Title XVI Claims Specialist Basic Training Curriculum

Title II Fundamentals and MMA Student

SOCIAL SECURITY ADMINISTRATION,
Office of Human Resources, Office of Learning
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TABLE OF CONTENTS

LESSON PLAN

Objectives

At the completion of this Module, the trainee will be able to:

- State factors of entitlement for Title II disability benefits.
- Determine if insured status is met, and determine date last insured.
- Identify and apply the non-medical factors for developing a date of onset for disability
- Complete an abbreviated disability claim using MCS.

Length of Module

4 hours

Instructional Aids

Publication # 05-10024 entitled, “Understanding the Benefits”

SFNet eServices

National eServices Site

Social Security.gov Online Services

BACKGROUND AND RATIONALE

General Background

The Social Security Act established a number of programs with the basic objectives of providing for the material needs of individuals and families, and for protecting aged and disabled persons against the expenses of illnesses that could otherwise exhaust their savings. These programs include:

- Retirement insurance
- Survivors insurance
- Disability insurance
- Hospital and medical insurance for the aged, the disabled, and those with end-stage renal disease (ESRD)
- Black Lung benefits
- Supplemental Security Income (SSI)

Retirement, survivors and disability insurance benefits (RSDI) are paid under a social insurance program administered by SSA. A person must file an application for benefits and he or she must meet certain eligibility requirements. The payments made under this program are commonly known as Social Security benefits, DIB, or Title II benefits. Specifically, Disability payments under Title II are commonly called DIB benefits. They are paid monthly by check or direct deposit to the beneficiary, or to a representative payee if the beneficiary is incapable of managing his or her own funds.

Purpose

The Social Security program is compulsory, work related, and based on insurance principles. It is designed to partially replace earnings lost due to the retirement, disability or death of an insured person. Whereas individuals in private insurance programs must pay a certain amount in premiums before they can collect any benefits, participants in the Social Security program must perform a specified amount of work on which they pay Federal Insurance Contribution Act (FICA) or Self-Employment

Contribution Act (SECA) taxes before they (and their qualified dependents or survivors) collect benefits. If they perform the specified amount of work, they have insured status. This was discussed in Agency Fundamentals. This work requirement is different from the rules for SSI. Although SSI uses income and resources as a factor of eligibility, Title II DIB does not. Work credit and the resulting insured status is the basis for Title II disability.

Age Closely Related to Insured Status

You will see that age is closely related to insured status because the number holder's (NH) date of birth is the starting point for determining the number of Quarters of Coverage (QC) needed for fully insured status.

You will learn that insured status requirements under disability are different from RSI requirements. In addition to being fully insured, a worker must also meet Disability Insured Status. This means they must have worked in covered employment for at least 5 of the previous10 years (20 out of 40 quarters) before the onset of disability. For persons who are blind or became disabled before age 31, a less restrictive insured status requirement must be met.

Screening for Entitlement

At times, a number holder may apply for SSI and Title II disability benefits concurrently. Although the NH may not be insured, it is critical to check and see if the NH may qualify for any other types of Title II benefits. Be aware of key factors indicating possible entitlement to other benefits. If a NH is over age 50, has a prior marriage, is approaching retirement age (62) or was disabled before age 22, you should check for eligibility on other records. Anytime you are unsure, check with someone in the Title II unit, or ask your supervisor. Missing an entitlement is an easily avoidable mistake that could mean the difference between a denial for Title II, or eligibility for your claimant.

OBJECTIVE 1:

State factors of entitlement for Disability Insurance Benefits DIB.

Factors of Entitlement – Disability Insurance Benefits (DIB)

DI 10105.060

To be entitled to DIB (cash benefits), an individual must:

- Meet DIB insured status. This means the individual is fully insured and meets 20/40 or special insured status if disabled prior to age 31.
- Be disabled.
- Serve a waiting period (or be exempt from serving one).
- Not have attained full retirement age (FRA).
- File an application.

Childhood Disability Benefits (CDB)

RS 00203.080

A child who is over age 18 may be eligible for Childhood Disability Benefits (CDB) or Disabled Adult Child (DAC) if he/she:

- Meets the requirements for child's benefits except:
  - He/she has attained age 18; and
  - Has a disability that began before age 22.

In these cases, check to see if the person filing has a parent who is receiving Disability or Retirement benefits, or who died fully or currently insured.

OBJECTIVE 2:

Determine if insured status is met, and define Date Last Insured.

