IBM Cúram Social Program Management
8.0.2

*Cúram Integrated Case Management
Guide*

IBM

Note

Before using this information and the product it supports, read the information in "Notices" on page 45

Contents

Tables

Chapter 1. Cúram Integrated Case Management

A business overview of Cúram Integrated Case Management and where it fits into the Needs to Delivery approach. The needs to delivery process consists of meeting needs through the delivery of programs in the form of benefits and through service deliveries and referrals.

Cúram Integrated Case Management works along with the IBM Cúram Outcome Management application module by providing a holistic approach to assessing the needs of families and meeting these needs through delivery of programs and services and through outcome management.

Cúram Integrated Case Management focuses on identifying needs and delivering programs and services to meet these needs. Outcome Management assesses needs and designs plans to achieve sustainable outcomes.

Although Outcome Management is referenced, the focus is primarily on the needs to delivery process.

Needs to Delivery - Integrated Case Management

Cúram Integrated Case Management includes a set of business processes to assess client needs and deliver programs in the form of benefits and services.

These processes follow a logical progression from assessing client needs through to delivering programs and services. The initial contact between clients and agencies can happen in many ways, including triage, screening, and intake. Working with the client, the agency assesses the client's complex needs and matches those needs to a range of potential programs and services. Information is captured about the clients and is used to determine their eligibility and entitlement for benefits, which are then delivered to the client. In addition to benefits, services can be recommended to meet the needs of clients.

The Cúram Integrated Case model moves away from the traditional approach that determines whether clients are eligible for single benefits within set timeframes. The model moves toward determining eligibility and entitlement across a range of benefits and services and over extended periods of time, even over the client's lifetime.

It also aims to measure the effectiveness of the delivered programs and services over time. By expanding the determination period for programs and services, agencies can measure the ultimate success of these programs and services in improving the lives of its clients.

Care and protection are provided to clients by the delivery of benefit-based programs through product delivery cases and the delivery of services through service deliveries and referrals.

Delivering benefits through product deliveries

The product delivery case determines eligibility for the benefits that best meet the needs of families and delivers those benefits.

The creation of a product delivery case follows on from a client's initial contact with the agency during which time the client's needs are screened. Based on screening results, the client is found potentially eligible for a range of benefits and one or more product delivery cases are created to determine real eligibility for these benefits.

Eligibility and entitlement processing results in a determination that spans the lifetime of a case, which can span the lifetime of a client. The determination contains one or more decisions, each decision defines the client's eligibility and entitlement for one or more components of a benefit. Financial schedules are created from any decisions that indicate eligibility and entitlement for benefits. These financial schedules are used to generate financial instruction line items, which in turn are processed into financial instruments.

For example, a client who has recently become unemployed contacts the agency. This contact leads to a screening, which shows that the client is potentially eligible for unemployment benefits for a number of weeks since they became unemployed. An unemployment product delivery case is created to capture

more data about the client. This case starts a chain of events that includes gathering evidence about the person's job loss, determining whether the person is eligible for unemployment benefits, and delivering those benefits.

Data capture continues over the lifetime of a product delivery case and can result in new determinations that reflect the client's current eligibility and entitlement. For more information about the product delivery lifecycle, see "Delivering benefits to clients through product delivery cases" on page 6.

Meeting needs through service deliveries

Services can be provided directly to a client by the agency or provided by a third-party provider but paid for and tracked by the agency. Additionally, client eligibility might need to be determined for some services and some services can have their own payment determination process.

To accommodate the different types of services, agencies can deliver services to clients by using product delivery processing, IBM Cúram Provider Management (CPM) processing, or a combination of both. An example of a service that might be delivered by product delivery is a Mileage Reimbursement service that reimburses a client's mileage expenses. This type of service is provided by the agency and can be used to provide payments to a client or another participant. The agency can use product delivery processing to check client eligibility based on client data and issue payments to the client or another participant in respect of the service.

If a service is provided by a third-party provider, the agency can use service delivery processing, which uses CPM financial processing to pay the provider. This type of service can be used when eligibility does not need to be determined for the service. For example, a service delivery can be used to meet a one-off need of Home Help. The agency can record details of the third-party provider who provides the Home Help service, deliver the service to the client, and pay the provider in respect of the service.

If eligibility needs to be determined for a service that is provided by a third-party provider, agencies can use some or all aspects of product delivery processing along with CPM service delivery processing. For example, if payments for a Physiotherapy service are based on a custom rate that can change over time or change based on circumstances, the agency can use all aspects of product delivery processing. The agency can record details of the third-party provider, use product delivery processing to check client eligibility, determine the amount to pay based on the custom rate, and issue payments to the provider for the service.

Alternatively, agencies might want to use only the eligibility determination aspect of product delivery processing and use CPM to pay the provider. An example of a service that can be delivered in this way is a Counseling service that is paid based on a flat rate contract. Agencies can use product delivery processing to determine eligibility and CPM financial processing to pay the provider.

The process of delivering services to clients is described in detail in "Creating services for clients" on page 17.

Service delivery processing works along with the IBM Cúram Provider Management application module. The services are registered as part of CPM so this module must be installed for caseworkers to deliver referrals to clients.

Related concepts
Provider Management Overview

Meeting needs through referrals

You can use referrals to services to refer clients to third-party service providers who might have no formal contract or relationship with the agency but who might be better able to meet the client's needs. After referral, unless follow-up is needed, the agency usually has no further contact with the client.

For more information about the process of delivering referrals to clients, see "Referring clients to service providers" on page 18.

Referral processing works along with the IBM Cúram Provider Management application module. The referral services are registered as part of CPM so this module must be installed for caseworkers to deliver referrals to clients.

Assessing needs - from initial contact to integrated case creation

An overview of the process of initial contact between a client and the agency, the assessment of a client's needs by using triage, screening and intake, and the creation of an integrated case to manage programs and services that meet client needs.

To streamline the process of getting clients the care they need, a range of triage, screening, and intake processes are available. These processes can determine the potential needs of a client on initial contact with the agency. Triage, screening, and intake typically happen before an integrated case is created for clients and their families. Each integrated case allows everything that is identified as meeting the needs of a family and all of the efforts to address these needs to be managed from one place. Typically, each integrated case is used to manage the actual determination and delivery of identified services and programs.

Supporting the triage, screening, and intake processes

Tools that are designed to support the agency's triage, screening, and intake processes are provided. These tools can help to establish a person's needs on initial contact with the agency, and to determine potential eligibility and actual eligibility for needs-based programs or services.

The tools allow clients to communicate with the agency through different channels and allow the agency to manage the following tasks:

Triage
A person is asked a short set of questions to quickly identify services, screenings, and products that might meet their needs.

Eligibility Screening
Individuals are screened to determine their potential eligibility for specific programs offered by the agency. If eligible, these programs are typically delivered to the individual in the form of benefits.

Program Intake Processes
A person might be eligible for needs-based or protection-based programs that were identified as a result of screening or independent of the screening process.

Life Event Management
Life event management allows the agency to manage the reporting of a person's change of circumstances, such as the birth of a child, marriage, or a change of address or employment.

The following components include tools and features that help clients and agencies with intake:

- Cúram Common Intake provides a set of features that an agency can tailor to meet the requirements of its internal intake processes, see the ../CommonIntake/ctr_CommonIntakeBusinessGuide.dita.
- IBM Citizen Engagement is a citizen-focused module that allows clients to interact with the agency online by using a web self-service application, see IBM Cúram Universal Access.

Triaging clients for programs and services

Triage is used to quickly identify and recommend services, government programs, and screenings that might meet a person's needs. The aim of triage is to quickly recommend potential courses of action for a person who contacts the agency for help.

Typically triage is performed for people with no prior interaction with the agency and who do not know what help might be available to them. For example, a person might have an emergency need for food for their family and might not know about benefits that are available to meet this need.

During the triage process, the person is asked a short set of basic questions about the following core needs, food, shelter, health, financial, education, and safety. Based on the person's answers to these questions, the system recommends services and programs that might address those needs. The person can be referred to various service providers identified by the system, continue to screen for potential eligibility for recommended programs, or apply for programs directly.

Screening clients for programs

Screening is used to establish a person's potential eligibility for particular programs. For example, a person might be potentially eligible for Food Assistance benefits based on their answers to the screening questions.

The difference between triage and screening is that triage directs a person to screen for programs, and screening determines a person's potential eligibility for one or more programs. Examples of screenings include Cash Assistance and Food Assistance. A person might choose to be screened for eligibility after they complete the agency's triage process or might choose to screen independently of triage.

During the screening process, a person is asked more complex questions about their life and their answers are recorded and stored on the system. For example, personal details such as the person's name, date of birth, address, living arrangements, and family relationships are recorded. The answers are used to establish if the person is potentially eligible for benefit-based programs and if they were already registered on the system as a client of the agency. Family relationships that are recorded are also automatically stored on the system.

Depending on the type of screening, answers to more complex questions can also be recorded. For example, some questions might relate to the client's resources, income, or household circumstances. When all of the screening questions are answered and the screening is completed, the system determines the programs for which the person is potentially eligible by running screening rules against the answers.

Based on the screening results, the client can submit an application for the programs identified. Alternatively clients can apply for programs independent of the screening process.

Program intake processes

In general, clients might be eligible for needs-based or protection-based programs. Examples of needs-based programs include Cash Assistance and Unemployment Benefits. An example of a protection-based program is Child Welfare. The intake processes that are used by agencies can differ greatly depending on whether the intake is needs-based or protection-based.

For needs-based programs, a client usually needs to complete an application form, and the agency determines eligibility for programs based on the information that is provided. A person can apply for benefits by using a number of methods:

- Submitting an online application to the agency.
- Calling the agency by telephone.
- Calling to the agency in person.

During the application process, the person provides the agency with detailed information, such as personal details, income, expenses, employment, or education. This information is recorded as evidence on the client's case by the agency when the case is created and is used by the system to assess a client's need for services. A needs-based program intake is provided as part of Cúram Common Intake, see the Cúram Common Intake Guide.

For protection-based programs, such as Child Welfare, intake can include the capture, through a number of channels, of a reported incident of suspected child abuse or general concerns about a family situation. All relevant information, such as allegations, are captured so that the claims can be investigated by the agency. A protection-based program intake is provided as part of IBM Cúram Child Welfare, see Cúram Child Services Business Guide.

Creating an integrated case

If an agency has a defined intake process, an integrated case can be created for clients automatically on application. Alternatively, if no intake process is defined by the agency, a stand-alone integrated case can be created.

Each integrated case is initially created for a person or prospect person and their household to manage the delivery of benefits, services, and activities that are identified to meet their needs. After an integrated case is created, a product delivery case is created to deliver benefits to clients. If an agency has a defined

intake process, the product delivery case is created automatically when a benefit is authorized on the application. For more information about the process for delivering benefits to clients through product delivery cases, see "Delivering benefits to clients through product delivery cases" on page 6.

Service deliveries and referrals to services can also be added to an integrated case to deliver services to clients. For more information about the process, see "Delivering services to clients through service delivery and referrals" on page 16.

An integrated case is created for a person or a prospect person who is already registered on the system or the user has the option of registering the individual as a person or prospect person when they create the case. If the agency uses intake processing, the individual is registered as part of the intake process. For more information about person and prospect registration, see the Cúram Participant Guide. During manual creation of an integrated case, the integrated case type is selected.

An integrated case has three steps in its lifecycle, case creation, case closure, and case reopen. When an integrated case is created or reopened, its status is set to open.

An integrated case can be closed when all the associated benefits and services end. If the clients on the integrated case reapply for benefits or services later, the integrated case can be reopened to resume the delivery of benefits and services without the need to create a new integrated case. Alternatively, organizations might choose to leave integrated cases open regardless of the status of the associated benefits or services.

Assigning initial case ownership

Cases are created and managed by users with case owner and case supervisor user privileges.

The case owner is responsible for a case. Typically, the case owner maintains case information, gathers case information, checks eligibility, and submits the case for approval. The case supervisor verifies the data that is entered by the user and approves the case for activation.

The application provides a sample case ownership strategy that can be overridden by agencies if needed. The sample case ownership strategy determines the initial case owner based on whether the case is an integrated case or a product delivery case. When an integrated case is created, the case ownership strategy automatically sets the initial case owner to be the administrator of the primary client. When a product delivery case is created, the system automatically sets the owner of the related integrated case to be the initial owner of the product delivery case. When an integrated case is reopened, the case ownership strategy sets the reopened case owner to be the administrator of the primary client.

The agency's own case ownership strategy can be configured depending on its requirements. For example, an agency might want to direct Food Assistance cases to one set of users and Medical Assistance cases to another set of users. For more information about configuring case ownership, see Configuring a case ownership strategy.

The case owner can also be manually set to be any user or organization group such as an organization unit, position, or work queue. If the case owner is set to an organization unit, work queue or position, any users who are members of the organization group can progress work on the case. For more information, see "Changing the case owner and case supervisor" on page 31.

Integrated case information

After an integrated case is created, different levels of information are automatically stored as part of the integrated case, integrated case information, case participant information, and information specific to the type of case or service in the integrated case. Information for each of these levels can be accessed and maintained from the integrated case.

Certain information, such as notes, can be maintained for integrated cases, product delivery cases, and services. These categories of information do not affect case eligibility. Other categories of information are only maintained for specific cases. For example, client translation requirements are only maintained for the integrated cases and product deliveries. An overview of key information about entitlements from cases within the integrated case is available, see "The case overview" on page 29, but it is off by default.

