**SPECIAL ASSISTANCE SECOND PARTY REVIEW FORM**

**RECERTIFICATIONS**

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| --- | --- | --- | --- |
| Case Head Name: | Date Recertification keyed in NC FAST: (mm/dd/yyyy) | Income Support Case (ISC) Number: | Product Deliver Case (PDC) Number: |
| Worker Name:  | Program: | Certification Period: (mm/dd/yyyy) - (mm/dd/yyyy) | Payment Authorization Period:(mm/dd/yyyy) - (mm/dd/yyyy) |
| Supervisor Name: | County: | Recertification Due Date: (mm/dd/yyyy) | Disposition: [ ]  Recertified  [ ]  Administratively Reopen [ ]  Withdrawn  [ ]  Terminated |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***REDETERMINATION***  | ***Yes*** | ***No*** | ***N/A*** | ***COMMENTS*** |
| DAAS-8191 Completed in entirety, signed, dated & copy in file |  |  |  | Date: |
| Intent to Return checked on DAAS-8191  |  |  |  |  |
| Intent to Return Form completed, signed, dated & copy is in file  |  |  |  | Date: |
| Dependent/Spouse living in home  |  |  |  |  |
| Documentation in file to indicate facility was contacted |  |  |  | Date: |
| SCU visit completed  |  |  |  | Date of Visit: |
| Transfer of Assets discussed, verified & documented per Policy |  |  |  |  |
| Sanction determined correctly & applied  |  |  |  | Sanction Period: |
| 1st DMA-5097 Request for Info completed correctly, sent to client & copy in File  |  |  |  | Date: |
| 2nd DMA-5097 Request for Info completed correctly, sent to client 12 calendar days after 1st DMA-5097 expired  |  |  |  | Date: |
| DSS-8110 Notice of Change completed correctly, sent to client & copy in file  |  |  |  | Date: |
| DSS-8108 Notice of Benefits completed correctly, sent to client & copy in file  |  |  |  | Date: |
| SAIH Interagency Transmittal requested (with copy to case file) |  |  |  | Date of Request: |
| SAIH Interagency Transmittal response rec’d from SAIH Case Manager/LME/MCO (with copy to case file) |  |  |  | Date of Response: |
| Voter Registration Form completed, signed, sent to Board of Elections & copy in file  |  |  |  |  |
| Were other health/supplement insurance(s) addressed appropriately & is there documentation in file |  |  |  | List other Health/Supplement Insurance(s): |
|  |  |  |  |  |
| ***VERIFICATION*** | ***Yes*** | ***No*** | ***N/A*** | ***COMMENTS*** |
| OLV / OVS / AVS completed  |  |  |  | Date: |
| 1619 (b) recipient |  |  |  |  |
| Facility SA eligible/facility screen printed  |  |  |  |  |
| Authorized Representative/POA/Legal Guardian info keyed in NC FAST |  |  |  |  |
| Copy of POA/Guardianship papers/Authorized Rep forms in file |  |  |  |  |
| Medicare A ~ B ~ D documented in case file |  |  |  |  |
| FL-2 requested according to policy  |  |  |  | Date of Request: |
| FL-2 is completed correctly & valid according to SA policy  |  |  |  | FL-2 Date: |
| Valid FL-2 Signature Date matches NC FAST Level of Care (LOC) Certification Start Date |  |  |  | LOC Certification Start Date: |
| ***INCOME*** | ***Yes*** | ***No*** | ***N/A*** | ***COMMENTS*** |
| Unearned Income Benefits verified correctly |  |  |  | Source:  |
| Monthly Gross Unearned Income Amount(s) correct in NC FAST |  |  |  | Amount(s): |
| Other Unearned Income verified correctly |  |  |  | Source: |
| Other Monthly Gross Unearned Income Amount(s) correct in NC FAST |  |  |  | Amount(s): |
| VA Income form completed, signed & copy response in file |  |  |  | Date: |
| Pension/Retirement Income verified per SA policy |  |  |  | Source: |
| Monthly Gross Pension/Retirement Income is correct in NC FAST |  |  |  | Amount(s): |
| Earned Income verified according to SA policy |  |  |  | Source: |
| Earned Income Base Period correct |  |  |  | Base Period Date: |
|  Wages correctly converted to countable monthly gross amount |  |  |  | Monthly Amount: |