Fully Insured Status

RS 00301.105, RS 00301.250, RS 00301.230

2019 Quarter of Coverage (QC)

The fully insured status test is a "duration of work" test. The NH must have earned enough QCs to be fully insured. A NH needs at least 6 QCs, but no more than 40 QCs, to be considered fully insured. This was discussed in Agency fundamentals

For 2019, one quarter of coverage, or QC, is $1,360 in gross earnings. Gross earnings of $5,440 will result in 4 QCs.

Note: A person can earn a maximum of 4 QCs in a calendar year, regardless of how much income he earns.

1-for-4 Rule

A person is fully insured if (s)he has one quarter of coverage (QC) for each calendar year after 1950, or after the year in which (s)he attained age 21 if later, up to the year in which the NH attains age 62, dies or becomes disabled, whichever occurs earlier.

Insured status is acquired as of the first day of the quarter in which the qualifying QC is earned. This was previously discussed in Agency Fundamentals.

Minimum/Maximum QCs

Six (6) QCs is the minimum number required and 40 QCs is the maximum QCs required. See Exhibit 2 (Determining Fully Insured Status).

Lag Earnings

RS 01404.005

Lag earnings are un-posted earnings in the current year and the preceding year (the lag period) which could provide insured status if counted. Lag earnings MUST be developed in the following situations:

Insured status is dependent upon the lag earnings

- The claimant insists we use lag earnings in the computation and the lag earnings evidence is provided within 10 days
- The case is a DIB case and the DLI is less than 2 years in the future
- The case is a DIB case that involves worker's compensation/public disability benefits and the lag earnings affect the ACE (average current earnings)
- The use of lag earnings establishes entitlement to spouse's benefits
- An employment or coverage question is raised by the claimant and the discrepancy affects either the PIA or deductions
- The NH alleges posted earnings during the lag period are incorrect
- It is apparent the lag earnings will not be posted timely

NOTE: You do not have to develop lag earnings UNLESS one of the factors requiring development exists.

If you are required to develop lag earnings, you will need to request proof. Often in lag situations, the employer has not yet issued a W2. If this is the case, the NH can submit a statement from his/her employer as evidence of lag wages. RS 01404.018

DIB Insured Status

RS 00301.120; RS 00301.122

DIB Insured Status

To be insured for DIB, the NH meet two separate insured status requirements. He or she must have at least 20 QCs during a 40 quarter period that ends with the quarter the waiting period begins AND the NH must be fully insured in that quarter. There is an exception to both fully insured status and 20/40 in blindness cases. There are also special DIB insured provisions for individuals who were disabled prior to the age of 31.

NOTE: When determining DIB insured status, be sure to consider lag earnings. You can use DISCO to determine if including lag earnings will affect the NH's insured status. Also see Exhibit 2 (Determining Fully Insured Status).

20/40

RS 00301.120

The 20/40 QC requirement is in addition to the fully insured requirement. It specifies that a NH must have 20 QCs during a 40 quarter period ending with the quarter in which the waiting period begins.

Since we are counting the number of QCs within a certain time frame, it is important to note that QCs can be moved within a year to advantage a claimant. Quarters of coverage are flexible in that they may be assigned to any quarter in the calendar year whenever necessary to meet the requirements for insured status. See RS 00301.230.

NOTE: A less restrictive insured status requirement applies to persons who become disabled before the quarter of attainment of age 31, or who are blind. We will discuss this further in "special insured status."

EXAMPLE A:

DOO (Date of Onset)- 2/12/10

Count back 40 calendar quarters beginning with the 3/10 quarter. You end with the 6/00 quarter. There must be 20 "Cs" within this period.

1999--CCCC	2003--NNNN	2007--NNNN
2000--CCCC	2004--CCNN	2008--CCCC
2001--CCCC	2005--CCCC	2009--NNNN
2002--NNNN	2006--CCCC	2010--NNNN

In this example, 20/40 is met by the NH.

EXAMPLE B:

DOO- 08/31/10

1997--NNNN	2002--NNNN	2007--CCCC
1998--NNNN	2003--NNNN	2008—CCCC
1999--NNNN	2004--NNNN	2009--CCCC
2000--NNNN	2005--CCNN	2010--NNNN
2001--CNNN	2006--CCCC	

Count back 40 quarters beginning with the 9/10 quarter. In this example, the NH does not meet 20/40. The NH has only 19 QCs out of the last 40 quarters.

Special DIB Insured Status

RS 00301.140

Age 24 to 31 Requirements

For an individual who is age 24 but not yet 31 years old at onset, the individual is too young to acquire a 40 quarter (ten year) work history, so the requirement to be insured for DIB is modified. (S)he must have one QC for every 2 calendar quarters that have elapsed since age 21, up to and including the quarter of onset. Quarters of coverage earned in or before the quarter of attainment of age 21 MAY NOT BE USED to meet this requirement. Keep in mind, though, that QCs may be moved within a year to advantage a claimant.