Information that is specific to product deliveries and service deliveries is kept separate from the integrated case information. For example, communications for a product delivery case only display on that case's list of communications. However, evidence for product delivery cases can be maintained at the integrated case level if shared across multiple product deliveries within the integrated case.

Delivering benefits to clients through product delivery cases

An overview of the business processes that allow the agency to deliver benefits to clients. The processes include creating a product delivery case, capturing information about the client, client eligibility and entitlement determination, and the delivery of the benefit to the client in the form of monetary payments. The product delivery case is used to deliver care and protection to clients in the form of benefits.

Creating a product delivery case

Product delivery cases are created within the integrated case so that integrated case functions can be used for that product delivery. For example, evidence can be captured at the integrated case level and shared between product deliveries for the same person or for persons within the same family.

During product delivery case creation, the user selects a case member from the integrated case and the benefit for which they are applying. The selected case member becomes the primary client of the product delivery case and is known as the primary client. The primary client is the participant on the case who is deemed to be the main person for whom eligibility is determined.

For example, John Smith is applying for an unemployment benefit because he lost his job. John's application and integrated case includes his partner and three children. While John's partner and three children are part of the application group, John is the primary applicant as it is his circumstances that determine overall eligibility for the benefit. While the evidence of John's partner and three children also determine his entitlement, John is still the primary applicant on which eligibility is based.

The primary client role on the product delivery case cannot be changed after it is set. If a new primary client for the same benefit is needed, a new product delivery case must be created and a different case member of the integrated case selected as the new primary client. The primary client is also assigned as the default nominee on the product delivery case, that is, the recipient that is nominated to receive the actual benefit payments.

Note: By default, the system automatically sets the first person that is added to the product delivery case as the primary client.

To help users while creating the product delivery case, they can see a list of any other existing integrated cases and product delivery cases on which the individual is a primary client. The product delivery case details are then specified. Case details include the date that is received by the agency and the expected outcome of the case, for example, financial support.

Users also specify how payments in respect of the case are to be issued to the nominee. This information includes the case delivery pattern. The case delivery pattern is the default payment method and frequency by which financials are issued to a nominee, for example, weekly by check in advance on a Monday. If the primary client has a preferred payment method, for example, check or cash, the preferred payment method is displayed when creating the product delivery case to indicate to the user the most appropriate delivery pattern to select.

The product delivery case is created when the user records all the needed information. When a product delivery case is created, its status is open. Information is then captured in the form of evidence to determine the client's eligibility and entitlement.

Capturing information about a client

Information that affects the primary client's claim for benefits is captured as case evidence. For example, to qualify for benefits, clients might need to provide evidence about their income. The type of evidence that is captured can come from different sources.

For example, a client might provide a birth certificate to verify the date of birth, a university can provide a letter that confirms a person's full-time student status, or a doctor might certify a person's disability.

Users can maintain evidence with the evidence workspace. The evidence workspace includes views that allow users to capture, manage, and maintain evidence records.

The evidence dashboard provides caseworkers with an entry point to preconfigured evidence types that can be captured.

Active and in edit evidence listings are provided. Separate lists are provided for evidence verifications, issues, and for incoming evidence. Incoming evidence that is shared from other cases is only available if the IBM Cúram Evidence Broker is installed. For more information, see Sharing evidence by using the evidence broker.

For more information about the evidence views and on managing case evidence, see Evidence.

Identifying concerns with evidence that affects eligibility

Outstanding information or concerns with evidence might affect a client's eligibility for benefits. For example, client can be determined ineligible because mandatory information is missing from an application or a doctor's verification of illness outstanding.

Separate lists of issues with evidence and verifications (received and outstanding) are also provided to help users to identify concerns with evidence so that they can be resolved.

The verifications list is available only if IBM Cúram Verification Engine is installed. For more information, see the Verification guide.

Cúram Advisor

Cúram Advisor is a tool that provides context-sensitive tips such as reminders for users. Concerns with evidence such as issues that affect eligibility can also be detected by the Advisor.

The Advisor is configured with rules and text that is used to detect and highlight issues with evidence. It automatically analyzes information that is recorded or known for a registered client and alerts the user to issues with the information that might need attention. For example, if an application is submitted by a client with missing mandatory information, the Advisor displays the issues with the mandatory information. Users can then address the issues.

For more information, see Configuring Advisor.

Checking eligibility for active and in-edit evidence

Evidence is captured at the integrated case level for open product delivery cases before they can be approved for payment. Typically, the user who is the case owner captures evidence and checks eligibility before they submit the case for approval. A user can capture evidence from the evidence dashboard or the active and in-edit evidence listings.

Each evidence record is assigned an in-edit, active, or canceled status. In-edit evidence can be modified without affecting eligibility and entitlement. When changes are applied to in-edit evidence, the evidence becomes active. Active evidence is used in determining eligibility and entitlement. Therefore, the most important status for benefit eligibility determination is active as payments are only issued on active evidence records.

A user can choose to check eligibility for active evidence only. Eligibility can be checked on active evidence only if the case owner does not want to take in-edit evidence into account.

Otherwise, the system checks eligibility on both active and in-edit evidence. Checking eligibility with in-edit evidence shows how the client's eligibility would be affected if the in-edit evidence was activated.

The check eligibility process uses the evidence to create decisions about the client's eligibility and entitlement over the lifetime of the case. The eligibility and entitlement rules are applied to the client's information to create these decisions. These decisions define whether the client is eligible. If eligible, these decisions define the amount and frequency, for example, the client is eligible for $100 each week. For more information about decisions, see "Reading decisions, eligibility, entitlement, and explanation" on page 9.

Approving payments and activating a case

Before a case is activated for payment, the case details and case decisions that are generated during the check eligibility process are typically validated to ensure that they are correct before benefit payments are issued on the case. After the case approval process is complete, the case is activated and payments are issued to the nominee on the case.

Approval checks allow agencies to define the percentage of cases submitted that automatically require approval by a supervisor.

Submitting a case for approval

This stage has two parts, submitting the case for approval and approving or rejecting the case. A case is submitted for approval when the user who is working on the case is satisfied that all case details are entered correctly and the case is ready to progress to the payment or case activation stage. Eligibility is determined when a case is submitted for approval to provide a snapshot of the client's eligibility then. Cases that are submitted for approval have a status of 'submitted'.

Approving or rejecting a case

Typically, case supervisors check and verify details that are entered by the user. By approving the case, the case supervisor indicates that they are satisfied that the case details are correct and that the case is ready to be activated. If the user has approval permissions as part of their security profile, or if the case supervisor submits the case, the case is automatically approved. Approved cases have a status of 'approved'.

After a case is approved, it is ready for the next stage in the lifecycle, case activation. If the case is rejected, the reason why the case was rejected is entered and the user who submitted the case for approval is notified of the case rejection. If rejected, the case status returns to 'open' and the case must be resubmitted to progress through the lifecycle.

Activating a case

Cases that are approved can be activated by using batch processing or manually by a caseworker.

The Determine Product Delivery Eligibility batch process activates product delivery cases when the system is offline, such as after office hours, so that it does not interfere with normal business. For more information about batch processes, see Configuring batch processes.

This batch process determines eligibility for all product delivery cases with an approved status, and activates any eligible cases. If the organization configures the application to automatically close cases that are ineligible, ineligible cases are closed. Otherwise, the cases are activated with an ineligible decision and any further updates to evidence can result in reassessment and a potentially eligible decision. An agency can configure the system to automatically close ineligible cases with an application property in the administration application. For more information about this property, see Configuring case suspension and case closure.

Alternatively, a single product delivery case can be activated manually by a caseworker. When the product delivery case is activated, eligibility is determined and the case is activated for payment provided it is eligible. If ineligible, and the system is configured to close all ineligible cases, the product delivery case is closed. Otherwise, the product delivery case is activated with an ineligible decision and remains open. Manual activation supports front office payments. For example, to provide emergency assistance to persons in need. When a product delivery case is 'active', benefits for that case can be delivered.

If a case is accidentally activated, it can be suspended and then unsuspended to change its status back to open, and prevents the issue of payments. Payments are issued again only after the case is approved and activated.

If a user attempts to activate a case while a reassessment is already in progress for that case, the user is prevented from doing so until the in-progress reassessment completes. The user is not blocked indefinitely from activating the case. This lockout time is configurable with the

`curam.case.reassessment.aggregation.wait.period` application property. After the lockout time elapses, the user can activate the case even if another reassessment is in progress.

Applying rules to information to make decisions

Agencies use rules to apply legislation to a client's real life circumstances to make decisions about the client's eligibility and entitlement for care and protection programs. Typically a person must satisfy rules to qualify for benefits. For example, to be eligible for income support, a person's income must fall beneath an income threshold. Rules also can be used to make connections between different pieces of information, for example, to determine the members of a household based on a common address.

Information is captured for clients as case evidence to determine their eligibility and entitlement. For example, when a person's income amount is recorded and eligibility is checked, a pre-defined eligibility and entitlement rule set that defines the income threshold amount that must be satisfied is applied to the income amount recorded. Based on these results and the results of other rules that govern income support eligibility, the system determines the person's eligibility and calculates their entitlement.

When eligibility is checked, a determination is created that contains a set of decisions that are created over the lifetime of the case. Each decision includes an effective period, eligibility result, and an entitlement amount and frequency (if eligible).

In addition to eligibility and entitlement results, the application allows agencies to provide decision details that explain decision results. Any changes to the information referenced by the eligibility and entitlement rules automatically result in rerunning the rules against the new information. This rerun can result in a new set of eligibility and entitlement decisions and decision details over the lifetime of the case. For more information about decisions and decision details, see "Reading decisions, eligibility, entitlement, and explanation" on page 9.

Reading decisions, eligibility, entitlement, and explanation

When a case is approved, activated, reassessed, and eligibility is checked, eligibility decisions are generated based by applying pre-defined rules to a client's information. Each decision that is generated indicates whether a person is eligible or ineligible and displays the person's benefit entitlement over a period. Each benefit entitlement consists of the financial and non-financial results that are generated when eligibility is checked.

For more information about checking eligibility, see "Checking eligibility for active and in-edit evidence" on page 7.

A number of decision views help users to understand the eligibility results. Each view gives a user a different level of information that describes how eligibility and entitlement decisions were reached.

Decision views provide clarity on why a person is or is not entitled to benefits and shows users how the system arrived at that eligibility result. For example, clients might be deemed ineligible for benefits because of an incorrect date format on their benefit application. Decision views provide a level of clarity to the process of eligibility and entitlement determination. Providing users with visibility on why the person is or is not entitled reduces the likelihood of benefit fraud. This visibility also allows users to give clients a clear picture of their eligibility and entitlement results thus enabling users to do their jobs more effectively.

Each decision includes the client's total entitlement amount. The agency can configure the frequency to display for the entitlement amount. For example, the agency might want to display entitlement amounts in a weekly format of $70 per week instead of a daily format of $10 per day. The frequency at which the entitlement amount is displayed is defined when a product is configured during administration.

More views are provided to allow users to understand the decisions made over the lifetime of the case.

The decision details view of an individual decision provides an explanation of how the decision was reached. The information that is displayed to the user can be grouped into categories and the information can be displayed on a number of different tabs. For example, a Household Information tab might display detailed information on the composition of the household and a Medical Expense tab detailed information

on the family's medical expenses. The agency can configure the categories of information and the order that the decision information on each tab is displayed as part of the application administration.

Agencies must develop the rules for determining eligibility and entitlement, displaying decisions, and displaying explanations. For more information, see Defining rules and configuring rule sets.

Note: The key decision factors feature is deprecated. This feature displayed the key decision factors that were involved in determining eligibility, such as a change to total household income. Changes to information can result in a new set of key decision factors. For more information, see Deprecated features.

A graphical view includes key decision factors that influenced eligibility decisions. Key decision factors help users to understand how a client's information impacts their eligibility and entitlement by providing an understandable explanation of the determination results. For example, if a client who is receiving single mother benefits reports a significant life event such as a marriage, that client may no longer be eligible to receive single mother benefits. The following are examples of key decision factors, Susan Smith got married, or Susan Smith turned 19. This information allows the agency to determine what a rule means and provide an explanation of the rule that the user and client can both understand.

Viewing decisions over the lifetime of a case

When eligibility decisions are created at various points in the lifecycle of a case, a determination is created that groups these decisions together, allowing a user to clearly see what decisions are associated with a particular determination of client eligibility. Different views are provided to allow users to view determinations and decisions over the lifetime of a case.

Current determination and determination history views
The current determination view displays the list of decisions for the most recent determination on the case that results from initial case assessment or case reassessment on an active case.

For example, the determination that was created during activation of the case or upon subsequent reassessment of the client's eligibility due to a change in circumstance. The date and time on which reassessment last completed and the date and time when decisions were last updated is displayed. You can see when reassessment last completed, and if reassessment didn't result in a new determination and decisions. For example, new asset evidence that does not result in a change to the client's eligibility or entitlement, or to the decision details that are displayed.

Informational messages are also displayed to provide further details about the status of reassessment within a case. These messages indicate when reassessment is in progress, when changes that will result in reassessment were made but are pending, and when reassessment is deferred to batch processing due to an unanticipated error with online reassessment processing. This information helps the caseworker distinguish between delays because of assessments in progress or because of an error in the reassessment process.

