

Quality Review Checklist for SSI/SSDI Applications and Disability Determinations

I. Establishing Protective Filing Date		
A. Was SSA contacted to establish protective filing date? What method was used?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Phone (to local SSA) <input type="checkbox"/> On-line <input type="checkbox"/> 1-800-772-1213 (SSA toll-free) <input type="checkbox"/> Faxed Consent	
B. Was filing date noted in individual's chart?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
C. Does the worker have proof of establishment of protective filing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
D. Protective Filing Date:	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>MM DD YYYY</small>	
II. SSI/SSDI Applications: Non-Medical Aspect		
<i>A. SSI Application (SSA-8000)</i>		
1. Was SSA-8000 initiated:	By phone? <input type="checkbox"/> Yes <input type="checkbox"/> No In person? <input type="checkbox"/> Yes <input type="checkbox"/> No On outreach basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Date SSI Application completed:	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>MM DD YYYY</small>	
3. Critical parts of SSI Application		
(a) Was documentation of marital status needed? If yes, was it gathered and submitted?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
(b) Did immigration status need to be addressed? If yes, was documentation submitted?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
(c) Did legal complications (felony warrant and/or violation of probation) exist? 1. If legal complications existed, were these taken care of?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
(c) Was living arrangement documentation provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(d) Was documentation of assets/resources provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(e) Was documentation of income provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>B. SSDI Application (SSA-16)</i>		
1. Was application for SSDI (SSA-16) completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(a) Submitted on-line?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(b) Submitted in-person?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(c) Submitted by phone?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Date completed:	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>MM DD YYYY</small>	
C. Was Appointment of Representative (SSA-1696) signed and submitted?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
III. SSI/SSDI Applications: Internet Disability Report SSA-i3368		
A. Was SSA i3368 Internet Disability Report completed?		
1. Submitted on-line?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Submitted in-person?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Submitted by phone?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
B. When SSI/SSDI applications were completed, was information about date of onset of disability and date last worked consistent?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
C. On the Internet Disability Report (SSA-i3368), was the following information provided:		
1. Additional contact person besides appointed representative on page 1?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. All physical and mental health problems listed in the individual's words?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Clear explanation of how health problems keep individual from being able to work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Complete listing of employment history from past 15 years with best estimates of tasks, duration, pay, and dates worked?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

5. Comprehensive listing of medical clinics, hospitals, health care providers (addresses, phone numbers, and dates of treatment, where possible) for ALL past and current physical and mental health treatment, including: (a) Reasons for treatment/treatment provided? (b) Medications currently taking, what they're for, and ALL side effects? (c) All recent medical tests with approximate dates and location?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Are ALL questions answered with complete information and any clarifications included in remarks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Are all questions answered in individual's words?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Is additional clarifying information included as needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Were enough releases of information (SSA-827) completed for all treatment sources, signed and dated in accordance with local SSA office requirements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
IV. Medical Summary Report	
<i>A. Introduction</i>	
1. Does the first section of the Medical Summary Report accurately provide the physical description of the individual, the person's interacting pattern, pattern of speech, ability to answer questions, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Does the description give the reader an understanding of what it is like to be with this person?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>B. Personal History- Does this section cover:</i>	
1. Any trauma issues, including physical and/or sexual abuse (Brain damage is covered under physical health)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Educational history, including information on learning difficulties, grades repeated, special education, relationships with other students/teachers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Employment history for past 15 years, including all jobs, reasons for leaving, job skills, problems on-the-job in terms of task completion and relationships with supervisors/co-workers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Legal history, i.e., arrests, convictions, incarcerations (including treatment in jail/prison), probation, parole?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Problems in personal/intimate relationships, including problems with children and current relationships?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>C. Treatment History</i>	
1. Does treatment history include substance use history and treatment, including detox?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Does substance use history address reason for use, impact of use (what person feels is positive/negative), treatment history, current drug of choice and why?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Physical health history: Hospitalizations? Surgeries? Falls/accidents/fights involving head injuries? Current health problems? Medications? Primary care provider? If no treatment now, why?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Mental health history: First symptoms? Age and impact of first symptoms? Hospitalizations? Day treatment/partial hospitals? Outpatient treatment? Psychiatric rehab. services? Emergency room visits? Medications? If no current treatment, why?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>D. Functional Information</i>	
1. Description of all functional levels of impairment separated by: activities of daily living, social functioning (incl. ability to be with and relate to other people), impairment of persistence and pace in completion of tasks, decompensation lasting at least two weeks 3 or more times in last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>E. Summary Ending</i>	
1. Does the report contain a summary of diagnosis, impairment, evidence of significant functional impairment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is report co-signed by a physician/psychiatrist or psychologist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are contact names and phone numbers included for the primary writer of report and the co-signing physician/psychiatrist/psychologist?	<input type="checkbox"/> Yes <input type="checkbox"/> No