When the required period described above involves an odd number of elapsed calendar quarters, the odd quarter is dropped in determining the number of QCs required for insured status.

Age 24 or Younger

For individuals age 24 or younger, the requirement is modified even further to require six quarters of coverage in the 12 quarters ending with the quarter of onset. This can include quarters before age 21 if they fall in the 12-quarter period.

NOTE: Both of these younger individual groups must still meet 'fully insured' status.

Special Age 31 Insured Status Examples

EXAMPLE 1: (This example is also explained in Exhibit 2)

NH's DOB 12/14/80; DOO 7/10/10

2001--NNNN	2006--NNNN
2002--NNNN	2007--CCNN
2003--CCCC	2008--CCCN

2004--CCCC 2009--CNNN

2005--CNNN 2010--CCNN

ANSWER:

This NH is fully insured and meets the special insured status, since (s)he needs 17 QCs in the period 01/02 (qtr after age 21)-07/10 (qtr of onset) and has 17.

EXAMPLE 2:

NH's DOB 9/2/85; DOO 12/17/10

2005--CCNN 2008--CNNN

2006--CNNN 2009--NNNN

2007--NNNN 2010--CCCC

ANSWER:

This NH is fully insured, but does not meet 20/40 or special insured status.

Eight QCs are needed for special insured status. This NH only has six QCs in the period 10/06 (qtr after age 21) – 12/10 (qtr of onset).

NOTE: If it would have provided insured status, the QC in the first quarter of 2006 could have been moved to the last quarter of 2006.

Date Last Insured

RS 00301.148

Definition

The DLI (Date Last Insured) is the last day in the last quarter in which DIB insured status is met. The term “Date Last Met” (DLM) is also used and means the same thing. Essentially, this is the last date that a claimant’s work and earnings provide disability coverage. This is the date the claimant’s insured status “runs out.”

Purpose

The FO and Disability Determination Service (DDS) need to know when disability insured status is last met because it determines the amount of development required.

- If DIB insured status is not met, do not send the claim to DDS.
- If the DLI is in the past, medical development of the NH's current condition is not necessary. This saves processing time.
- If a claim is finally adjudicated as a medical denial after the DLI, a new medical decision will not be made later unless the requirements for reopening are met or the NH has subsequent work that extends the DLI beyond the date of the denial.

Examples

- With no prior health problems, NH was injured in an accident on 3/21/11 (a traumatic onset), DLI is 9/30/10; claim must be technically denied in FO and must not be sent to DDS for a medical decision. The NH is not insured; his coverage has "run out."
- NH had heart attacks in 2008 and 2010 (non traumatic onset). DLI is 3/31/09. DDS must be informed to evaluate medical evidence only through 3/31/09.

DLI Points to Remember

In all DLI computations, the quarter arrived at is only a valid DLI if none of the QCs counted were earned after that quarter, and fully insured status is met as of that quarter.

Be sure to consider lag earnings, including the current year.

The DLI is shown on the MCR1 screen in Earnings Computation (EC) facility in MCS.

You can use DISCO or ICERS to calculate the DLI.

The DLI will change if the NH does additional work.

DISCO

DIB Insured Status Calculator Online (DISCO)

This is a program accessible through the PCOM Toolbar. DISCO uses uncertified earnings and therefore is used for informational purposes only, but it does a consistently accurate job of computing DIB insured status, date first insured, and date last insured.

You must open a PCOM session that matches the session listed on the DISCO screen. DISCO will obtain any queries needed in computing insured status—SEQY, NUMI, SSID, AACT. It will even order an ICERS (Informational/Certified Earnings Record System) if you request it. It will then compute the DIB insured status and date last insured (DLI) based upon the date of birth or onset the user provides.

If you wish to manipulate the QC pattern by adding or changing the earnings and posted quarters for computational purposes, DISCO allows you to do this and will refigure the insured status and DLI based on the new information.

OBJECTIVE 3:

Non-medical factors for date of onset.

Date of Onset

DI 25501.000; DI 25501.210; DI 25501.220

The onset date is the first day a claimant meets the definition of disability by satisfying the following requirements:

- Absence of substantial gainful activity (SGA); and
- Has a medically determinable impairment; and
- Duration is expected to last at least 12 months or result in death.

Unlike TXVI cases, TII cases may have retroactive onset dates prior to the date of filing. Whenever you are unsure of the correct onset, confer with a TII Claims Specialist.