Agencies can configure whether the informational messages are displayed by enabling or disabling the messages in application administration. For more information, see Working with configurable validations, and Case-level reassessment.

Within the determination, the decisions are listed over the lifetime of the case. Each decision includes the coverage period for which the decision is effective, the eligibility decision, for instance, eligible or not eligible, and the entitlement amount. The entitlement amount is the amount that the client is expected to be paid for the period in which the decision is effective. The format of the entitlement amount is configured during administration.

The determination history view lists all of the determinations on an active case that resulted from initial case assessment or case reassessment. The current determination includes the date and time the determination was made, the reason the client's eligibility was determined, and the name of the user who made the determination. The previous determinations in the history are superseded by the current determination. A determination can be superseded as a result of case reassessment.

For example, clients who were previously ineligible for income support benefits can be found to be eligible due to the loss of their jobs and the recording of new evidence that places their current incomes

under the income threshold. On reassessment, new eligibility determinations that contain the eligibility decisions are displayed for the current date. This determination supersedes the previous determination. From both the current determination and determination history view, the user can view a summary of the decision details for each decision in the determination.

Graphical and list determination view

The graphical view of a determination allows users to clearly see the connection between the eligibility result and the information that influences it. This level of visibility highlights the information that affects eligibility and entitlement and plots it across a timeline that spans the lifetime of the case.

Note: The key decision factors feature is deprecated. For more information, see Deprecated features.

For example, if the system determines that a person is ineligible because their income was $300 at the case start date, and their income drops under the required threshold to $200 a week, the system can determine the person to be eligible, and a key decision factor is displayed on the date of the change in income, along with a new decision for the change in eligibility that explains that the person is now eligible because their income information changed.

Allowing the agency to see how updated information affects the person's eligibility result empowers users to explain to clients how their circumstances have affected their claims. For example, a client seeming to meet all eligibility requirements for a care and protection program, but who forgot to prove their citizenship, might contact the agency to find out about their eligibility status. By displaying citizenship verification status as a key decision factor, the user can quickly observe the reason for the client's ineligibility status and communicate this to the client.

The graphical view can also be displayed in a flat list view, which shows all decisions in chronological order.

Decision details view

The decision details view displays detailed information about an individual decision within a determination and is accessed by selecting an individual decision from the list of decisions of a determination. This view consists of multiple tabs that display information to assist the user in understanding the client's eligibility.

For example, a person might be eligible for a medical expense allowance. The total amount of entitlement and the household members that are included in eligibility determination might be displayed on a Summary tab. A Medical Expense tab might display detailed information on the family's medical expenses that were factored into determining the medical allowance. The decision details view can also be used to display information on why a person was found ineligible.

You can create a decision details view. Decision details rules are used to determine what information is displayed in this view and are configured during administration. For more information about decision details rules, see Assigning rules to products. Display categories and decision details rules, which include a display order that the system automatically uses to determine the order in which the tabs display, can be associated with a product.

Comparing decisions

Decision comparison allows users to compare a decision within a determination to a previous decision within the determination. Decision comparison provides the ability for a user to easily understand changes in client eligibility and entitlement. For example, a user might want to use the decision comparison to better understand if income was a primary factor in the change to a client's eligibility.

Users can also use decision comparison to understand why an over or under payment was generated by the system. The decision comparison view allows the user to see the previous and current values of key information that is used in determining why the client's eligibility changed. For example, a change in the client's net income might cause a client to become ineligible for benefits.

Agencies must develop the decision details rules to use for displaying decision comparison information. For more information, see Defining rules and configuring rule sets.

Scheduling payments and bills - the Financial Scheduler

This overview describes the financial processing that occurs when a product delivery case is activated. Payments and bills are automatically scheduled when a product delivery case is determined eligible and activated. Payments and bills are scheduled, processed, and issued to the primary client or to a case participant that the primary client nominated as a recipient for a case component.

For more information about financial processing, see the Cúram Financials guide.

Case nominees and case components

A case nominee is a case participant who receives payments or bills. A case nominee is assigned to each case component. Case components for product delivery cases are the types of entitlement, typically financial types of entitlement, that are available with a benefit.

For example, an income assistance and medical assistance component might represent the types of financial entitlement available within an employment benefit case. The income assistance component has a weekly rate of $70. If the product delivery case is found eligible for this case component, the component is delivered to the client who was nominated to receive this case component. In this example, the nominee receives a payment of $70 a week.

A case might have more than one associated case component. A nominee can be assigned to one or more of these components. Multiple case components can have multiple case nominees. A component assignment history is maintained for each case component to track the nominees that are assigned to a component over time.

The default case nominee for all case components is the primary client. A case participant other than the primary client can be nominated to receive benefits for a case component. For example, a person's employer can be nominated to receive a person's benefits.

Alternatively, a case participant can be specified as the default nominee. This specification automatically assigns all case components to the case participant and eliminates the need to assign each component separately. Each time a case component is assigned to a nominee, a delivery pattern from the list of nominee's delivery patterns and a component assignment date must be entered.

Scheduling payments and bills

Financial components are used to schedule payments and bills. These financial components define the amount, delivery method, frequency, and period for which a payment or bill is issued to a nominee. Each financial component is used to deliver eligible case components to case nominees. When a product delivery case is activated, these financial components are created.

Financial components are delivered to nominees according to the nominee's delivery pattern. Delivery patterns are used to create financial schedules for each case component delivered. The delivery pattern includes the method and frequency for the benefit to be delivered to a nominee. For example, a nominee's delivery pattern might indicate that all benefits are to be delivered to the nominee by check at the start of every month.

For example, a nominee receives an income assistance case component with a weekly rate of $70. According to the nominee's delivery pattern, the nominee receives payments by check at the start of every month. Based on this delivery pattern and the case component, a financial component is created for the income assistance case component. This financial component is issued by check to the nominee at the start of every month in the amount of $280, at a rate of $70 per week for the month.

Delivery pattern information is set up for each case nominee. A new delivery pattern can be specified for a nominee as part of nominee component assignment or the default delivery pattern that is specified for the case is used. Changing delivery patterns for a nominee enables agencies to pay different case components to the same person at varying frequencies. Alternatively, a user can create a new nominee and assign one or more case components to the nominee or set a nominee to be the default nominee on the case to change the component assignment to suit the client's needs. A nominee can also have multiple active delivery patterns for the same period.

Depending on how the product delivery case is configured at administration, each financial component might potentially pay indefinitely until circumstances change on the case, or the expected end date is explicitly set on the case. If the decision on an open ended case is eligible, an open ended financial component is automatically created. Financial components that are set up to pay indefinitely on a case are called open-ended financial components. This open-ended approach is reflected in the decisions on the case and potentially on the resulting financial components. For more information about configuring a case to be open ended, see Configuring eligibility determination and decisions.

Payment and billing processing

As payment and billing processing occurs, financial components are generated into instruction line items. Instruction line items are created when financial components are processed. Whereas a financial component is a schedule to pay or bill, an instruction line item is an instance of that schedule, that is, a payment or bill.

For example, a financial component indicates that John Smith is to be paid $25 by check on January 1st. On this date, the financial component is processed into a financial instruction line item. Information that is carried over from the financial component includes the nominee, the delivery pattern, the amount, and the period of the payment or bill. Where a financial component is a schedule, an instruction line item is the actualization of that schedule.

Financial instruction line items are rolled up into financial instructions. These financial instructions can be generated into payments or bills for nominees. For example, an instruction line item of $100 a month is created for each month over a three-month period. These instruction line items can be rolled up into one payment instruction for $300. The $300 is then paid into the nominee's bank account.

For more information, see the Cúram Financials guide.

Issuing payments and bills

Payments and bills are issued for product delivery cases automatically during batch processing or manually by a user.

For example, the agency can issue benefit payments automatically when a batch is run at the start of every month.

Users can also manually issue benefit payments on cases that are approved and activated before system batch processing is run. By manually issuing payments, users can issue payments to clients that are paid by methods other than EFT immediately to clients. For example, if a client is eligible from 2 weeks ago, their payment schedule might be set up to be paid weekly by cash in arrears. Typically the payment is generated during the scheduled financial batch run. However, as the customer is due benefit arrears, the user can issue a front office payment immediately instead of making the client wait until the following week for a payment that is needed now.

One-off manual payments can also be issued for benefit products if the system is down and a person is in dire financial need. In this case, the user can issue a check manually to the person without waiting for the scheduled batch job to run. The manual payment can be recorded on the system later.

Setting up case deductions

Case deductions are used to allocate a portion of a benefit toward a liability or a third party. Users can set up case deductions from benefit payments as a means of budgeting or to clear an existing debt.

Three types of deduction are available:

- An applied deduction is an agreed monetary amount that is subtracted from a benefit and applied toward an outstanding liability that is owed by the person. For example, $10 of a person's benefits can be applied toward paying off an overpayment that was issued to the person.
- An unapplied deduction is an agreed amount of money that is deducted from a person's benefit payment and used to make a general refund to the agency. For example, if a one-off emergency payment is issued to a person, the agency can deduct the payment from a future benefit payment that is issued to the person.

- A third-party deduction is an agreed monetary amount that is deducted from a person's benefit and paid to another participant. For example, $15 of a person's monthly benefits can be applied toward paying off a gas bill that is owed to a registered utility.

For more information about case deductions, see the Cúram Deductions overview.

Simulating payments

Payment simulation allows users to preview a payment due for a future date. A user can see all payments and deductions that are due to a participant for a specific date before the payment is issued. A simulation of the payment for that week or for the delivery period of the case is displayed along with nominee details for the cover period.

The reducing balance of the total benefit payment minus any deductions per case component is also displayed. Any tax adjustments that are defined for the product are simulated and applied to the benefit payment before any deductions are processed. The user can also save and store payment simulations. Users can compare the effects of each simulation, along with any tax that was initially deducted from the benefit.

The system automatically stores a list of payment simulations. Users can view a summary of the payment simulations that were saved from this list. A user can view further detail on each simulation and can also permanently remove all existing saved simulations.

Viewing financial transactions

The system automatically maintains a list of all financial transactions on cases. Financial transactions are the payments and bills that are issued for eligible and active product delivery cases. These financials are automatically included on the list of transactions as a result of payment and bill generation.

Transaction details on the list include the amount of the processed transaction, the transaction type, for example payment, the name of the nominee who receives the payment or bill, the method of payment, and payment due date.

Each financial transaction can be expanded to see full payment or billing details that include a full breakdown of the amounts that were issued per eligible case component and any deductions that were applied to those amounts. For example, tax deductions that were applied to payments.

For more information about financial transactions, see the Cúram Financials guide.

Monitoring recent case transactions

The application provides tools that help users to monitor their recent case transactions. Users can use these tools to see how their cases are progressing and identify which cases require further work.

The system automatically maintains separate lists of each user's recently assigned, recently approved, and recently viewed cases. These lists can be used by users to organize and manage their caseload. For example, users can use their recently assigned case list to identify new cases that are included in their caseload and plan their work.

A list of related cases is automatically maintained by the system. Users can also manually record case relationships between cases that are related to one another. Case transaction logs provide users with a quick summary of events that occur throughout the lifecycle of a case. A case status history is automatically maintained for each product delivery case by the system. The case status history provides an overview of the case processing statuses each product delivery case goes though during its lifetime.

Monitoring recently assigned, approved, and viewed cases

The system automatically maintains lists of a user's recently assigned, recently approved, and recently viewed cases. Each list includes both integrated cases and product delivery cases owned by the user.

Case details displayed for each case include the case reference number, the name of the case, and the name of the primary client of the case.

The recently assigned case list displays cases that have been recently assigned to the user. All cases owned by the user or their organization unit, position, or work queue are displayed. An administrator can configure whether cases belonging to a user's organization group are displayed as part of administration. The system displays the following additional details for each recently assigned case: the date and time on which the case was assigned to the user, the name of the previous case owner assigned to the case, and the case status, for example open or approved.

The recently approved case list includes cases recently approved by the user as well as the cases submitted by the user for approval. The name of the user who submitted the approved case is also displayed.

The recently viewed case list allows users to see all cases they have recently viewed. In addition to general case details, the last transaction on the case, the case start date, and case status are also displayed.

Agency administrators can use application properties to set the length of time for cases to be recently assigned, approved, or viewed. For more information about these properties, see Configuring recent case actions.

Viewing related cases

A case relationship is a link between one case and another case. Case relationships are either created manually or automatically during case processing. A relationship can be manually created between two cases for a number of reasons.

For example, if a person is receiving two product deliveries fraudulently, a relationship can be created between the two product delivery cases.

The following case relationships are created automatically during case processing:

Integrated Case to Product Delivery Case
    A case relationship is automatically created between an integrated case and a product delivery case when a product delivery case is created within an integrated case.

Product Delivery Case to Product Delivery Case
    A case relationship is automatically created when an over or underpayment case is created following reassessment. This relationship ensures a historical link between the over or underpayment case and the original product delivery case.

Product Delivery Case to Appeal
    The system creates a case relationship record when an appeal is created to appeal a decision on a product delivery case.

