and easier to manage. Setting aside a specific time each day to work a particular list will help.

Below are some factors to consider when prioritizing work; however, this is not an all-inclusive list nor is it in any particular order of priority. Your management, your workload, and your judgment will be your guides.

- Age of the item. (Is it extremely old, or about to become extremely old? Is it new and processing today will meet office targets?)
- Public Relations. (Do you have a case which is becoming a public relations problem and may result in adverse publicity?)
- Claimant Need. (Is the claimant going to be evicted or suffer some other loss because the issue has not been processed?)
- Management/Administration Designation. (Is this a designated priority workload, either locally or nationally?)
- Congressional Interest. (Has there been a Congressional inquiry?)
- Difficulty of processing. (Can you process the claim quickly, or are there outstanding issues which need resolution?)

Mail/Email

Stay on top of your inbox, and keep your mail current. This will prevent you from making unnecessary follow-ups with the claimant while efficiently and effectively meeting their needs.

Open your Outlook early in the morning and keep it minimized during the day so you can keep up on your emails. You can try to read the messages as they come in between phone calls/interviews/adjudicating claims. Once you've read it; act on it, file it, or delete it. Try not to leave items setting in your inbox. For your key workloads, set up folders relating to the topics you are receiving email on. This way the information will be easily retrievable when you work on that type of case. Determine how email fits into your established priorities.

Phone Calls

Phone calls are, by their very nature, a priority. Whether from the public or another SSA employee, they are all our customers. Serving our customers timely and courteously is a major focus of SSA. A prompt response to a phone call is one of the best public relations tools we have.

Use your voice mail message to indicate when you are most likely to be returning phone calls. If you want a 24-hour window, leave this as your voice message. On the other hand, if you will be out of the office for a specific period, (e.g. vacation or work assignment) alert your customers of this, too. These small courtesies go a long way in keeping positive communication between you and the public you serve.

Remember phone calls do not keep us from our work – they **are** an important part of our work.

Interviews

Interviews are always a priority and whenever possible, schedule your interviews. While office policies and practices may limit your options, a scheduled interview is a work item under your control.

Breaks and Lunch

A person cannot work indefinitely without a break. SSA has breaks and lunch built into the workday for a reason. Use this time to refresh your body and mind. It's good for you and will put you in a better position to serve your customers.

OBJECTIVE 3:

Apply the principles of time management to work assignments

Minimizing Distractions and Interruptions

A CS's Day

The typical CS day is anything but typical. Depending upon the structure of your office, you may be working:

- scheduled appointments,
- assisting walk-in claimants,
- taking telephone calls, or
- managing the reception window.

Your workload could consist of:

- processing initial entitlement claims,
- processing overpayments,
- processing Continuing Disability Reviews (CDRs), or
- a multitude of other tasks.

In fact, the typical CS day requires constant shifting of gears and changing priorities. Staying flexible while remaining focused on a specific task can be challenging in this work environment. Time management is a critical skill to ensure your success.

Mission Focus

One of the most important time management techniques you must develop is the ability to stay focused on your mission during contact with the claimant.

Interviewing

As a CS, you are responsible for directing the interviews and focusing the client on the specific information you need to support him or her. This interviewing skill may come naturally to you or will develop over time. They might be providing you information you normally would not have known or asked. These are some helpful tips:

- Before starting the interview, remember to do a **thorough pre-interview** to determine the reason for the contact and develop your plan of action;
- During the interview, focus on the interview's purpose and on getting the information you need;
- The interview must be comprehensive and complete;
- When you request an action from the claimant, tell them specifically what you need and by when; and
- Try to avoid seeing the same claimant in your office about the same issues repeatedly.

Time Wasters

Time management requires balance and self-discipline. You must continually balance competing demands and focus on performing critical job tasks. You will become more comfortable and confident about these choices as you gain experience in the job.

In any work place, there are common time wasters. If you can recognize these time wasters in advance, you can create strategies to minimize them.

Common time wasters include:

- Crisis mode claims processing. Always “putting out fires” instead of working your caseload with the appropriate lead-time;
- Forgetting to set objectives and prioritizing your workload for the day;

- Becoming overly empathetic – while it is important to listen to your claimant, you still need to assist them in staying focused on the interview and not allowing the interview to get off topic. Remember, your role is to assist the claimant in giving you the information you need;
- Personal disorganization, including a cluttered workspace, can prevent you from achieving your objectives;
- Procrastination or a lack of self-discipline; and
- Leaving difficult tasks unfinished or postponing decisions.

Remember: keep clear communication, either with the claimant, with other employees in your office, or with other organizations.