Alleged Onset Date (AOD)

The alleged onset date (AOD) is the date a claimant reports he became unable to work because of the effects of his illnesses, injuries or conditions. Determining the AOD is generally straightforward if the disabling condition is of traumatic origin because disability is usually immediate. If the claimant's illnesses, injuries, or conditions did not result in immediate disability, but have imposed increasing limitations over time, it may be more difficult for that claimant to determine the date he became unable to work because of the effects of his condition.

The AOD is always the date the claimant alleges he became unable to work, regardless of whether that date appears to be appropriate. The AOD must be developed during the initial interview. Record what the claimant tells you. This is their allegation of disability onset.

EXAMPLE:

Claimant alleges onset of disability as 07/01/2010, but did not contact a medical source about the impairment until 05/01/2012. We will use the claimant's allegation of 07/01/2010 for the AOD.

NOTE: All work activity performed after the claimant's AOD must be documented on an SSA-820 or SSA-821 and an SSA-823 UNLESS the work is clearly not SGA. This development is critical for DDS. Clearly not SGA means the earnings are clearly below the trial work period (TWP) service month threshold level, which is $850 per month for 2018. Refer to your lessons on SGA for more information.

Potential Onset Date (POD)

The potential onset date (POD) is the earliest date that disability can be established based on non-medical factors alone. A Claims Specialist determines the POD based on the claimant's work record, insured status, allegations, and any evidence in the file. This date may be the same as, earlier, or later than the AOD. It is the claims specialist's responsibility to determine a POD and alert the DDS examiner of the need to develop the case for an onset other than the AOD. DDS development is bound by the POD set in the claim. It is crucial to set an accurate POD.

Factors to consider in establishing the potential onset are:

- The date the claimant believes that his/her health problems became so severe that they prevented work.
- The last day the claimant worked.
- The changes in the claimant's work pattern related to impairment.
- The last date of SGA (considering unsuccessful work attempts).
- Special considerations, situations, assistance (Subsidy – specific or nonspecific).
- Any allowable impairment related work expenses paid by the claimant.
- Insured status.
- The day after a prior administrative law judge (ALJ) decision.

Use of Alleged Onset Date (AOD) or Potential Onset Date (POD)

The FO informs DDS of the claimant's date last insured (DLI), evaluates any earnings after the AOD, and notifies DDS of the AOD and POD.

Based on field office development, DDS uses either the AOD or the POD as the starting point for medical development. Ultimately, DDS determines the Established Onset Date (EOD). DDS makes the final determination of the onset date based on medical and/or work evidence.

Your role in developing the onset date is very important. The EOD DDS establishes will determine when disability benefits begin and the amount of benefits payable, and this EOD is based off of the POD.

Traumatic/Non-traumatic

DI 25501.440; DI 25501.460

Traumatic Onset

Traumatic onsets, such as an accident, have a clear-cut date of onset, and do not require much development. Onset is the day of the injury. The fact that the claimant worked on the day of the trauma is not relevant.

Non-traumatic Onset

Non-traumatic onset involves progressive or gradual conditions that may have existed for a long period of time. A thorough interview is necessary to obtain and assess all of the information.

Some illnesses, such as diabetes, may not be severe enough to meet the definition of disability until several months, or even years, after the initial onset. When interviewing the NH, it's important to find out the exact point at which the illness caused the NH to make changes in work activity. Information from employers, family and friends can help to pinpoint the date of onset. Without medical evidence covering earlier years, the DDS team may have to make informed judgments according to the facts of each particular case.

EXAMPLE:

Henry Rogers, age 58, applied for DIB on February 26, 2011, alleging inability to work since April 13, 2010, due to "bad legs." He stated that he had worked in the lumber industry all his life and had to walk many miles a day in his work; however, cramps and numbness in his legs had become so bad that he could not now only walk a quarter of a mile. The only medical information available, dated January 2009, showed that he had peripheral arterial disease of a listing severity.

Since no other medical evidence was available, the employer was contacted by DDS and he stated that the claimant had worked for him for many years but in the last few years Henry had become less and less able to cover his assigned area. Finally, 04/13/10 he was laid off because he couldn't adequately do his job. A neighbor said the NH used to frequently hunt and fish until his condition worsened to the point where his legs would no longer support him. This was in 2010.

The DDS examiner makes a decision on the medical evidence available showing the severity of the NH's condition. The examiner decided that it was reasonable to believe that the NH was unable to work due to his medical condition as of 04/13/10. In this case, the lay evidence was consistent with the medical evidence.

Sources of Onset Information

Information can be obtained from the disability report form(s), the application screens, postings on the earnings record, information on the work activity reports (SSA 820 or SSA 821), or statements from the claimant's employer(s), family, or friends.

Onset development is sometimes required after the initial interview, primarily when earnings development is involved. Any changes in the AOD must be made over the claimant's signature. The payments can be retroactive for up to 12 months from the date of filing for monthly benefits. This is different from SSI. The date of onset is not limited.