Using the case transaction log

The case transaction log is used to view a summary of processing that occurs within a case. A case transaction log is automatically maintained for every case. The case transaction log is automatically updated whenever the system detects a pre-defined instance of processing for a case. For example, if a communication is sent in relation to a case, the system updates the case transaction log to this effect.

Other examples of transactions that cause the case transaction log to be updated include payment suspensions, case creation, and additions and modifications to evidence recorded on a case. In addition to these transactions, agency administrators can use code tables to select specific case processing functions to display in the case transaction log. For more information about code tables, see Configuring code tables.

The case transaction log displays the case transaction event type, for example Product Delivery Submitted, and a description of the event. Event descriptions provide the user with additional information about the event. The case transaction event log also displays the name of the user who performed the transaction and the transaction time. Additionally users can view the specific details of a transaction and view their own user details.

Viewing the case status history

A case status history is automatically maintained for each product delivery case throughout its lifetime. The case status history provides information on the stages the case passes through during its lifetime. The series of stages the product delivery case passes through is called the case lifecycle.

Each product delivery case within the integrated case has its own lifecycle. The main stages in the product delivery lifecycle are case creation, case approval, case activation, and case closure. Other optional stages in the product delivery case lifecycle include suspending a case and then reactivating the case.

Important information that is displayed for each status change includes the date and time of the status change. Users can use the date and time to determine the exact sequence of case processing if a case passes through multiple statuses on the same date. The case status history also includes the name of the user or system process that caused the status change. Any updates to the case status history are displayed in chronological order, the most recent status change is displayed first.

The following table describes the product delivery statuses in full.

Table 1. Product Delivery Case Type Statuses.

This table describes the statuses a product delivery case can have.

Status	Description
Open	A product delivery case status is open when the case is first created on the system. Certain processes cause a product delivery status to return to open from another status. Unsuspending, reactivating, and rejecting a product delivery case reverts its status to open.
Submitted	A product delivery case status is submitted when it is submitted for approval.
Approved	A product delivery case status is approved when the case is approved by an authorized user, such as a case supervisor.
Active	A product delivery case status is active when the case is activated online by a system user or offline by batch processing.
Suspended	A product delivery case status is suspended when the case is suspended. Case suspension prevents the generation of future financial payments for the case.
Pending Closure	When a closure date is entered later than today's date, the system sets the status of the case to pending closure so it can be closed when the closure date is reached.
Closed	A product delivery case is closed when normal business is complete for that case. A case can be manually closed by a system user. The system automatically closes the case when the Evaluate Certification Grace Period batch process is run if the certification grace period expires. The system automatically closes the case when the Close Cases Pending Closure batch process is run if the closure date for a case that is pending closure is reached. The application can also be configured to automatically close any cases that are found to be ineligible during activation (by default this setting is off).

Delivering services to clients through service delivery and referrals

This overview describes the business processes that allow the agency to deliver services to clients. These processes support the agency in providing its own services to clients and services that are provided by

external providers and paid for by the agency. Cúram Integrated Case Management also supports client referrals to services that are not paid for by the agency.

The service delivery process includes creating a service, checking a client's availability to attend the service, finding the best service provider, requesting the service, and paying the client or provider. To ensure that services are successfully meeting the needs of clients, users can also record an outcome for a completed service and evaluate the quality of the service.

The referral process includes referring a client to a suitable provider and following up with the client if needed.

Service deliveries and referrals processing are highly configurable, see Configuring services and referrals.

Creating services for clients

Creating a service for a client includes specifying an appropriate service for one or more clients, the owner of the service, the required number of units of a service, and authorizing a provider rate.

As part of service creation, the service frequency, the client's required participation in the service, and the nominee to receive payments in respect of the service are specified. The service creation process also includes checking a client's availability to attend a scheduled service, see "Checking client schedules and availability" on page 20.

Specifying an appropriate service for a client

During service creation, a user specifies an appropriate service to meet the needs of the client. For example, a user might select a counseling service to help a client who is in need of counseling sessions.

Note: Taxonomy is deprecated. For more information, see Deprecated features.

The user can search for a service by using a taxonomy search. The user then specifies the appropriate service from the list of services returned.

At least one client must be specified to be the recipient of the service. For an integrated case with one client, the system automatically creates the service for that client by default. Services can be appropriate for one client or for multiple clients. If a service is appropriate for multiple clients, multiple clients can avail of the same service. For example, a user might want to send a married couple on a marriage guidance course.

Agencies might want to track each service for each client separately instead of using the one service for all clients. For example, a user might want to track counseling sessions for individual members of the same family separately. A service can be configured to be automatically created for each client that is specified for the service. For example, if four members of a family are to receive 10 counseling sessions each, the service can be created once, and the system automatically creates four identical services, one for each client. The counseling sessions for each client can then be managed separately.

Assigning service ownership

The owner of a service is the user who is responsible for monitoring the client's participation in the service. The owner of a service can be the user who creates the service or any other user on the system. If a service can be owned by any user, the user who creates the service can assign themselves to be the owner or can manually assign ownership of the service to another user.

Depending on how the service is configured, service ownership can be automatically assigned to the user who creates the service, in which case, the user does not have to manually assign an owner. Administrators can configure how service ownership is assigned in service administration.

Recommending the required number of units of a service

Users can recommend that a client receives a certain number of units of a service. For example, a client might be required to receive 10 counseling sessions. In certain circumstances, it might not be appropriate for a user to recommend a number of units for certain services. For example, a client might be due to

receive Infant Care from 1 January 2011 to 31 January 2011. In this case, the number of units of a service such as Infant Care is always 1 and is defaulted to 1 by the system. This default eliminates the need for a user to specify the number of units.

Authorizing the provider rate

The provider rate is the amount of money that is paid to a provider for each unit of the service that is delivered to the client. For example, the rate for one counseling session might be $50. The standard rate at which a provider must be paid is configured for each provider during service administration. This rate can be overridden by caseworkers if they want to pay a different rate.

Authorizing the provider rate at the case level allows a caseworker to override the rate that is defined for the provider in administration if required. If an authorized rate is specified by a user, the service must be manually approved by a supervisor.

Recommending the Frequency of the Service

Services are usually delivered to clients at particular frequencies. For example, a client might be due to receive part-time child care twice a week on a Monday and on a Thursday from 1 January 2011 to 28 February 2011. A user can recommend the frequency of the service. Sometimes it might not be appropriate to specify a frequency for a service. For example, a client might be due to receive 10 physiotherapy sessions between 1 January 2011 and 28 February 2011. A client can avail of this service at any time during the period so no frequency is required.

Indicating the client's required participation in the service

Frequently, clients might be required to participate in a service so that they can keep receiving benefits. For example, to continue to receive cash assistance, a client might be required to participate in career guidance sessions for two hours once a week or incur sanctions on their benefits. A user can indicate the frequency and the duration, in hours, of a client's required participation in the service.

Specifying a nominee to receive payments in respect of the service

The designated payee for payments that are issued in respect of the service can be specified. For example, a client might receive physiotherapy sessions from their own physiotherapist. In this case, the agency can pay the client in respect of the physiotherapy sessions and the client then pays the physiotherapy provider. If a nominee is not specified, a default nominee is designated according to the delivery type for the service.

For more information about defining nominees for a service, see Configuring Service Deliveries.

Specifying a provider and provider type

In most cases, a user specifies an appropriate provider or type of provider to deliver the service to the client.

For example, an agency might want to allow a user to always choose a provider to deliver a service. For example, the agency might have a contract with a particular provider so it is more cost effective to use this provider. To cater for different scenarios, service configuration allows the agency to configure how a provider is specified by a user at the case level. For more information, see Configuring services.

Referring clients to service providers

This overview describes the process of referring a client to an external service provider. The referral process is used to refer a client for a service that is not paid for by the agency. Typically, the providers of these services have no formal contract with the agency. The process includes specifying a referral service, indicating whether to follow up with a client, and sending notification letters to the client and service provider.

Users can also check a client's availability to attend the service and avail of tools that enable them to find the best service provider.

For information on configuring referral services, see Configuring referral services.

Specifying a referral service

When referring a client for a service, the user specifies an appropriate service to refer the client for. The service dictates whether the referral can be created for multiple clients or for a single client. A user can select from a list of referral services that are registered in CPM or alternatively the user can manually specify an unregistered service.

At least one client is specified as the recipient of the service. If the integrated case has only one client, the system automatically creates the referral for that client by default. To aid users and clients, referral services can be appropriate for one client or for multiple clients. If a service is appropriate for multiple clients, multiple clients can avail of the same service. For example, a user can decide to refer a married couple for parenting classes.

Recording the referral date

An important part of referring a client for a service is to record the referral date. The referral date is the expected date on which the client meet the provider of the service. If the client does not contact the provider by the specified date, the application provides the ability for notifications to be sent by the system to users after this date elapses to alert them to follow up with the client.

Specifying to follow up with a client

Users might want to follow up on a referral to check whether a client contacted a provider. To allow for this, users can indicate that they want to follow up on a particular referral.

To aid users who have many clients to follow up with, system notifications functionality is available. If follow-up is required, notifications can be automatically sent by the system to the user to remind him or her to follow up. If a referral date is specified, users can specify the number of days after the referral date after which notifications should be sent. If a referral date is not specified, the user can specify the number of days after the referral creation date after which notifications are to be sent.

If a user does not specify that a client has contacted the provider within the specified timeframe, notifications can be sent to the user's supervisor to escalate the issue. For example, a user might refer a client on the 1 January 2011 and specify to follow up on the referral in 30 days. An administrator specifies that notifications should be sent to a user's supervisor after 10 days. The user does not follow up on the referral. So, a user notification is sent on the 31 January 2011. A supervisor notification is sent 10 days later on 10 February 2011.

Users can record that a client contacted the provider. If the user specifies that the client has contacted the provider, no follow-up notifications are sent by the system.

Sending notification letters to the service provider and client

When a user refers a client to a provider, both the client and the provider are notified of the referral. Clients and providers are notified by notification letters that are sent to the client and provider. The user can record notification text that is displayed in the provider and client referral letters. Notification letters can be issued by email, by printing the letter for posting or to hand it to a client.

The notification letters that are sent to clients and providers are based on pre-defined templates.

Users have the option of sending notification letters to the client or provider automatically or they can send them at a later date by printing and posting them to the client or provider. If the notification letters are sent automatically, the system determines how the notification letters are issued based on the preferred communication method recorded for the participants during registration and on any communication exceptions recorded for them. If a client and/or provider has a preferred communication method, such as email, the system automatically issues the notification letter by email.

Communication exceptions are methods that cannot be used for contacting the client or provider. If a communication exception of email exists for a client or provider, the system will not issue notification letters by email. In this situation and if no preferred communication exists, the system will inform the user so that the client and provider can be contacted by a different means, for example, by phone.

Checking client schedules and availability

For both services and referrals, the period during which the service is to be provided to the client is recorded. A start date must be specified but an end date is optional. When a start date is specified, a user can check the client's availability.

Any services, referrals, or meetings that are already scheduled for the specified dates are shown so the user does not schedule activities during periods when the client is involved in other activities, such as other services.

A configuration setting is provided for services that dictates if they are to be returned when availability is checked. For example, a mileage expenses reimbursement service might not be relevant to the clients availability to receive other services.

Finding the best service provider to meet client needs

If a service or referral is provided by an external provider, you must find a suitable service provider to successfully deliver the service to the client. Finding a suitable provider, when the providers are registered on the system, includes locating the nearest service provider, and viewing information to validate provider credentials and estimate the cost of the provider.

When finding a service provider, it is important that the user considers fully the client's circumstances. In addition to cost considerations, it is equally important that services are readily available and easily accessible to clients, that they are of good quality, and that they are a good match to the client's needs.

Referral and service delivery processing helps users to find the best service provider to meet the needs of the client and ultimately assist them in achieving positive outcomes by achieving their goals.

Locating the nearest service provider

The application provides tools that allow users to locate the nearest service provider to a client. Finding a service provider who is accessible to the client and who also specializes in the client's needs can be a complex task for users. Users can search for a provider based on a number of criteria.

A user can search for a registered provider by name so that if a client requests a particular provider, the user can easily find them. A user can also find providers who are situated close to a client's address and can also filter this search by specifying to return only providers that are located within a specified proximity of the client's address.

The application also provides a specialty search that can also be used to return providers who specialize in particular areas, for example, if the client speaks Spanish, the user can search for all providers who are Spanish speaking.

For all providers returned from a search, a map is automatically displayed so that a user can easily identify their location in relation to the client's address.

Validating provider credentials

When choosing providers, it is also important for a user to consider their credentials to evaluate their standards. To assist users, the system automatically keeps a record of important provider information. This information can be used by users to decide whether a particular provider is suitable to meet the needs of a client. The following information is available:

- Licenses, accreditations, other services that the provider provides, and provider service centers.
- Details of a provider's staff members can be accessed by users. Background check information is also available so that users can ensure that they do not select a provider who, for example, have staff members with criminal convictions recorded against them.

- Incidents that are recorded against a provider are displayed. For example, a user looking for an appropriate child care provider would not select a provider that has bullying incidents recorded against it. For more information about incidents, see the Cúram Participant Guide.
- Investigations that are recorded against providers are displayed. For example, a user might not want to select a provider who has, for example, a number of licensing violations recorded on the system. For more information about investigations, see the Cúram Investigations overview.

