1st Level Review _____
2nd Level Review _____

Georgia Department of Human Resources
ABD Medicaid Supervisory Review

County _____

Worker's Name _____ CL #_____ Month(s) Under Review _____

Case Name _____ AU Number(s) _____

COA(s) _____ Type of Action _____ Date of Action _____

Other Programs Related Case Number(s) _____

Review Element	N/A	C	I	Comments
A. Case Record				
1. Organizational format				
2. Application/Review source				
B. NARR				
1. Reason for action taken				
2. HIPAA				
3. Prior Months				
4. Validity of QIT				
5. Documentation Standards				
C. ADDR				
D. AREP				
E. STAT				
1. CMD/Correct COA				
2. Reason for closure/denial				
3. Finl Resp				
4. Documentation Standards				
F. DEM1				
1. DOB/Age				
2. SSI Status				
3. Documentation Standards				
G. DEM2				
1. TPL (including trusts)				
2. Disability				
3. Citizenship/Alienage				
4. Documentation Standards				
H. ALAS				
1. EMA				
2. Documentation Standards				
I. INST				
1. LOC/LOS				
2. PL/CS Deductions				
3. Payment and Slot Dates				
4. PL Inc Amt				
5. KB Cost Effectiveness				
6. Documentation Standards				
J. RES1				
1. Burial Funds/Contracts				
2. Life Insurance				
3. Financial Accounts/Liquid Assets				
4. Documentation Standards				
K. RES2				
1. Real Estate Property/Homeplace				
2. Other Assets				
3. Documentation Standards				
L. RES3				
1. Other Assets				
2. Documentation Standards				
M. TRAN				
1. Transfer of Assets/Penalty				
2. Documentation Standards				

Review Element	N/A	C	I	Comments
N. ERN1/ERN2				
1. Earned Income				
2. Documentation Standards				
O. DEAL				
1. Deemed/Allocated Income				
2. Documentation Standards				
P. UINC				
1. Application for Other Benefits				
2. Unearned Income				
3. Deductions				
4. Documentation Standards				
Q. PLAW				
1. Correct Info for Public Law COA				
2. Documentation Standards				
R. ISM1				
1. Documentation Standards				
S. MISC				
1. OSOP Delay Reason				
2. QMB Override				
3. Documentation Standards				
T. MAFI				
1. PL/CS Correct				
2. Eligibility Budget Correct				
3. Review Period				
U. SDME/SPAU				
1. Correct Amounts				
2. Correct Bills				
3. FDL Correct				
4. BAD Correct				
V. Notice Requirements				

ACCURACY REVIEW FINDINGS

Total C _____	_____ Ineligible AU/Ineligible Member	Benefit Error:
Total I _____	_____ Invalid Denial/Termination	_____ PL/CS
Total N/A _____	_____ Invalid Approval for Month(s): _____	_____ AMN SD/FDL/BAD
Total All __79__	_____ Incorrect Class of Assistance (COA) _____	

 # Correct Elements (C) Divided by Total # Elements Addressed (C + I) = _____ % Accuracy Rate

Medicaid Goal Accuracy Rate = _____%

Action to be taken: _____

_____

_____ Date Due: _____

_____ _____

Supervisor Signature Date

_____ _____

Caseworker Signature Date