Prioritization

Managing your time requires self-discipline, organizational skills, and the ability to balance competing demands on your time and attention. Plan your day's activities early each morning or at the end of the day in preparation for the next day. Start with the high-priority items. Make sure to set aside time for the difficult cases.

The following are some planning steps which may be helpful to you:

1. Analyze the situation (Where am I now in my workload?).
2. Develop reasonable assumptions about what will happen in the time span of your day.
3. Establish what objectives you want to accomplish in a given period of time.
4. Develop workable alternatives to employ when your plan is derailed.
5. Make and implement a decision about how to proceed.
6. Establish, review, and control procedures. (Did it work? Did I achieve the objective? What could I improve for the next time?)

It is a good idea to spend some time before and/or after the hours your office is open to the public to plan and set priorities while interruptions are minimal.

Setting Goals

All good time management begins with a solid set of goals. To be effective, goals must be:

- **Specific.** Ensure the targets you set are not vague and you understand exactly what it will take to achieve them.
- **Measurable and observable.** Define milestones so you can track your progress.
- **Attainable and realistic.** Make sure you have the abilities, knowledge, and resources needed to achieve the objective.
- **Flexible.** Adjust to and respond to changes which occur in your office. This is especially important in the CS work environment.

Again, try to spend some time each day thinking and planning toward your goals. Record them and post the goals in a visible workspace.

To-Do Lists

Our computer has many electronic tools which help with work management. Some you'll want to become familiar with and use are the various workload lists, the calendar with built-in reminder, and the task list on Outlook.

To-do lists can be helpful. A to-do list consolidates all of your tasks into one place. You can then prioritize the items on the list allowing you to tackle the important ones first. The following can help you in creating your own to-do lists:

- The CS's to-do list should be ongoing, arranged by priority, and reassessed at the end of each day.
- Make it a habit to spend 5 to 10 minutes every day either making or reviewing your to-do list.

- The next step is to review your list and determine the priority items. One common way to do this is to assign each item an A, B, or C. “A” items are crucial to your daily objectives and must come first. “B” items are less important tasks and can wait until you are done with As. “C” items are the ones to be completed after Bs, or can be safely moved to another day.

To-do lists are wonderful tools, but they are just this, tools. As previously stated, the CS’s day is unpredictable. The most important thing to build into your to-do list is flexibility. You need to be able to change your list, digress from it, and abandon it if circumstances dictate.

Some other tips for using a to-do list include:

- Be realistic. The list is there to help you stay organized and on target, not to exhaust and frustrate you.
- Break the big tasks into smaller, manageable pieces and work on one item at a time.
- Order your tasks creatively. When possible, alternate difficult and easy tasks, long and short workloads, and functions that are routine and those requiring some thought. Changing the pace of activities can keep you fresh.
- Schedule for long-term as well as short-term goals and format your lists to accommodate these.
- Cross items off the list when you finish. You deserve a reward and it is satisfying to see your list shrink.

Personalize Your Approach

When scheduling your time, keep in mind your own personality strengths.

- You may need to limit distractions. So, if you have a complicated case, tackle the case immediately. Set aside quiet time (morning or late afternoon) and get the case completed. Do not set the case aside to work it “when you have the time.”

- You may thrive on variety. If so, try not to limit yourself to one workload; do mixtures of each type of work every day (clear a claim, load a reconsideration, develop a work issue, etc.).
- Maybe you like to focus on one workload. For instance, make all your phone calls at one time, and if you have to leave a message, keep the folder in a special place on your desk (e.g., by your phone) until you get the return call. When leaving phone messages which require a call back, be specific as to when they should return your call so you don't waste time playing phone tag.

Whatever approach you select, be sure to evaluate your method regularly. If it doesn't work, try another one.

Strategies for Dealing with Procrastination

Why We Procrastinate

Procrastination is a major time waster for most people. All the greatest time management techniques will be useless if you allow yourself to put off difficult or unpleasant tasks.

Putting off decisions and actions causes delays in the normal workflow, costs time, and creates unnecessary stress.

A procrastinator:

- Thinks he or she will have more time tomorrow;
- Waits for the "right" time when faced with a difficult task;
- Will not start a project unless he or she can finish it;
- Spends time doing routine daily activities when there is an important project or caseload; and
- Is a perfectionist.

Reasons for procrastination range between lack of motivation or commitment, placing low priority on the task, lack of knowledge or

resources, and fear of failure. Identify the reasons you procrastinate and weigh the consequences of delaying action.

Just Do It

Countering the tendency to procrastinate requires self-discipline and determination. Here are some guidelines to help overcome procrastination.