Estimating the cost of a service

Cost considerations are an important part of planning services for clients. To assist users, the system automatically estimates the cost of a service when it is scheduled for a client. When a user decides on an appropriate provider, the estimated cost is updated based on the provider-specific rates.

The following information is used to calculate the estimated cost, if specified by a user when they schedule the service:

- Start date of the service.
- End date of the service.
- Number of units that the client is authorized to receive.
- Frequency of delivery of the service to the client.
- Rate to be paid to the provider for each unit of service.

The rate that is used in the estimated cost calculation can be one of the following rates:

- Custom rate - if a custom rate is specified for the service, this rate is used.
- Authorized rate - if a user specifies a rate to be paid to a provider, this rate is used.
- Contract service rate - where the service authorization does not specify a service rate, the contract service rate is used.
- Provider service rate - where no service rate is specified for any of the previous rates, the provider service rate is used.
- Service rate - where no service rate is specified for any of the previous rates, the service rate that was set up as part of configuring a service offering is used. The average of the minimum and maximum amount that is specified is used.

Any flat-rate or utilization contracts that exist for the period of the service are automatically displayed. This information helps with cost comparisons between all providers of the service.

Enquiring about services and recording provider responses

Enquiries can be made to providers to request a service for a client during a specific time period. Enquiries help to prevent a user from scheduling a service if providers cannot deliver services during the required timeframe. The provider can then respond to the enquiry and indicate whether they can provide the service. Agencies can make enquiries by email, online, or by phone.

Enquiries sent by web enquiry can be accessed by the provider within their provider portal account. For information about provider portal accounts, see the Provider Management Overview. When a web enquiry is made, an email is automatically sent to the provider to alert it to the web enquiry. Enquiries made by phone can be recorded.

Providers can respond to enquiries to indicate whether they can deliver the service or they can add a comment or question to the enquiry. Responses to email enquiries are sent by email and the user can then update the enquiry on the system to reflect the provider's response or comment. Responses to web enquiries can be recorded in the provider portal. In this case, the enquiry is updated automatically by the system. An email is sent to the user who sent the enquiry to alert them that the provider has responded to the service enquiry.

How an enquiry is made to a provider depends on two things: the preferred enquiry method of the provider, which can be set on registering a provider, and whether the provider has a valid email and provider portal account.

If a preferred enquiry method is specified for a provider, the method specified is the only method that can be used to send an enquiry. If a preferred enquiry method is not specified, an enquiry can be sent by email only if the provider has a valid email address on the system. A web enquiry can only be sent if the provider has a provider portal account. If a provider does not have a valid email address on the system or does not have a provider portal account, only phone enquiries can be recorded.

Statistics are also automatically generated that highlight the average length of time that it takes a provider to send an initial response to an enquiry and the percentage of enquiries that they responded to. Statistics help users to identify whether to contact a particular provider and the length of time they might have to wait before they get a response.

Approving service deliveries

The application provides a service delivery approval process that allows the agency to approve a service delivery to ensure that the service details are correct before the service is provided to the client. For example, a case supervisor might want to manually approve services that are scheduled by novice users.

For services that use product delivery processing to determine eligibility, service approval triggers eligibility determination.

For services that have no eligibility determination processing, service approval authorizes the client to receive the service.

Agencies can do approval checking by specifying that a percentage of services that are submitted automatically require approval by a supervisor. For more information, see Configuring evidence types.

Submitting a service delivery for approval

A service is submitted for approval by the user after creation. If a service is configured so that the specification of a provider or provider type is mandatory, the system allows the service to be submitted only after a provider or provider type is selected.

When the case supervisor or a user with approval privileges submits the service, services that have no eligibility determination processing are automatically approved and the client is authorized to receive the service. For services that use product delivery processing to determine eligibility, the client's eligibility is determined when the service is submitted. If eligible, the service is approved and the client is authorized to receive the service. If the client is ineligible, the service remains in a status of open and the client is not authorized to receive the service.

Services that are submitted by a user without approval privileges require manual approval by a user with the appropriate privileges. The system automatically assigns a task to the user with the required approval privileges. This task includes instructions to the user to either reject or approve the service. Services that are submitted for approval have a status of submitted. Services for which an authorized rate is specified always require manual approval by a supervisor.

Approving or rejecting a service delivery

During this stage, the service is either approved or rejected. Typically it is the case supervisor who checks and verifies the service. By approving the service, the case supervisor indicates that they are satisfied that the service details are correct. For services that have no eligibility determination processing, when the service is approved, the client is authorized to receive the service. For services that use product delivery processing to determine eligibility, the client's eligibility is determined when the service is approved. If eligible, the client is authorized to receive the service. If the client is ineligible, the service returns to a status of "open" and the client is not authorized to receive the service.

If the service is rejected, the reason why the service was rejected is entered and the user who submitted the case for approval is notified of the rejection. If rejected, the service status returns to open and the service must be resubmitted to progress.

Authorized services have a status of not started if the start date of the service is greater than today's date. Authorized services have a status of in progress when the start date is effective.

When a service that is provided by a third-party provider is approved by a user, an extra level of approval is provided at the CPM level, which allows the agency to approve the payment of invoices that are submitted by the provider before the agency pays the provider for the service.

Viewing service approval requests

Users can frequently have many services that are waiting for approval from a supervisor. To help users track the number of approval requests sent to their supervisor, the system automatically maintains a list of service approval requests. When a service is submitted and then approved or rejected, the approval request information is recorded. The approval request details include the name of the user that submitted the service, the date of submission, the name of the user who approves or rejects the service, and the date of approval or rejection.

Paying clients and service providers

After a service delivery is approved, service financial processing occurs and payments are made to clients and service providers in respect of the service. Users can also view details of the payments that are issued to clients and providers.

Processing payments

Services provided directly to the client by the agency use standard product delivery processing to determine eligibility and issue payments to the client or other participant for the service. Services that are provided by a third-party provider can be paid for by using service invoices, attendance rosters, or flat rate contracts. If payment for the service is based on receipt of a service invoice or attendance roster, the service can either use CPM processing or product delivery processing to issue the payments to the provider, depending on whether the payment amount is based on a custom rate.

- If payments are based on a custom rate that can change over time, product delivery processing is used to calculate the payment amount and upon receipt of an invoice or roster, issue the payments.
- If payments are based on a fixed rate, CPM processing is used to issue the payments for the service. CPM processing is also used where payment is based on a flat-rate contract.

If eligibility is determined for a service, a service authorization and one or many service authorization line items are automatically created if the client is determined eligible. For services where eligibility is not determined, the service authorization is created after service approval. Each service authorization line item represents a specific date or date range within which the client is authorized to receive the service, and the number of units that are authorized. The service authorization line item might also contain a specific provider or provider type from which the participant is authorized to receive the service.

Before a payment can be issued, a service authorization is required for services that are paid for based on receipt of a service invoice or attendance roster. Services where payment is based on flat rate contracts, do not require a service authorization to be paid. Users can view eligibility decisions and determinations in respect of a service for a client in the same way that they are viewed for product delivery cases. For more information about viewing eligibility decisions, see "Reading decisions, eligibility, entitlement, and explanation" on page 9. For more information about CPM financial processing and configuring services for delivery, see the Provider Management Overview.

Viewing financial transactions for services

The system automatically maintains a list of all financial transactions for a service. Users can use these lists to ensure that the payment arrangements for services are being met by the agency. Financial transactions can be viewed for service providers who are paid by the agency for providing services and for clients who receive payments from the agency for services.

Viewing payments to service providers

The system automatically maintains a list of all payments that are made to a provider in respect of invoices and attendance rosters that are submitted by the provider. If invoices are the means by which a provider is paid, invoice details are also displayed in addition to payments.

For services that use product delivery processing to issue payments, other financial transactions that apply to product delivery case financial processing are also displayed for the service. For example, deductions, components, delivery patterns, nominees, and payment simulations.

Payments made to a provider under a flat-rate contract are not displayed because flat-rate contracts do not apply to one service. Since a flat-rate contract can be associated with multiple services, the cost of a particular service that is covered by a flat-rate contract cannot be attributed.

For more information about how provider payments are processed, see the Provider Management Overview.

Viewing payments to clients

A list of payments made to a client by the agency in respect of a service is automatically maintained by the system. As payments made to a client in respect of a service use product delivery processing, all financial transactions that apply to that service replicate product delivery case financial processing.

For example, how the system processes deductions, components, delivery patterns, nominees, over and under payments, and payment simulations in respect of a service is the same as the way that they are processed for product delivery cases. For more information about product delivery case financial processing, see "Scheduling payments and bills - the Financial Scheduler" on page 12.

Determining the actual costs of services

Agencies must be aware of the actual cost of a service. For services provided by a third party, the cost of services is automatically updated each time units of the service are delivered.

The number of units that are delivered is determined automatically by the system and depends on the provider's method of payment. If a provider is paid based on invoices, the number is updated each time that an invoice is submitted in respect of the service provision that includes a number of units that are delivered to a client by the provider. If a provider is paid based on attendance, it is updated each time an attendance roster is submitted that indicates the number of units that were delivered to the client. Users can review the service to identify how many units were delivered to date and how many units remain.

In addition to determining the units of service delivered, the system automatically calculates the actual cost of the service from the payments that are issued in respect of the service. The actual cost of a service is automatically updated each time that a payment is made to a payee in respect of the service.

Changing services

A user might need to change services based on a client needs. For example, a user might increase the recommended units of a service or might change client evidence that affects the client's eligibility and entitlement. Any changes to a service or to the evidence used to determine eligibility for a service are automatically reflected in the payment processing mechanism that is used by the service.

For example, changes to the number of units, unit amount, authorized or custom rate, start or end date of any third-party service are reflected in the service authorization line items for the service. Any changes to the start date or end date of any service that uses product delivery processing are also reflected in the product delivery for the service.

If a user cancels a service, any associated service authorization line items are automatically canceled. If the service has an associated product delivery, that product delivery is automatically closed.

Completing services and recording outcomes

Service completion happens when a service was delivered to the client. Service completion allows the agency to measure how successful the service was in meeting the needs of the client. Service completion also indicates that the service was delivered and that the client no longer needs to participate in the service.

As part of completing a service, the user records the outcome for the service. The outcome helps the user to identify the client's progress and also to decide whether the service is suitable to be used by the agency in the future. A completed service can have an outcome of successful or unsuccessful. If a service was not successful, the reason why it was unsuccessful is also recorded.

Evaluating the quality of services

Users can evaluate the quality of services that are delivered to a client. To provide flexibility to users, a service evaluation can be done before or after a service is completed.

Service evaluation can be used for three purposes:

- Ensure that the service effectively meets the needs of the client.
- Help other users to choose suitable providers.
- Help agencies decide whether to continue to use a particular provider in the future.

Provider strengths and weaknesses are evaluated across a number of criteria. For example, a user can evaluate a provider of counseling services for punctuality, facilities, and staff. During the evaluation, users assign a rating of 1, 2, 3, 4, or 5 for each evaluation area. The system then automatically calculates an average rating of all evaluations that are submitted by users of the service. This average rating can be used by other users to choose providers and in future discussions on provider quality in general.

The criteria used to evaluate a service provider is configured as part of configuring services. For more information, see Configuring services and referrals.

Viewing the service delivery status history

The series of stages the service delivery passes through during its lifetime is called the service delivery lifecycle. Each service delivery within the integrated case has its own lifecycle. The system automatically maintains a status history for the service as it passes through the various stages in its lifecycle.

Each service delivery has a status that describes its progress and changes during service processing. The following table describes each status.

Table 2. Service Delivery Statuses	
Information	**Description**
Open	A service status is Open when first created on the system or when a service is rejected. For services where eligibility is determined, the service status is also Open if the client is determined ineligible after the service is submitted or approved.
Submitted	A service status is Submitted when the service is submitted and approval is required.
Not Started	For services where eligibility is not determined, a service status is Not Started when it is approved by a supervisor or if approval is not required and the start date is greater than today's date. For services where eligibility is determined, a service status is Not Started if the client is determined eligible after submission or approval of the service, and the start date is greater than today's date.

Table 2. Service Delivery Statuses (continued)	
Information	**Description**
In Progress	For services where eligibility is not determined, a service status is In Progress when it is approved by a supervisor or if approval is not required and the start date is effective. For services where eligibility is determined, a service status is In Progress if the client is determined eligible after submission or approval of the service, and the start date is effective.
Completed	A service status is Completed when the service is manually completed by a user or automatically completed by the system when the last authorized unit of service is delivered.
Canceled	A service status is Canceled when the service is deleted by a user. Only services with a status of Open, Submitted, and Not Started can be deleted.

The caseworker workspace

The caseworker workspace provides tools that help caseworkers to efficiently balance their work and quickly access important case information.

Accessing caseload

The caseworker workspace allows caseworkers to easily access their caseload. Case workers can access all cases that are directly assigned to them or to groups to which they belong.

A list of cases that are owned by the caseworker or by the organization group that the caseworker is a member of is automatically maintained. Caseworkers can access the cases to which they are currently assigned and cases that are owned by other organization groups that they belong to, as defined by the agency administrator.

To access cases, caseworkers can filter the list of cases to show only cases that are currently assigned to them or by their organization group as needed. The filter options that are available depend on the case ownership strategy that was set up during system administration. For example, if case ownership is assigned to users and positions, the caseworker can filter cases to access all cases that are assigned to their position in the organization structure.

