NOTIFICATION OF QUALITY ASSURANCE/QUALITY CONTROL FINDINGS

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
ECONOMIC ASSISTANCE - QA/QC
SFN 502 (11-2016)

Clear Fields

County	Review Number	Case Number	Review Month

Case Name	Review Completion Date
Child/Individual ID (applicable to CCAP and HCC only)	Re-Review Date
Child/Individual Name (applicable to CCAP and HCC only)	Review Findings Notification Date

Reviewer Name

Program	Sample Type

Type of Review

☐ Open ☐ Closed ☐ Denied ☐ Claim ☐ Zero Benefit

Health Care Coverage Type (applicable to HCC only)	Most Recent Action
☐ ACA ☐ Non ACA ☐ Healthy Steps (CHIP)	☐ Application ☐ Review ☐ Reported Change

Review Findings:

☐ Correct Findings ☐ Error Findings

Error Type:

☐ Improper Payment
- ☐ Overpayment - Amount: $
- ☐ Underpayment - Amount: $
- ☐ Due to Insufficient/Missing Documentation

☐ Administrative Error
- ☐ Calculation of Earned Income ☐ Calculation of Unearned Income ☐ Timeliness
- ☐ Allowable Deductions / Expenses ☐ Notice Requirements ☐ Other

☐ Insufficient / Missing Documentation

☐ Eligibility Error
- ☐ Ineligible
- ☐ Overstated Client Share - Amount: $
- ☐ Understated Client Share - Amount: $

☐ Invalid Claim Establishment

☐ Invalid Negative
- ☐ Closing
- ☐ Denial
- ☐ Notice Requirements
- ☐ Timeliness

Response Requirements:

☐ No response required by County Agency.

☐ Pursuant to 448-01-55-10-15, county agency response is required in 20 days.

Date Response Due

Manual Reference(s)

Summary of Review Findings

QA/QC Administrator/Designee Signature	Date
Program Administrator/Director Signature (applicable to Health Care Coverage only)	Date

County Response

☐ Agree ☐ Disagree

If agree, provide details of corrective action.
If disagree, provide details of the case to support the challenge of the QA / QC error, along with manual references to support the decision.

County Representative Signature	Date

QA/QC Response (2nd iteration, if applicable)

☐ Agree with County ☐ Disagree with County

Reasons(s)

Manual Reference(s)

QA/QC Administrator/Designee Signature	Date
Program Administrator/Director Signature (applicable to Health Care Coverage only)	Date

County Response (2nd iteration, if applicable)

☐ Agree ☐ Disagree

If agree, provide details of corrective action.
If disagree, provide details of the case to support the challenge of the QA / QC error, along with manual references to support the decision.

County Representative Signature	Date

QA/QC Response (3rd iteration, if applicable)

☐ Agree with County ☐ Disagree with County

Reasons(s)

Manual Reference(s)

QA/QC Administrator/Designee Signature	Date
Program Administrator/Director Signature (applicable to Health Care Coverage only)	Date

County Response (3rd iteration, if applicable)

☐ Agree ☐ Disagree

If agree, provide details of corrective action.
If disagree, provide details of the case to support the challenge of the QA / QC error, along with manual references to support the decision.

County Representative Signature	Date