- Make sure you have the necessary knowledge. Often we put off difficult tasks because of a fear of failure. Don't be afraid to enlist the help of your mentor, CTE, or a more experienced CS.
- Break larger tasks into smaller pieces; you don't have to do it all at once, as long as you finish discrete pieces of the task.
- Pick one workload you tend to put off and tackle it. Get in the habit of working those items first. Don't leave the hardest work for when you are most tired.
- As we have already discussed, learn to set priorities and stick to them. Focus on one problem at a time.
- Set deadlines for yourself and make them public. You are more likely to follow through on what you have told your supervisor or a co-worker you would do.
- It is okay to be detailed-oriented, but don't let perfectionism paralyze you.
- Reward yourself when you are finished.

Making Decisions

A substantial barrier to effective time management is the inability to make decisions. Indecision wastes time and causes stress. Do not be afraid to ask questions from your mentor, CTE or another experienced CS. They have all been in your shoes. Also, do not forget to utilize the help desks in your Regional Office.

Be kind to yourself. As you do your daily job, your confidence will build with each of your successes. And when you succeed, we all succeed.

Also, stay focused on your objectives in dealing with each claim: listen, analyze, and decide.

Handling Job Related Stress

Understanding Stress

At some point in our lives, whether at work or at home, we have all experienced stress. Stress acts as a force, pressure, or strain on your physical, emotional, or mental system. Stress can have adverse effects on your health and productivity. Any number of physical, emotional, and behavioral symptoms can indicate a high level of stress. Inability to handle stress can lead to poor job performance, difficulties in your personal life, and can even cause illness.

Stress is sometimes unavoidable. The heavy caseloads, the changing nature of the work, changes in technology, and dealing with the public can make us feel out of control. Take a deep breath and work your cases one at a time. Always know you are not alone.

Good time management is actually a useful method for controlling stress. This is why we have so many resources for you to utilize!

Recognizing Stressful Situations

The work you do to assist the public is something you should take great pride in. If you have an unusually difficult interview, once you complete it, recognize you may need a few moments to regroup before you take the next one. Know your limitations and understand you can only take one claim at a time. Stress will result from this hectic work environment simply because of the multiple demands on your time and attention. Just be aware you are not alone. Your fellow co-workers have been there, too.

We all respond to stress in different ways. A stressful situation for one individual may not be stressful for another. Consider the events which cause you to experience stress in the course of your day.

- What workloads tend to be stressful for you?

- What are the disruptions or unanticipated events which are particularly stressful for you?
- Are there certain decisions you must make which cause you stress?
- Do changes in operations or procedures cause you stress?
- Do you feel especially stressed when dealing with a particular claims situation?

Recognizing and anticipating these stress-inducing situations will better prepare you to deal with them.

Devising a Strategy

The first step in controlling stress is to identify situations which cause you stress and gather information about how you respond to them. If you feel you did not handle a situation correctly, analyze the situation and decide what you could have done differently to make it better. Use this information, obtain feedback from your supervisor or other experienced interviewers in the office, and incorporate this knowledge for future use when the next situation arises.

- Are there stress-inducing situations you can avoid?
- Can you prepare differently for a stress-inducing workload?
- How might you respond differently to alleviate a stressful situation?

Some people find it helpful to use specific techniques such as breathing, muscle relaxation, and visualization exercises. At a minimum, you can seek out the support of colleagues. Talking with others, asking for advice, and sharing options for responding to stress will often help. Just knowing others are experiencing the same kinds of pressure can help relieve the strain.

OBJECTIVE 4:

Apply good organizational techniques for timely and efficient workload processing

We have discussed many organizational techniques in this lesson. In this objective, we will concentrate on actual desk organization and management – the physical side of organization.

As with other methods discussed, talk with your mentor and other successful CSs to see how they organize their desks. Take the best parts from each source. Just be sure to reassess your situation regularly.

Cutting through the Clutter

Clutter can cause you to waste time. Picking through piles of paper, looking for documents which are misfiled or mislaid, and simply moving files from one place to another are all time consuming. If you are going to control your time, you will have to control clutter.

A simple two-point assessment can help you determine whether clutter in your workspace has become a time management issue for you.

- Can you find it? Do you really know where everything is? Can you put your hands on an important document while you are on the phone with a claimant? Can someone else working your desk find it? If not, your clutter is costing time.
- Clutter can slow you down even when you know where everything is. Discomfort with an awkward arrangement of your workspace also leads to stress.

Cleaning it Up

A cluttered and disorganized workspace is a sure barrier to implementing good time management practices.

As with all the guidelines we have discussed in this module, the method for clearing your workspace of clutter will be an individual choice. The following are some tips for clearing up the clutter.