An option to filter the cases further by specifying to display only cases according to their status is also provided. For example, if a caseworker wants to access only cases that need follow-up action, the user can specify that only open, approved, suspended, and active cases be returned. The case statuses displayed as filter options reflect the case statuses that the case can have.

The filter criteria that are specified by the user is automatically stored for when they next return to the page. The user can change the display criteria as needed.

Viewing daily workload summaries

To assist caseworkers in their daily work, caseworkers and their supervisors can view summaries of their daily workload. When a caseworker logs in to the application, a number of pre-defined summaries are displayed.

For example, if defined, a summary of currently assigned cases that might require attention are displayed to the caseworker. Case workers can see cases and activities that relate to them and need to be addressed. Each summary provides a snapshot of work for the day and allows for quick access to the

information. Caseworkers can access the full list view for each summary in the relevant area of the workspace and complete the relevant actions on particular information from there.

Case workers and supervisors can change the display of the summaries from the caseworker workspace if needed. For example, a caseworker who rarely uses the case queries summary can turn off the display of the My Case Queries summary if needed.

The following summaries are available to caseworkers:

Quick Links
Quick Links allow for quick access to common actions. Examples of common actions include searching for a case, searching for a person, searching across all participants, and changing the application login password. The operations that are displayed are configured as part of the application administration.

My Appointments
The My Appointments summary displays appointments that are recorded in a caseworker's calendar. Case workers can use the summary to view activities that are scheduled for today and next week. Any activities that are scheduled for today are highlighted to the caseworker. Case workers can complete the relevant activities within their case calendar. For more information about the case calendar, see "The case calendar" on page 27.

My Tasks
A list of the work that is available to the caseworker. Each task is listed in order of priority.

My Items of Interest
A list of items of interest that is recorded by the caseworker. For example, caseworkers can record a case that they are tracking as an item of interest. Caseworkers can access each individual item of interest and access their list of items from the pod.

My Case Queries
A list of the caseworker's recorded case queries. For example, caseworkers can run a query on a case that was previously assigned to them. A caseworker can access recorded queries from this list and run new queries from the summary as needed.

Caseload Summary
A graphical representation of a caseworker's open, submitted, suspended, active, approved cases. The graphical view allows caseworkers to easily track their workload. This axis that is displayed in the graph is automatically updated according to the number of open, submitted, suspended, active, approved cases. Case workers can also access their case load from the summary.

In addition to the caseworker summaries, the following summaries are provided for supervisors to track their daily work and the work of their team.

My Work Queues
A summary of the supervisor's work queue.

Assigned Workload
A snapshot of the assigned workload of the caseworkers managed by the supervisor.

Open Workload
A snapshot of the open workload of caseworkers that are managed by the supervisor. Open workload is the workload that is not assigned to individual caseworkers.

My Organization Units
Details of the supervisors organization units.

The case calendar

A case calendar is provided to help caseworkers and clients to schedule and maintain events, activities, and meetings that relate to the agency's cases and clients. In particular, the caseworker calendar is used to schedule activities and meeting that address the needs of the agency's clients and their families.

The caseworker calendar provides a view of a client's activities and meetings and also provides access to calendaring information about a client's cases and family members. Calendar activities and meetings can be set monthly, weekly, and daily.

A calendar is provided for each integrated case and product delivery case so that associated case events can be displayed in a caseworker's calendar. The integrated case calendar is maintained at the integrated case level and track events or activities that are automatically created during case processing or manually created by caseworkers. Integrated case calendars are also used to schedule meetings for caseworkers or participants about a case or client. Product delivery calendars are used to track case events and meetings that are created at the product delivery case level.

For more information about using the case calendar to track and schedule events, activities, and meetings, see "Schedule meetings and track case events with the case calendar" on page 32.

For more information about the different calendars provided by the application, see the Cúram Calendaring Guide.

Searching and querying cases

Caseworkers can do case searches and query cases. Case searches can be done at the user or organization level.

The user level case search provides access to any cases that are assigned to the caseworker who is logged in. The organization level case search accesses any cases in the organization regardless of which caseworker they are assigned to.

Searching for specific case information

Case searches can access specific case information across the whole organization. A quick search by reference number is also provided.

The standard case search allows caseworker to search for a case-by-case reference number, client reference number, or both. The client reference number is an identification for a person or prospect person, for example, a passport number or medical card number. Searching by client reference number searches for any cases that involve the case participant with that client reference number.

Case workers can also search for cases by case name, case status, or case start and end date. The case search also provides a number of filter options. Caseworkers can filter the case search to display only cases that have an associated appeal, issue, investigation, and service plans. For example, if a caseworker searches for open benefit products and filters the search to display only cases with issues, the results displays only open benefit products that have an associated issue.

Administrators can configure whether a type of case is listed as a filter option on the case search on a case-by-case basis. For more information about the "Display in My Cases Filter" setting, see Configuring common case information.

Note: The Generic Search Server is deprecated.

The enhanced case search facility, which used the Generic Search Server, allows caseworkers to specify the same search criteria as the standard case search. Case workers can also specify a client name as another search criteria to differentiate between cases for clients with the same name. Administrators can configure the case search with application properties. For more information, see Configuring the enhanced case search.

Quick search by reference number

Caseworkers can search by reference number from anywhere in the application, which searches all cases, participants, issues, and incidents. If the reference number entered matches the reference number of any existing cases on the system, the related case is displayed. Additionally, if the reference number matches an identification for a participant who is also associated with a case, the system displays the details of every case that the participant is associated with.

Monitoring cases by using case queries

Caseworkers can use case queries to monitor cases currently or previously assigned to them. The caseworker can choose specific criteria that is important to them and can then save the search criteria as a personal query that they can run again.

If the standard search facility is used, caseworker can query cases by case reference number, client reference number, case category, and type and case status. Caseworkers can filter the query further with a time period or a client reference number, such as a medical card number or benefit reference number. Case workers can also query only cases that have investigations or cases under appeal.

If the enhanced search facility is used, caseworker can query cases by client name.

Recording items of interest

Caseworkers can record items that they have a special interest in, such as cases, issues, and participants.

For example, if caseworkers are working on cases that need to be tracked, they can record the case as an item of interest. Case workers can then quickly access that case without searching. A list of recorded items of interest is automatically maintained for each caseworker. Case workers can add and remove items of interest. Types of items of interest that can be marked by caseworkers include cases, issues, and audit plans, and items that are not case-specific such as appeals or participants.

Case workers can search for their items of interest by type. Caseworkers can filter the search to display all their items of interest, or they can filter the search to display only items that are recorded for issues, audit plans, or cases.

Ongoing case management

The application provides a case overview and tools that facilitate the ongoing management of an agency's cases. Ongoing case management helps users track their cases and progress them towards achieving sustainable outcomes for their clients. Ongoing case management includes managing case participants, auditing cases, managing and reassessing case eligibility and entitlement, as well as tracking issues and legal proceedings.

The case overview

An **Overview** tab on integrated cases provides caseworkers with a summary of the latest important case information. Case-specific information is collated and presented in a summary view, from which you can navigate to more detailed pages only if necessary. You can configure the overview tab to be shown on specified integrated case types.

The Entitlements card

The **Entitlements** card shows the latest entitlement and payment information for cases in an integrated case. High-level information for cases is displayed in sections, which you can expand to show more case-specific information. Links are provided to pages with more detailed information.

The **Entitlements** card provides summary information about product delivery cases. You can configure the product delivery cases to display. For more information, see Configuring the case overview. For product delivery cases with a financial component, the **Entitlements** card displays extra entitlement and payment data to the caseworker. Links are provided from the summary information to more detailed pages on the product delivery case tab. To return to the **Overview**, select the integrated case tab.

The following entitlement and payment information for active and suspended benefits is shown on the **Entitlements** card.

Programs
A list of the active and suspended programs on an integrated case. Agencies can configure which programs to include for each integrated case type. A **Suspended** tag indicates that a case is suspended.

Click a program name to open the product delivery case in a new tab. To return to the Overview, select the integrated case tab.

You can expand a program to see the following information:

Program type
If the program name is different than the program type, the program type is displayed.

Start date
The start date is the date that the product delivery case was created.

Case status
For example, **Active** or **Suspended**.

Case owner
The current case owner.

Delivery schedule

The nominee (payee), the component, and the frequency of the payment. For example, **Maria Hernandez, Income assistance, Monthly by EFT in advance on the 1st**.

Entitlement

The current entitlement amount and the period for which the citizen will receive that amount. If a new determination is created, such as for a change of circumstance, an 'updated' field that shows the most recent determination creation date is also displayed.

View determination history
A link to the determination history for the program, see "Current determination and determination history views" on page 10.

Members
A list of active members on each program who have the primary or member role.

Expected next payments
The total amount of the upcoming payments is shown for each program with a financial component. A calculated total amount for all programs with a payment due on the next payment date is also shown. An **Adjusted** tag indicates whether an adjustment was made that affects the next payment, for example after a change of circumstances. You can expand a program to see extra payment information:

Expected next payments
Details of deductions or supplementary payments that result from overpayments, underpayments, or taxes are displayed if they affect the next payment. For third-party deductions, the recipient of the deduction is listed after the payee.

A red down arrow ▼ or green up arrow ▲ indicates the impact of recent changes to the next payment. For example, if the benefit payment amount was increased after a change of circumstance, a green arrow indicates that the next payment is more than the previous payment of that type. The arrow is removed after the first payment of the new amount is processed.

Previous payments
Details of previous payments, including the amount and the payment period for each payment component, are displayed. Details of any deductions or supplementary payments that result from overpayments, underpayments, or taxes are also displayed. A calculated total amount for the payments that were issued for the previous payment due date is also displayed.

If payments are issued to multiple nominees with the same due date, the contents of each payment are listed separately under the previous payment and a calculated total of the payments is displayed.

View payment details
A link to the **Transactions** page on the **Financials** tab of the product delivery case tab. For more information about financial transactions, see "Viewing financial transactions" on page 14.

View over or underpayments

A link to the **Over or Under Payments** page on the **Financials** tab of the product delivery case tab. For more information about over or underpayments, see "Reassessing case eligibility and entitlement" on page 40.

The links are shown only when an overpayment or underpayment occurred.

For more information about configuring the case overview tab and Entitlements card, see Configuring the case overview.

Changing the case owner and case supervisor

The initial case owner that is determined by agency's case ownership strategy can be manually assigned by a user to any organization object. For example, to another user, or an organization unit, position, or work queue. User or users within an organization unit, position, or work queue can then work on a case.

Assigning case ownership to an organization object, group, or work queue provides visibility on the case to more than one user. All users in a specified organization unit, position, or work queue can see the case in their list of assigned cases. Cases don't need to be reassigned individually if a user who is normally the case owner is on vacation or has a heavy workload. Instead, all members within the specified organization object have equal ownership of the case and can progress work on the case.

The case supervisor can either be automatically determined by the system based on the owner of the case or explicitly set by a user. If explicitly set, the case is assigned to the specified case supervisor when it is submitted for approval. If no case supervisor is explicitly set, the system automatically assigns the supervisor to be the user who the case owner reports to in the current organization structure.

For more information about users, positions, organization units, and work queues, see the Cúram Organization Administration Guide.

Viewing contextual information

Contextual information is automatically displayed for cases. When users go to different areas in the application, the main case information is always displayed. The information is visually prioritized so that the user can quickly see key information about the case and highlighted items that might require further attention or follow-up action.

Contextual information for cases

The following contextual information is common to both integrated cases and product delivery cases: the name of the primary client and photo if it exists, the case status, and case owner. The user can click each photo to access client contact details if they exist. Users can access summary details for the case owner, whether it is an organization group, position, work queue, or user.

Current special cautions that are recorded against the primary client or case members are also displayed for both product delivery and integrated case types. Special cautions are highlighted to the user with a special caution icon that is displayed near the case member image. For more information about special cautions, see Special Cautions.

Issues and legal proceedings, including issues, appeals, and legal actions, are also displayed if they exist. Appeals and legal actions are only displayed if IBM Cúram Appeals is installed. For more information about issues and legal proceedings, see "Tracking issues and legal proceedings" on page 39.

Contextual information for integrated cases

Contextual information that is specific to an integrated case includes the members of the primary client's family that were added to the integrated case and their relationship to the primary client. Users can use either the list view to view the case members or they can use the photo view. In the photo view, each case member is represented by a photo if available and the age of the case member in years, months, or days is also displayed.

The relationships that are displayed are inherited from the relationships that are defined for the primary client in the participant manager. If no relationship exists between the primary client and a case member, a relationship is not displayed in the case context panel for that case member. If a case member was involved in an investigation or incident and has a role on the incident or investigation other than reporter, it is highlighted with an icon. Users can hover their mouse over the icons to view specific details about the incident or investigation.

Any outstanding evidence items to be verified and in-edit evidence are also displayed and highlighted to the user.

In the case context panel for an integrated case, the number of issues that are associated with the integrated case and the number of appeals that are associated with any issues or product deliveries in the integrated case are also displayed.

Contextual information for product delivery cases

Contextual information that is specific to a product delivery case includes details of the benefit that is being delivered, important dates such as the case start date, the date up to which the case is certified (if certification is applicable to the case), benefit payment dates, and the next case review due date.