Development When Insured Status is an Issue

DI 11005.065

The NH must be insured at the onset date to be eligible for benefits.

Onset development can be curtailed if:

- The DIB claimant does not have DIB insured status as of the AOD or later (even considering lag earnings), depending on the type of onset: Traumatic or Non-traumatic.

Traumatic Onset

In cases of traumatic onset (bodily injury by external force or violence, e.g., a broken back), development of onset is curtailed when the NH does not meet insured status as of the AOD or later, based on posted and lag wages.

Non-traumatic Onset

In cases of non-traumatic onset of an acute impairment (e.g., myocardial infarction, meningitis and encephalitis), the onset date is usually self-evident and will not require further development to pinpoint an AOD.

Some impairments are characterized by progressive or gradual onset of symptoms (e.g., arthritis, mental illness, cancer). In determining the onset date in these cases, compare the AOD with the claimant's medical and vocational history.

If the probable onset is contradictory or unclear and is within 1 year of the calendar quarter in which the DLI is met, develop the case fully and forward it to the DDS for a disability determination (DI 25501.460).

EXAMPLE:

Jerry retired in 2007 at the age of 55. He was in good health and has been enjoying fishing ever since. He has had arthritis for 3 years, but now it has worsened to the point he can no longer go fishing. His neighbor told him he should file for disability. Jerry can’t pinpoint an onset date but he says

his arthritis got really bad around 07/04/2013 and he had to be hospitalized. His DLI is 12/31/2012.

Even though Jerry's AOD of 07/04/2013 is after his DLI of 12/31/2012, his case will need to be sent to DDS for a medical decision. His claim involves a non-traumatic impairment and his AOD is less than 1 year after his DLI (DI 11010.075).

In this case, it is possible that a DDS examiner will be able to establish an onset prior to the DLI. Because Jerry's condition gradually worsened, it will be up to the DDS examiner and the evidence to pinpoint an exact onset date. If the case never makes it to DDS, Jerry will never have a chance at a disability determination. Send all cases with non-traumatic onset within 12 months of the DLI to DDS for a decision.

OBJECTIVE 4:

MCS and deferred disability claims.

Modernized Claims Systems (MCS) Screens

MS 03500.000

The most efficient and preferred method of processing a claim for benefits is through MCS. MCS is a fully automated and completely self-contained system.

Applications

Applications are created from data you enter on the MCS application screens. These can be accessed from the main menu by selecting #1 "Title II/Initial Claims". To start an application, enter the number holder's SSN, select #1 "Establish", and #3 "New Claim." This is similar to starting a MSSICS claim.

Development

The development screens are used to print the application and to serve as a record of evidence requested and received. These screens can be accessed by selecting #2 "Update" and #5 "Claims Development" from the MCS Main menu.

Optional Clearance Screens

The optional clearance screens record data that cannot presently be derived from the application, such as specific paragraphs to be used in award or denial letter to the claimant, etc. From the MCS Main menu, you can access these screens by selecting #2 "Update" and # 6 "Claims Clearance."

Earnings Computation (EC)

The EC screens display the earnings record, compute the benefit amount and can be used to adjudicate the claim.

EC Clearances

Most claims can be adjudicated through MCS because the EC section within MCS is capable of combining all the necessary data to establish the MBR, generate notices to the claimant and certify a request for payment to the U.S. Treasury. When a claim is adjudicated through the EC process, the application for benefits is usually the only paper output in the claims file. The earnings record is displayed online. Edits and errors are also revealed to you on the computer screens.

Completing an Abbreviated Disability Claim

The abbreviated application process shortens development time and provides a mechanism for making formal determinations based on essential information. When you take an abbreviated application, MCS determines which application screens you need to complete and sends you the screens in a prescribed order.

Requirements for Using Abbreviated Disability

Use the APPL screen to deny DIB claims when all of the following apply:

- The number holder and the claimant are the same person;
- Insured status is not met;
- There are no outstanding issues involving earnings, military service or extending the prescribed filing period;
- The claimant will not attain full retirement age within the next 5 months; and
- The requirements for DIB are not met and will not be met within the next 12 months.

For screen by screen instructions, see Exhibit 4.

Online Services

Online Title II Applications

GN 00204.055

In response to customers' requests for more Internet services and the requirements of the Government Paperwork Elimination Act of 1998, the Social Security Administration (SSA) implemented the I-Claims to allow claimants the opportunity to complete and electronically sign an application on their own behalf on the Internet. Claimants can use I-Claims to apply for Retirement Insurance Benefits (RIB), aged spouse's benefits, Disability Insurance Benefits (DIB), and Medicare. Claims Specialists can see replicas of the I-Claims screens at (b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)

Password Services

Title II beneficiaries who file for benefits via the internet have the option of obtaining a password that will allow them to check the status of their claim, change their address or phone number, or request direct deposit. Beneficiaries may choose to block this password access at any time. Be aware of this option in case a claimant asks you about it.