Basic Desk Management

Workflow

Understanding the workflow in your office is an important step toward implementing time management principles.

A basic concept of time management is to determine what your constant workloads will be and manage around them. You should be able to determine which days you will have the constant workloads and fit in the other tasks appropriately within your week.

Prioritize your workloads which are outside the constant duties. It is important to separate time-sensitive tasks from those less so and allocate the time accordingly.

Perform similar workloads together as much as possible. For example, sort and process to completion claims ready to clear. Then process any post entitlement actions, and address Continuing Disability Reviews (CDRs). This saves time as you establish a pattern or routine making it easier for you to process work.

It is important to keep things moving. If you get too far behind, talk to your mentor. Communication is critical to success.

Desk Organization

Get started with a plan. Clean off your desk at the end of the day. It's easier to greet a clean desk in the morning, instead of a disaster area.

Organize your physical desk space. Have a specific, predictable spot for your envelopes, folders, pens, etc.

Use labels for drawers and within drawers for particular workloads and actions. This can be done for items on your desk with labels and "In" and "Out" boxes.

Designate separate sections in drawers for different pending workload types (e.g., teleclaims, completed claims, EM 2.8 actions, work issues/CDRs, medical CDRs, overpayments, students, rep payees, appeals, inputs etc.). **Do not** mix PE and initial claims workloads. Have separate places for these workloads along with places for specific workload reference materials.

Now You're Organized, Keep It That Way

Once you get your work area the way you want it, keep it the same way.

- Touch things once, finish the task, and put things away.
- Do whatever you can to avoid simply moving piles around on your desk.
- Use computerized resources, like the Calendar and Reminders in Outlook, to stay organized and keep paper clutter to a minimum.
- Go through your pending drawer frequently to make sure nothing is missed or misfiled.
- Sometimes initial claims may need to be held for a future MOE, Advanced Filing, 6-month Close Out or PE inputs. It is helpful to have a separate section for holding these actions once all development is completed.
- Minimize clutter next to your computer so you have room to work on one case at a time without distraction. (This also minimizes the overlapping of files and/or papers from different claims.)
- Be sure to save website addresses you refer to frequently as "Favorites." Being able to select them directly from a favorites-tab rather than searching saves valuable time.

[Exhibit 1](#) contains a collection of helpful hints from veteran CSs. The practices have all worked well for someone. Whether they will work for you depends upon your own personal approach and the accepted practices in your office.

Summary

Time management is a critical skill for you as a CS because of constantly changing priorities, varying types of workloads, and the need to work with the public throughout the day. Time management principles of particular importance include flexibility, prioritization, and organization.

You should learn to recognize common time wasters and implement strategies to minimize distractions and interruptions. Practicing sound time management has the added benefit of reducing stress in the work place. It is important for you to prioritize your workload using the time management tools and techniques which work best for you.

Avoiding procrastination, clearing out the clutter, and basic desk management practices all contribute to good time management. You must maintain balance and self-discipline so you can provide vital services to the public.

EXHIBIT 1: SUGGESTIONS AND BEST PRACTICES

LISTS

Pull and/or review the following lists daily:

- MCS
- RPS
- PCACS
- MDW
- RSHI Action List
- DIB Action List
- EDCS Actions List

Pull the following lists weekly:

- DMS
- 2.8 Earnings Modernization
- MAPS Workload Listing

TICKLE LIST TIPS

MCS tickle lists are useful if pulled and maintained regularly. When used daily or at least several times a week, the tickle list is an efficient means of managing your workload.

To keep the MCS tickle list manageable, encourage claimants to return requested proofs by a certain date, follow-up timely on proofs, and issue close-out notices when appropriate.

The tickle list can be an invaluable tool for following-up on initial disability claims issues. You can check tickles for evidence needed to process a claim via non-medical completion.

For online tickles, pending issues are shown from the worksheet screens with only due and overdue issues being displayed.

Reminder items on tickles: When setting tickles, if you expect to receive the evidence in exactly 5 calendar days, do not make any entry since MCS will set a 5-day tickle. When updating tickles, be sure to press ENTER since MCS uses the information on the worksheet screen to update the record. When you press PF3 and exit off of the development worksheet prior to pressing ENTER, MCS ignores any new information on the screen and anything new you might have updated, will be lost.

NEVER use Xs in the REC (Received) field of the DDSDEC or for an application issue. The system does not properly read Xs in these fields and generates uncorrectable edits. These edits may cause the case to later be excluded unnecessarily from EC processing and can cause problems with EDCS.