An overview of any financial transactions that were issued on the case is also displayed. If payments were issued on the case, the last payment amount, the next payment amount, and the payment due dates are displayed. The user can access the individual payment details as needed. If a decision is recorded on the case, the date on which the latest case decision was reached is also displayed. The user can access the case decision view from the date that is displayed to view the decision detail. The current active case decision record created due to case reassessment is displayed.

Any overpayments or underpayments on a case are highlighted to the user. The user can roll over the icons to view the details. The case context panel displays the total number of overpayments that are created as a result of a reassessment of the benefit product delivery and overpayments that are not fully repaid, written off, or reversed. If underpayments exist on the case, the total number of underpayments is displayed. The user can drill down to the overpayment and underpayment list page to view the overpayment and underpayment details.

Auditing cases

A case audit is an examination of the agency's cases by a third party or evaluation by the agency of a case or cases. Case audits help agencies to evaluate performance, enabling them to identify ways to improve performance and affect positive changes in policy and case practice.

For example, a Quality Assurance Review audit might be conducted by an agency to evaluate the effectiveness of the delivery of a Food Assistance benefit. The audit might focus on a review of the timeliness of actions and verifications completed.

For more information about auditing cases, see the Cúram Case Audits overview.

Schedule meetings and track case events with the case calendar

The case calendar is used to schedule meetings and track events and activities to meet the needs of clients and their families. Meetings are appointments to which other users or participants are invited that are scheduled by a user about a client or a case. For example, a meeting might be held to determine the appropriate course of action for a family. An event is an individual milestone of significance to a case.

Events can be automatically created by the system as a result of case processing or manually created by a user. The following events can be created by a user manually: case activities, case referrals, case reviews, and appeals on services. An example of an event that is automatically created by the system is the case closure event that is created when a case is closed.

A calendar is provided for all events. Each calendar displays the name of the event and the date on which the event occurs in the appropriate date entry.

Scheduling meetings and recording meeting minutes

Meetings can be scheduled from the case calendar. Meeting minutes can also be recorded for each meeting to capture the meeting details and can be issued to attendees and other interested parties.

A number of meeting features enable an agency to coordinate meetings:

- Multiple participants can be invited to attend a meeting.
- Meetings are integrated with tools that allow meeting requests to appear in an attendee's external email account and calendar.
- Any individual who receives a meeting invite can accept or decline the meeting invitation by using their calendar.
- Meetings can be rescheduled.
- Meetings can be canceled.

Recording meeting minutes

Meeting minutes can be recorded and issued to meeting attendees and other interested parties.

The following meeting information can be captured:

- Meeting details, such as the meeting subject, location, start and end times, and name of the person who organized the meeting.
- Meeting notes and decisions.
- Meeting attendance allows the agency to capture information about meeting attendance.
- Meeting actions can be added to the meeting minutes.
- Meeting files can be attached to meeting minutes.
- Meeting summary of the meeting minute information.

When meeting minutes are recorded, the meeting organizer or the user who records the meeting minutes can issue them to any person invited to the meeting.

For more information about scheduling meetings and recording meeting minutes, see the Cúram Calendaring Guide.

Scheduling activities

Activities are events that are related to a case and scheduled for a specific time period. The two activity types are the standard activity and the recurring activity.

- A standard activity is a once-off event that is related to a case and scheduled for a specific time period. For example, a once-off meeting between the primary client of a case and a user.
- A recurring activity is an activity that recurs over a period. For example, a supervised weekly visit between a child and the child's parents.

When a standard or a recurring activity is created, other users or case participants can be invited to it. Each user invited to the activity can accept or decline the invitation.

Activities differ from meetings in that activities are used to set up a basic event in a user's calendar to schedule time for interaction with participants on a case. A concerning participant such as a primary client can be specified for standard and recurring activities. Users invited to the activity are informed of the activity by a task notification. Any conflicts with times between existing activities that are scheduled for a user and the planned activity are automatically displayed. The user can resolve or ignore any conflicts.

Referring clients for services

Referrals can be maintained for both product delivery cases and integrated cases from the case calendar. A referral is a request to a service supplier for consultation on a case. For example, a user might

schedule a medical examination with a physician who is registered as a service supplier for a person with disabilities.

Referrals from the case calendar are available only if IBM Cúram Provider Management is not installed. Provider Management provides enhanced capabilities to allow agencies to deliver services to their clients and make referrals. For more information about these enhanced capabilities, see "Meeting needs through referrals" on page 2.

Setting up case reviews

A review is the examination of case details by another user. A case review can be manually created or automatically generated by the system. The case review is conducted by a user who is assigned to the case reviewer user role. The case reviewer is informed of the case review by a task notification.

Automatic case reviews can be set up to occur at defined frequencies, for example, every 6 months. This frequency can be modified on a case-by-case basis.

Appealing services

Appeals can be created from within the calendar of a product delivery case. Appeals are used to manage disputes against service providers who are providing services to the agency's clients. The service supplier who is the focus of the dispute and the appeal type is recorded.

Examples of appeal types include conditions for disqualification, or payment rate. Additionally, an outcome can be recorded when the appeal is complete.

This feature is available only if IBM Cúram Appeals is not installed. Appeals provides enhanced capabilities to allow agencies to document a client's request to appeal decisions made within a case. For more information, see "Tracking issues and legal proceedings" on page 39.

System-generated events

Events can be automatically created by the system during specific case processing.

The following table describes these events.

Table 3. System-Generated Events.	
This table describes the system-generated events that are created during case processing.	
Event	**Description**
Case Submit for Approval Event	A case submit for approval event is automatically created when a product delivery case is submitted for approval.
Case Review Event	A case review event is automatically scheduled on the date a case is approved. Cases are reviewed based on the review frequency that is specified for the related product.
Case Approval Event	A case approval event is automatically created when a product delivery case is approved.
Case Rejection Event	A case rejection event is automatically created when a product delivery case is rejected.
Case Decision Event	A case decision event is automatically created on the date a decision is made on a case.
Case Payment Event	A case payment event is automatically created on the date a payment is made on a case.
Case Payment Approved Event	A case payment approved event is automatically created on the date that a suspended payment on a case is approved.

Table 3. System-Generated Events.

Event	Description
Suspend Case Payment Event	A suspend case payment event is automatically created on the date a payment is suspended.
Case Closure Event	A case closure event is automatically created when a case is closed.
Pending Closure Event	A pending closure event is automatically created when a case is pending closure.
Case Reactivation Event	A case reactivation event is automatically created when a case is reactivated.

This table describes the system-generated events that are created during case processing. *(continued)*

Case tasks

A task is an instruction to do an item of work. Tasks are either manually created by a user or automatically created by the system. They are maintained in a user's workspace as part of workflow. Tasks that relate to a case can also be maintained from the case's task list.

For example, a task can be created to approve a case that was submitted for approval. This task would appear on both the user's inbox and on the case's list of tasks.

Ongoing client management

The application provides tools to facilitate the agency in the ongoing management of its clients, their family members and any other parties who are involved with its cases.

Ongoing client management also includes managing case members and case participants, determining the need for a translator to mediate between a client and the agency, and maintaining client contact information. Client contact information includes contracts between the agency and its case members, communications between the agency and any case participant and attachments. Typically attachments are provided to the agency by a client in support of his or her case.

Managing case members and participants

Within an integrated case, each family member is assigned the role of case member. Case members are registered persons added to an integrated case for the purpose of determining their eligibility for benefits and services.

If relationships are recorded for the person who is the primary client of the case, users can add all of that person's family members to an integrated case. This eliminates the need for the user to add the family members one at a time. The family members that can be added are automatically derived from the relationships recorded for the person as part of participant management. For information about recording relationships, see the Cúram Participant Guide.

Any other individuals, organizations, or agencies that interact with the family members are assigned a case participant role. Case participants include any persons, prospect persons, employers, service suppliers, information providers, product providers, external parties, and utilities affiliated with the case; this includes the case members themselves.

Case participants also include any nominees, contacts, and correspondents on the case. Participant roles are created automatically based on the information entered about the case. For example, when a product delivery case is created, a primary client is added to the case's list of participant roles. The primary client is the person who the case is created for. A participant can have multiple roles on a single case. For example, if a communication is sent to a person, an additional role of 'correspondent' is assigned to the person. If the person is also the nominee who receives the benefit payment, a further role of 'nominee'

is assigned to the person. In this example, the person has three participant roles on one case: primary client, correspondent, and nominee.

Clients can also be associated to a case as part of a case group. Different types of case groups may be created, for example, a Benefit group can be used to group the case members that are eligible for assistance and a Financial group can be used to group the members whose income and resources are considered during eligibility determination. Case groups are typically created automatically by the system based on the execution of the eligibility and entitlement rules that are defined for a benefit product.

Determining the need for a translator

Occasionally, the agency might require a translator to mediate between a client and a user. Translation services might be needed if users on a case are unable to interact with clients in their preferred language.

A client's preferred language is recorded when the client is registered with the agency. For example, when James Smith is registered with the agency, his preferred language is recorded as "Spanish" as he cannot speak any other language. To interact with the client, the user responsible for managing James Smith's case must be able to interact with James in Spanish or have a translator who can mediate between them.

Determining the need for a translator is evaluated on a case-by-case basis that depends on the translation needs for individual cases. For example, a client might require translation services on one case but not on another. The need for a translator for a client can be recorded manually by a user or it can be determined automatically by the system. Whether the translation needs for a client are set manually by a user or automatically by the system is dictated by a configuration setting that is set for each type of case as part of the application administration. For more information, see Configuring common case information.

The need for a translator is automatically determined at various points throughout the lifecycle of a case. For example, when a new case member is added to a case, or when a case is reassigned to a new case owner. The system determines the need for a translator by checking whether the user's language skills match the client's preferred language. If they do not match, the system determines that a translator is needed. A user might also manually update the translation requirements for a case even if they are initially determined by the system.

If a translator is required for a case participant, users are kept informed of it when they view the case participant details. Additionally, the system displays the preferred language of the participant who requires the translation services.

Maintaining client contracts

A contract can be created for any member of an integrated case except for a member that is a prospect person. The prospect person must first be registered as a person in order for a contract to be created. Contracts are maintained for integrated cases only.

A contract acknowledges a case member's responsibilities specified under the terms of the contract. Examples of contracts include written contracts and verbal contracts.

Maintaining communications

A communication is a correspondence to or from the agency. Any communication created from a communication list page within a case automatically relates to that case.

Communications can be paper, telephone, or email based. Communication functionality can be integrated with Microsoft Word templates, XSL templates, or email servers.

The correspondent of a case communication is automatically assigned the case participant role of correspondent.

For more information about communications, see the Cúram communications overview.

Adding attachments

An attachment is a supplemental file, such as a text document that is attached to a case. The agency can attach scanned documents that provide information in support of a case such as a birth certificate or bank statement. Other examples of case attachments include marriage certificates, invoices, and pay slips.

A range of file types are supported including Microsoft Word, Microsoft Excel, and PDF. The system does not restrict the file size of the attachment although the agency might want to set a limit by using an application property. After the file is attached to the case, it can be accessed by other users who have appropriate security privileges.

Attachments can also be integrated with a content management system through the configuration of application properties as part of administration. If an organization chooses to integrate attachments with a content management system, the file is stored in and retrieved from the content management system rather than the application database. Information about the attachment can also be stored in the content management system. For example, the reference number of the case in which the attachment was created, the document type, and the date the document was received can be stored along with the document.

For more information about how the application can be integrated with a content management system, see the Configuring the system and the Integrating with a content management system (CMS).

Recording notes

Notes are used to provide additional information about a case. For example, a note can be added to a person's product delivery case if they have missed meetings to suggest that a home visit is scheduled.

Note: The spell check facility is deprecated. As an alternative you can use the browser spell checker.

Notes are recorded in rich text format and can be prioritized and given a sensitivity rating so that the note can be accessed only by users with the correct privileges. A spell check facility is also provided which allows users to spell check important notes. Additionally, the system can generate notes which describe case processing.

A note cannot be overwritten after it is created on the system. When a note is modified, the system maintains a note history which includes each version of a note, the time and date that the note was entered on the system, and the user who made the note modifications. The note history also includes the reason for the note, for example, created as a result of case suspension.

The system might automatically generate notes at specific stages of the product delivery lifecycle. A note is automatically generated and displayed on the case notes list every time a case is suspended, unsuspended, or reactivated.

Enabling configuration of a security allowlist for the Rich Text Editor

You can create notes by using content that is pasted from an external source. In certain circumstances, you cannot view the notes because filtering removes any unrecognized formatting tags and the content that is inside the tags. A customizable allowlist defines the set of tags that are supported.

About this task

The allowlist that is installed by default provides support only for tags that are required for features that are provided in the default configuration of the Rich Text Editor. It is possible to customize the allowlist to redefine the set of tags that are allowed, for example to include new tags to support extra markup. Also, when you create a note, an alert indicates when the allowlist filter removes any formatting or content is removed by the allowlist filter. You can then review and reformat the content as necessary by using the Rich Text Editor toolbar options.

Entries in the `whitelist.properties` file must match the following format:

```
tag=attribute1,attribute1
```

For example, the following entries allow content that is entered through the Rich Text Editor to contain a, div, and h1 tags. Also, a tags are allowed to contain href attributes. All other elements and attributes are filtered out.

```
a=href
div=
h1=
```

The allowed HTML elements and attributes are defined in the `whitelist.properties` configuration file, which is in the Resource Store. To customize the allowlist or to disable allowlist filtering, choose one of the options in the following procedure.

