SNAP PROGRAM NEGATIVE CASE REVIEW

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ECONOMIC ASSISTANCE-QUALITY ASSURANCE
SFN 293 (7-2024)

Clear Fields

Case Name	Case Number	County Name
Eligibility Worker	Reviewer	Date of Review
Action ☐ Denial ☐ Closure ☐ Withdrawn		Date Action Taken
Effective Date of Action		

REASON FOR DENIAL/TERMINATION/WITHDRAWAL

		CASE IS CORRECT	
PROCEDURE/POLICY	**YES**	**NO**	**NA**
Household composition correct	☐	☐	☐
ABAWD/Work Requirement correct	☐	☐	☐
Residence verified and correct	☐	☐	☐
Income calculations correct and documented	☐	☐	☐
Asset coded and counted correctly	☐	☐	☐
Expenses coded and allowed correctly	☐	☐	☐
Correct notice(s) were sent	☐	☐	☐
Applicant/Authorized Representative Identity Verified	☐	☐	☐
Other policy correctly applied to support action	☐	☐	☐
Timely agency action on reported changes	☐	☐	☐
Documentation/narrative explaining action taken	☐	☐	☐
Adverse action time period met	☐	☐	☐
Notice explains reason for action	☐	☐	☐
Are appropriate documents on file? ☐ Hardcopy ☐ FileNet	☐	☐	☐
Interface tasks processed timely (select only those that apply) ☐ NDNH ☐ PARIS ☐ UIB ☐ IEVS ☐ SDX	☐	☐	☐

DEFICIENCIES NOTED/CORRECTIVE ACTIONS REQUIRED

CORRECTIVE ACTIONS COMPLETED BY ELIGIBILITY WORKER

Reviewer Signature - Approves Corrections Completed	Date