Refer to Exhibit 5 for a list of services available from the Social Security website. To download copies of this brochure to give to the public, go to: (b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)

EXHIBIT 1: DETERMINING FULLY INSURED STATUS

I. Ending
   A. Enter year of disability onset _____
   B. Enter year of age 62 attainment _____
   C. Enter year of death (if applicable) _____

   Circle whichever of A-C is earliest

II. Compute the number of QCs required
   A. Enter the date circled above _____
   B. Subtract the year the NH attained age 22 (cannot be earlier than 1951) _____
   C. Result is the number of QCs required for fully insured status (minimum of 6) _____

NOTE: If there was a prior period of DIB, be sure to count the number of years either wholly or partially within the prior period. Then subtract that from the number arrived in II C. However, remember that it cannot be less than six QC's.

EXHIBIT 2: SPECIAL INSURED STATUS FOR DISABILITY BEFORE AGE 31

REQUIREMENTS -

- Become disabled before the calendar quarter in which he/she attains age 31, AND
- Be fully insured, AND
- If disabled after the quarter of age 24 attainment, have earned QCs in at least ½ of the calendar quarters beginning with the calendar quarter after age 21 attainment, OR
- If disabled in the quarter of age 24 attainment or earlier, have earned 6 QCs out of the 12 calendar quarters ending with the quarter of onset.

EXAMPLE 1 NH's DOB 12/14/80 DOO 7/10/10

2001--NNNN	2006--NNNN
2002--NNNN	2007--CCNN
2003--CCCC	2008--CCCN
2004--CCCC	2009--CNNN
2005—CNNN	2010--CCNN

NH became disabled in the 35th quarter after reaching age 21 and needs 17 QCs at that point to be insured. Since the NH has 17 QCs in that period, the NH meets special insured status.

EXHIBIT 3: STEPS TO PROCESSING A T2 DISABILITY ABAP

Step 1

From the main menu: Select #1, "Title 2/Initial Claims"

From the MCS Main Menu:

- Enter SSN of NH
- Select #1 Establish
- Select #3 New Claim
- Hit Enter

This brings you to the APPL (MS 03505.009) screen where the NH Name, SSN, DOB and Sex code is propagated. If you have proof of age, code accordingly. If not, enter A for alleged.

- Under "Select Claim Typed" select, "Disability"
- Put an "X" in the box by the statement, "Abbreviated Application" and hit enter. It is very important to put the "X" in before hitting enter. You only get one opportunity to indicate the claim should be "abbreviated". If you forget, you will not be able to go back and enter it and you will have to complete a full application. However, if you choose and abbreviated application and a full application is later needed, you may go back to this page and delete the "X" and a full path will then propagate.

This brings you to the Claim Contact Method Data (CCMD) screen (MS 03505.058).

- Select the contact method from the options listed under "Contact Methods (CM) Values and Meanings".
- Under "Internet/Phone Service Options", answer yes or no as the claimant states. You will also need to answer the notice option with yes or no. These are required fields, so you must answer the questions. Press enter.

The next screen is the Abbreviated Disability (ABBD) screen (MS 03505.048). The questions it asks are:

- Ever married or currently married
- Dependent children (any child under at 18, under age 19 and still in a secondary school, or disabled prior to age 22 – whether the child lives with them or not)
- Any work or earnings in years listed
- Onset date

Complete the screens and press enter. Based on how you answered these screens, additional screens could appear. If you answer yes to marriage information, you will be presented with a NH Marriage (NMAR) screen (MS 03505.037). If you answer yes to children, the Dependent Children of NH (DEPC) screen (MS 03505.026) will appear. List all applicable children. If you answered yes to any work or earnings, the screen Work History (WORK) (MS 03505.044) appears.

The next screen to appear in the pathway is the CLLG screen—Client Language. Choose which language the claimant wishes to use in pursuing his claim.2

Next is the U.S. Citizenship (CLCZ) screen (MS 00705.010). This is similar to the Citizenship (ACIT) screen in the SSI pathway. Complete this screen and press enter.

The following two screens are address screens. The first in the pathway is the Claimant Mailing Address (CADR) screen (MS 03505.046). Complete and hit enter. The second screen is Client Address (CLAD) (MS 02002.002). It collects the claimant's residence address.