| SA/ SAIH Budget completed & displaying in NC FAST correctly |  |  |  |  |
| SA/ SAIH Payment Review Period displaying in NC FAST correctly |  |  |  | From: To: |
| SA/ SAIH payment is correct |  |  |  | SA Payment Amount:  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***RESOURCES*** | ***Yes*** | ***No*** | ***N/A*** | ***COMMENTS*** |
| All bank accounts verified according to SA policy |  |  |  |  |
|  Checking Acct # |  |  |  | Bank Name: |
|  Savings Acct #  |  |  |  | Bank Name: |
|  IRA / Money Market, etc. Acct #  |  |  |  | Bank Name: |
| Patient Account Balance verified using correct Base Period |  |  |  | Patient Account Balance: |
|  Other |  |  |  | Source: |
| Property / Deed search completed & copies are in file |  |  |  |  |
| Home-site Property verified according to SA policy |  |  |  |  |
| Any contiguous property verified according to SA policy |  |  |  |  |
| All Vehicles / Boats / Trailers, etc. verified according to policy |  |  |  |  |
|  SA facility residence verified & documented in case file |  |  |  | Date Verified: |
| Does client have a burial contract? |  |  |  | Contract With: |
|  Irrevocable Burial Contract |  |  |  |  |
|  Revocable Burial Contract |  |  |  | Countable Amt: |
| Life insurance policy verified per SA policy & copy in case file |  |  |  | Insurance Company Name: |
|  Group policy name and policy number: |  |  |  | Total Face Value Amount: |
|  Term policy name and policy number: |  |  |  | Total Face Value Amount: |
|  Universal policy name and policy number: |  |  |  | Total Face Value Amount: |
|  Whole life policy name and policy number: |  |  |  | Total Face Value Amount:Total Countable Amt: |
| Burial Exclusion applied according to SA policy |  |  |  | Date Exclusion Applied:Amount of Exclusion: |
| Any/all resource exclusions applied according to SA policy |  |  |  | List Exclusions Used:  |
|  |  |  |  |  |
| ***TRANSFER OF RESOURCES / LOOKBACK*** | ***Yes*** | ***No*** | ***N/A*** | ***COMMENTS*** |
| Correct Facility Participant displaying in NC FAST |  |  |  | Facility Name: |
| Starting Point/Lookback Date established correctly  |  |  |  | Lookback Date: |
| First Moment Date verified according to policy & documented |  |  |  | 1st Moment Date: |
| First Moment Total Resources verified according to policy & documented in case file |  |  |  | 1stMoment Total Resources Bal: |
|  |  |  |  |  |
| ***RECERTIFICATION PROCESSED*** | ***Yes*** | ***No*** | ***N/A*** | ***COMMENTS*** |
| Recertification keyed timely |  |  |  | Date Recert Keyed: |
| All NC FAST evidences have been applied prior to activation  |  |  |  |  |
| Notices completed with correct dates & policy references |  |  |  | Date of Notice: |
| All Cancelled/Reversed payments addressed appropriately |  |  |  |  |
| Overpayment/Underpayments addressed, resolved & documented in case file according to SA policy |  |  |  | Overpayment Amount:Underpayment Amount: |
| Narratives in case detailing actions taken on case at recert. |  |  |  |  |
| Delivery Pattern & Banking Evidence is accurate and correct |  |  |  |  |
| If case is terminated, Passalong Evaluation done & documented in case file |  |  |  | Date Completed: |
| Benefit History is displaying correctly |  |  |  |  |
| COLA Dollar Off Cases addressed per SA policy  |  |  |  |  |

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***Caseworker Signature Date Supervisor Signature Date***

**FOLLOW UP:**

Date case corrections must be completed by (if applicable): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Date:**

After all case corrections have been verified, final review was completed by: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

  **Print Full Name and Title**

Date corrections, on all cited case errors, were completed: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Date:**