If you decide you do not need a piece of evidence requested, you MAY enter Xs in the corresponding REC field. MCS cancels the tickle date and takes the issue off the Tickle List.

When you clear your initial claim or other post entitlement action, be certain you have resolved all pending tickle issues before you put the case away. This will help minimize unnecessary tickles from appearing on your list.

A word of caution, do not set any tickle, 5-day or other, which will come due after MCS archives the claim (e.g. 120 or more days after clearance).

MISCELLANEOUS BEST PRACTICES

Check and answer e-mail and voice mail every day.

Make sure you document conversations with claimants and all actions taken in MCS so anyone working the case later will know exactly what has transpired.

Address PROTFL and T2CO issues on DW01.

- In remarks, indicate if you need to use PROTFL or if it is not applicable.

- Use the date the six-month close out was sent (if not already pre-filled) in the “receipt” field and indicate in remarks the close out was sent.

Do not use mail when you can call or fax a request.

Make sure to use Shared Processes, RPOC screen in MCS, eView, or NDRed to record necessary documentation. This will avoid possible duplicate development later.

Do not over-develop a case; there is no need to do unnecessary work.

Are you going to be out of the office for a few days? Try not to set tickle issues to come due while you’re away unless you have made special arrangements for a co-worker to check your list.

Think ahead. If you are gone from the office, does the electronic file provide enough information to allow your co-workers to answer inquiries and/or process the claim? If not, document it.

If a case requires research, create an issue, such as POMS, and tickle it for the timeframe you will need to take care of this.

If time allows, take the last few minutes of your workday to think ahead about what you’re going to do tomorrow. Do you want to see if the action you took actually hit the MBR or SSR? You can put the query or folder involved in an obvious spot on/in your (clean) desk so you’ll see it first thing in the morning. Or you can just type a quick reminder onto the Outlook calendar. An automatic reminder pops up when you sign on tomorrow, then you can check the MBR/SSR and the file will be off your desk in no time. If you have more than one such case, just make a list of the files in Outlook.

AUTOMATION TIPS

Open Outlook every day and leave it open. You can minimize the screen so you can read email as it arrives.

Read the Daily PolicyNet Instructions sent to your Outlook each day to stay current on relevant transmittals, updates, and Emergency Messages.

Use the Calendar or Tasks option in Outlook for reminders.

Use electronic forms as much as possible and make “buttons” for the forms you use most often.

Use SSA Intranet for desk aids, tools, and resource kits.

Use automated programs, such as WAC.

Pull lists first thing every morning and work tickles between interviews and phone calls.

Put all initial and PE actions on the system. Use MDW for tracking any actions which are not monitored through other PCOM programs.

INTERVIEWING

Think of the interview as “Show Time”. It may be your fourth retirement claim today, but it’s the first time this individual has ever contacted our agency. Bring your energy and focus to the claimant, because each claim is a different story.

Get a “claimant commitment” on all initial and PE requests. Ask for the documents on or before a specific date. If forms are mailed for completion or signature, state the specific return date on the request form.

Document expected return dates on your DW01 or RMKS screens.

Avoid routine tickle dates of 7 or 10 days. Customize them to be relevant to each individual case.

List and tickle **all** incomplete development on the DW01.

Close out any leads encountered in a claim and post appropriate information on DW01, DW03, or RPOC screens documenting your development. For example: xxx-xx-xxxx AACT PIA \$780.00 NO LEAD.

ORGANIZING

Keeping your desk organized not only helps you, but aids your co-workers handling work for you in your absence.

OFF-AIR ACTIVITIES

Discuss with your mentor the accepted practices and requirements for your office relating to workload management. Will you be expected to turn in annotated lists on a regular basis? Does management expect certain reports? Keep in mind regular use of the lists is a must for controlling your workload.

With the help of your mentor, set up and organize your work area.

Have your mentor, or SLC, demonstrate how to use the task feature and set up appointments on your Outlook calendar.

Discuss with your mentor best practices while using WAC and WorkTrack in your office.

EXERCISE #1

Brainstorm a list of tools you will implement to save time during your workday.

EXERCISE #2

Consider the following list of activities you might face in a single day. How would you prioritize them? (Hint: There really is no right or wrong answer.)

- Check email
- Process a redetermination
- Process a CDR
- Watch a VOD regarding a new systems release
- Open WAC to view pending and tickle lists
- Open WorkTrack to view and associate pending items
- Return phone calls from claimants inquiring about the status of their claims
- Perform COA inputs
- Check and review new policy updates and transmittals
- Follow up with claimant to obtain missing documentation
- Update your to-do list and plan activities for the coming week
- Review mail
- Process disability claim