The final screen in the application pathway is the Remarks (RMKS) screen (MS 03505.040). A good practice is to add remarks if applicable, such as: no lag earnings, no military service, no prior periods of disability.

Step 2

Unlike MSSICS, the MCS application path does not take you directly to the development worksheet (DW01) unless you use the "transfer" field on the RMKS screen. Otherwise, you will access the DW01 (MS 03508.002), select #2, "Update" and #5, "Claims Development." Next, select the

claimant on the DMEN screen by putting a “0” in the FUN1 field next to the claimant’s name, and press enter. On the DW01, complete these fields:

- Unit
- FO Code
- Phone Info
- Either set tickle for ABAP-D or receipt it in
- Attest to the applicant’s intent to file.
- Do not put any entries in the REQ field of the DDSDEC issue. Enter the current date in the DDS REC field. In the remarks, section put “Disallowance”.
- Press enter.

The next screen will be the PRST, Print and Store screen. This screen is used to print and/or store to ORS any of the MCS application summaries. This includes:

- 16 basic applications;
- Totalization applications;
- Amendment of application; and
- Two appeal applications

To determine what action you need to take, refer to MS 03508.011.

Step 3

Review the EC screens for any edits or alerts. The EC screens can be accessed from the MCS Main menu by selecting #2 “Update” and #21 “Earnings Comp Request.” These are the main screens you will see and the fields you should enter:

- MREQ (MS 03601.005) – when entering these screens to preview for edits, do not change any fields. Press enter and continue.

- MECN (MS 03601.004)-Make sure that a "2" for disability is entered in the "Claim Type" field and press enter.

- MCR1 (MS 03601.007) – In case display, select #1, "All". Before you hit enter, review this screen. Claim type should be "ABAP-D" and LAF code should be "N." Hit enter to continue with review.

- DRMK (MS03601.019) – These are remarks screens. There should be a remark that shows: "DISALLOWANCE – BIC HA DISALLOWANCE CODE 090 – NH NOT DIB INSURED." This remark shows the claim will be denied for lack of insured status.

- DEI1 (MS 03601.012) – This screen show insured status information. It will list the required QCs and the number of QCs the NH has. This is important information because if the person is only 1 or 2 quarters off and they are working, they could become insured. If this happens, consult with a TII Claims Specialist.

- There may be other pages, but the above are the key pages to review.

Step 4

In this sequence, you will have received your application and have receipted it in on the DW01 (see Step 2). You will have reviewed the EC screens and the claim is ready for adjudication.

- This can be accessed from the MCS Main Menu by entering the SSN and selecting #2 "Update" and #23 "Decision Input."

- Enter through the FDDS screen. This screen contains information if you need to alter the protective or actual filing dates.

- On the DECI screen, under DEC STAT enter 03-DIB TECH DIS. Complete "FO AUTHORIZER," "PHONE," and "FO DEC DATE" fields. Press enter.

Step 5

After the decision has been input, the final trigger is done through the EC screens.

- Select #2 “Update” and # 21 “Earnings Comp Request.”
- On the MREQ screen, answer “Y” to Adjudicative Request. Press enter.
- The next screen will be the Earnings Comp Determination (MCR1). Under “Case Display.” Select #7 “Approve” and press enter.
- The Earnings Comp Approval (DAPP) screen (MS 03601.034) appears. Answer “Y” to approve the claim.

Step 6

Hold the case for two days and check to be sure an MBR was established. Fax any supporting documentation to CEF or NDRed, whichever is appropriate, and shred all paper PII.

OFF AIR ACTIVITIES

Before the IVT presentation, the trainee should review the module and exhibits. The trainee should read the listed publication, “Social Security, Understanding the Benefits.”

NOTE: The publication can be obtained from local supply or the trainee can go into the Title XVI CS resource kit. Under the column heading, “Information,” click on English Publications (or Spanish Publications).

If a trainee is not very familiar with Title II programs, review the Introduction to Title II benefits section of Agency Fundamentals.

- After the IVT presentation, the trainee should complete the exercises and activities mentioned.

- Pull up several disability appointments from your disability appointment list and manually figure insured status (both fully insured and 20/40 or special insured status) and date last insured. Check your answers with DISCO.

- Request a cloned SSN for David Johnson, uninsured for Title II. Practice loading a Title II disability ABAP claim in the Training Region. Make up answers to the questions of being married, having any children, and working in the last two years.

EXERCISES

Exercise #1

Factors of Entitlement

1. What are the factors of entitlement for disability benefits?

2. What factor of entitlement do all claims have in common?

Exercise #2

Insured Status

1. What is the minimum amount of QCs needed?

Exercise #3

Non-medical Factors for Date of Onset

1. List all factors to consider when determining a potential onset.

EXERCISE ANSWERS

Exercise #1

1. Meet DIB insured status 20/40, or special insured status if disabled prior to age 31, be disabled, serve a waiting period (or be exempt from serving one), not have attained FRA, and file an application. DI 10105.060

2. They must file an application.

Exercise #2

Fully Insured Status

1. 6

Exercise #3

Non-medical Factors for Date of Onset

1. The Claims Specialist should consider all these factors in determining onset:

    - The last day claimant worked.
    - The last date of SGA (considering unsuccessful work attempts).
    - The claimant's beliefs that his/her health problems became so severe that they prevented work.
    - The changes in the claimant's work pattern related to impairment.
    - Any subsidies paid to the claimant by the employer.
    - Insured status/DLI.

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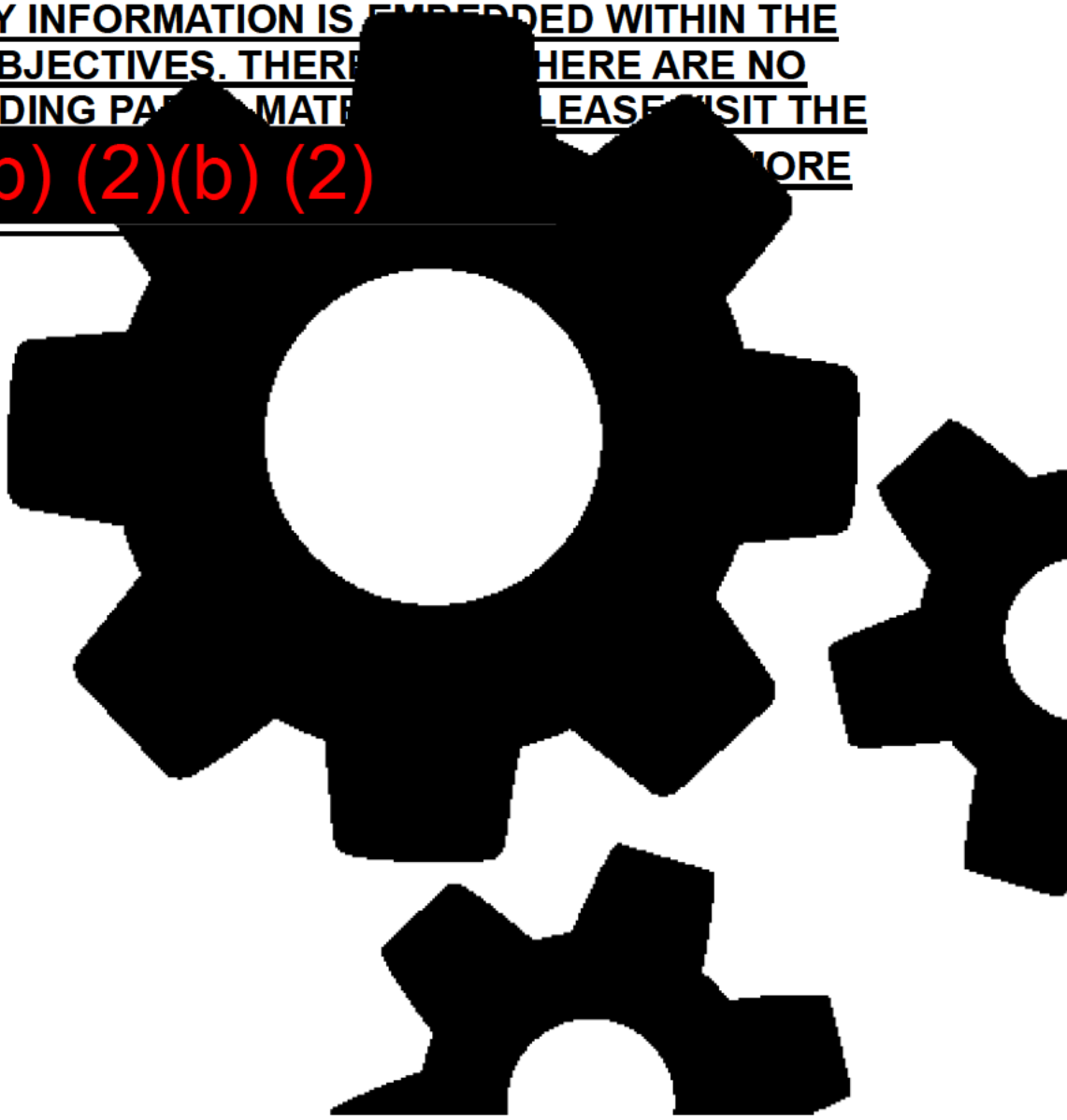

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