Procedure

Choose one of the following options:

- Customize the allowlist and persist the changes permanently to the database:
    a) Update the `whitelist.properties` file that is in `EJBServer\components\CEFWidgets\data\initial\blob`.
    b) Rebuild the database.
- Customize the allowlist through the administration user interface:
    a) Log on as an administrative user.
    b) In the **Shortcuts** panel, click **Intelligent Evidence Gathering** > **Application Resources**
    c) Search for and edit the `whitelist.properties` resource file.
    d) Upload the updated `whitelist.properties` file.
    e) To apply the changes, click **Publish**.
    f) Restart the server.
- Disable allowlist filtering by choosing one of the following options:
    - Update the custom `application.prx` file and set the value of the **curam.notes.whitelist.disabled** property to `true`.
    - Create a system property to disable the allowlist:
        1. Log on as a system administrative user.
        2. In the **Shortcuts** panel, click **Application Data** > **Property Administration**.
        3. Create a system property with a **Technical ID** of **curam.notes.whitelist.disabled** and a **Value** of `true`.
        4. Publish the update.

Certifying case evidence

A certification is the validation of case evidence during a set time period. For example, before the issue of an illness-related benefit payment, certification from a doctor might be needed to validate the person's illness. Certifications are maintained for benefit product delivery cases only.

Certification ensures that only certified periods are paid. Certifications are proposed periods of eligibility that are used to validate evidence. For example, if evidence is entered for a six-month period but only three months are certified, the evidence that is entered for the remaining three months is not validated until it is certified.

A default certification requirement can be set on benefits as a prerequisite to product delivery case eligibility. If a certification is required, the case is only active during the active certification period. Without a certification for the case, the case cannot be activated. For more information about setting the default certification requirement, see Configuring certification requirements.

Tracking issues and legal proceedings

Agencies can track issues and legal proceedings that concern case participants. Issues and legal proceedings include issues, investigations, appeals, legal actions, and special cautions. Agency can evaluate and, where necessary, escalate areas of concern and important developments that need special attention.

Issues

Issues are created on cases to manage and resolve problems that are identified during eligibility determination. For example, if the reason given by a client for leaving a job is different than the reason provided by their employer. Agencies can investigate further by creating an issue on the case to manage and resolve the discrepancy.

An issue can be created for any member of an integrated case except for a member that is a prospect person. The prospect person must first be registered as a person in order for an issue to be created.

For more information about issue management, see the Cúram Issue Management Guide.

Investigations

Investigations are used to inquire into the circumstances of an allegation or incident, such as suspected benefit fraud. Agencies receive thousands of reports each year that must be investigated.

For example, John Smith is in receipt of Income Assistance as he is unable to work due to a back injury. John's neighbor phones to say that John is working on a building site for cash and he is aware that he receiving Income Assistance.

Investigations allow agencies to record all relevant details about any type of investigation. All information about the allegation is recorded including interviews, assessments, notes, and communications sent or received. This information provides the agency with the relevant details to complete the findings, record a decision on the investigation and ultimately resolve the allegation or incident.

For more information about investigations, see the Cúram Investigations overview.

Appeals

Appeals are used to appeal one or more decisions on a product delivery, assessment delivery, or prior appeal case. For example, if a person receives benefits from the agency and the payment amount is reduced, the person can appeal the decision to restore their full benefit amount. The agency itself can also appeal decisions.

IBM Cúram Appeals

The IBM Cúram Appeals application module processes appeals for three types of appeals, hearing case appeals, hearing review appeals, and judicial review appeals.

A hearing case appeal is an appeal to overturn a decision on a case or a prior appeal. A hearing is held to decide on a hearing case appeal. This hearing is conducted by the agency and overseen by a hearing official who was not involved in the original case.

Like a hearing case, a hearing review appeal is an appeal to overturn a decision on a case or a prior appeal. However, hearing review decisions are decided by a panel of hearing reviewers and not a hearing official. Additionally, only certain case participants can attend a hearing review appeal. A hearing review is sometimes referred to as an appeals council review.

A judicial review is an appeal that is conducted by a court to overturn a decision on a case or a prior appeal. The main difference between a judicial review and other appeal types is that judicial review appeals are conducted by a court and as such, are outside the control of the agency.

For more information about Appeals, see the Appeals business overview.

Legal actions

Legal actions are used to manage directives, actions, or other activities that concern case participants that are conducted by a legal authority. Examples of directives and actions include hearings, petitions, orders, and requests. For example, a court might order a participant with a history of violence to stay away from the family home. Alternatively, the agency might prepare a petition for a court to detain a participant who committed an offense. Legal actions can result from another legal action, decision, or any other reason that is deemed appropriate by the agency. For example, a legal action such as a temporary custody petition might result in a temporary custody hearing that is scheduled as a result of the petition.

Three main categories of legal action are supported:

- Legal Petition
- Legal Hearing
- Legal Order

The process for managing hearings for both legal action hearings and hearings for appeals is the same.

For more information about legal actions and appeals, see the Appeals business overview.

Special cautions

Special cautions can be recorded for case members to highlight any items that need special attention. This information is recorded to ensure the safety of the person and the agency. Special cautions are typically directly associated with the safety of the person or the safety of others in relation to a person. Categories of special cautions include health alerts, behavioral alerts, and safety alerts.

The list of special cautions can be configured to meet the requirements of the agency. When a special caution is recorded for a case member, a special caution category and type is captured. Special caution types include suicide risk, health, such as allergies or contagious disease, special dietary needs, or safety issues. For example, pertinent criminal history such as violent or sexual offender. When a special caution is no longer current, an end date is recorded which saves the special caution on a list of historical cautions.

Users are kept informed of special cautions for case members with the special caution icon. When a case member has one or more active special cautions, this icon is displayed on the person's home page. The complete list of special cautions can be accessed by the icon. Special cautions can be recorded only for person participants.

Reassessing case eligibility and entitlement

Information about a client is constantly changing and those changes can impact their eligibility and entitlement. Case reassessment updates client eligibility and entitlement as circumstances change. Reassessment occurs automatically when evidence is added or modified that might change the result of previously created determination and decisions. Reassessment can also be initiated manually.

For example, when a client submits new income information, which is used to determine eligibility for income support, reassessment occurs automatically. Reassessment results in a new determination and decisions based on that income if the client's eligibility or entitlement changes.

Reassessment can also result in the creation of a new determination when changes to evidence only impact decision details. For example, if a change in circumstance update to the family's total income doesn't affect the client's eligibility or entitlement amount, but the information is displayed in decision details, a new determination and decisions is still created. An agency can configure whether a new determination is created when only decision details change, see Configuring a determination comparison strategy section.

When case reassessment results in a new determination, it includes any new decisions and new decision details information. Information about the date and time on which reassessment last completed and the date and time when decisions were last updated is displayed. Users can understand not only when reassessment last completed, but also when a reassessment doesn't result in the creation of a new

determination and decisions. For example, when new asset evidence is added to the case but does not result in a change to the client's eligibility or entitlement, or to the decision details displayed.

Informational messages are also displayed to provide further detail about the status of reassessment for a case. These messages indicate when reassessment is in progress, when changes that result in reassessment are currently pending processing, and when reassessment is deferred to batch processing due to an unanticipated error with online reassessment processing. Caseworkers can see whether assessments that are due are not complete due to an in-progress reassessment or to a failure in the reassessment process.

An agency can configure whether informational messages are displayed by enabling or disabling the messages with the configurable validations manager in application administration. For more information, see the Working with configurable validations and the Case-level reassessment.

If reassessment is in progress in a case, manual reassessment is prevented until the reassessment completes. Users are not blocked indefinitely from reassessing the case. This 'lockout' time is configurable with the `curam.case.reassessment.aggregation.wait.period` application property. After this time, the user can start manual reassessment, even if another reassessment is in progress.

An agency can also configure whether automatic reassessment occurs for a closed case. For more information, see the Configuring eligibility determination and decisions.

An agency can also choose to prevent reassessment and the creation of a new determination from occurring within a case under certain conditions. For example, after a payment is issued for cases with one-off payments. Development effort is needed for this use case, see Case-level reassessment.

Overpayment and underpayment processing

When a new determination is created, a comparison is done to see whether payments were processed based on the previous, now superseded decision information. This comparison can result in an over or under payment. When a reassessment results in new decisions, the system automatically compares the new decisions to any existing decisions that were processed into payments or bills. If the processed amounts are different from the eligibility and entitlement amounts in the new decisions, an over or under payment is created. An overpayment is when too much was paid on the case. An underpayment is when too little was paid on the case.

Although new determinations can be created when a case is in a status of "active", "suspended", or "pending closure", over and under payments are not created for a suspended case. Additionally, an agency can prevent the creation of new determinations and over and under payments for closed cases by setting an application property. For cases that include suspended payments, an over or under payment is still created when a new determination is created. Over or under payments might be related to several payments over a period, some of which might not be suspended and are therefore valid. This provides an agency with the opportunity to act on a suspended payment, or if the suspended payments cannot be acted upon in a timely manner and the agency does not want to create over or under payments on cases with suspended payments, the case itself can be suspended.

Users can view information about over or underpayments to understand which components were involved. For example, a user can view an overpayment of $200 and see that it resulted from an overpayment of $150 for Component A and an overpayment of $50 for Component B. Additionally, the two decisions that resulted in the over or underpayment can be compared. For more information about comparing two decisions, see "Comparing decisions" on page 11.

Three case types allow the agency to manage and correct over or underpayments that are detected during case reassessment:

- The overpayment case type is used to correct overpayments only.

- The underpayment case type is used to correct underpayments only.

- The payment correction case type can be used to correct either over or underpayments on a case. Unlike the overpayment and underpayment case types, users can see over and underpayment amounts that are broken down by case component for a nominee. For example, a user can view a breakdown

of an overpayment of $400 that is made up of an overpayment of $500 for Component A and an underpayment of $100 for Component B. An agency can configure whether a payment correction case is used.

An agency can choose to prevent the creation of over or underpayments as a result of the reassessment of a case. For example, if the creation of an overpayment in one case needs to be held for a period while a user continues to manage evidence changes for other cases that use the same evidence. Development effort is needed for implementation, see Developing with Eligibility and Entitlement by using Cúram Express Rules.

Suspending, closing, or reactivating cases

You can suspend, close, or reactivate product delivery cases during the case lifecycle.

Suspending a case

Agencies might need to suspend an active product delivery case. For example, the agency might suspend a person's benefits if it suspects that the person is committing benefit fraud.

Agencies can configure whether payments are issued up to the suspension date of a case with an application property in the administration application. For more information, see Configuring case suspension and case closure.

- If configured to continue payments, payments continue to be paid until the date of suspension.
- Otherwise, no additional payments are issued until the case is unsuspended, approved, and activated again.

A suspended case can be unsuspended. For example, if the agency later discovers that the person who is suspected of benefit fraud is innocent. The status of the unsuspended case returns to open. Future payments are issued only after the case is approved and activated again.

Closing a case

A case can be closed automatically by the system when its certification period expires or if it is found to be ineligible and the system is configured to automatically close ineligible cases. A case can also be manually closed at any stage during its lifecycle or set to close on a date in the future. The case closure date, actual outcome of the case, and case closure reason is specified.

When a case is closed, reassessment is initiated and a new determination is created if needed to reflect the final set of decisions for the case. For example, if a case is open ended with no expected end date, upon closure a new determination is created with a final eligible decision effective until the closure date of the case.

Agencies can configure whether payments are issued up to the closure date of a case with an application property in the administration application. For more information, see Configuring case suspension and case closure.

- If configured to continue payments, the financial components are recalculated based on the closure date provided.
- Otherwise, existing financial components are closed out and no further payments are issued.

All information and events that are associated with that case, such as case reviews and case referrals, are also closed and a case communication is printed for the primary client. A case communication is a correspondence to or from the agency that is created within a case. Additional case closure communications can be created for other case participants, such as a service supplier on a case referral.

When a case is set to close on a date in the future, the case enters a grace closure period during which new determinations might be created and reassessment might continue to occur, and the status of that case is set to pending closure. It remains in this status until the closure date is reached and the Close Cases Pending Closure batch process is run, or until a user manually closes the case. If the Close Cases Pending Closure batch process is run on a date after the expected date of closure, the closure date is set

to the date on which the case was closed. If a case is already closed, the case closure date cannot be moved to a future date.

By default, a case that has open tasks that are associated with it cannot be closed. The agency can allow cases that have open tasks to be closed by setting an application property in the administration application.

Reactivating a case

Cases with a closed or pending closure status can be reactivated. For example, a person's benefits might be discontinued when the person is in regular employment. If that person is made redundant from the new employer, and the person is again eligible for benefits, the existing product delivery case can be reactivated.

The status of the reactivated case is open. For benefits to be delivered on the case, the case must go through the case approval and case activation stages again. Benefits resume only after the case is approved and activated again.

Securing cases

Case security is used to secure access to important case and client information. When a user attempts to access case information, case participant information, or maintain a case, the system checks the user's security access to ensure that they have appropriate user privileges.

A user's security access is set up as part of security administration. The user's security privileges determine what case information can be accessed, viewed, and changed by users. Certain users might not have the same access as other users. For example, case supervisor users might be allowed to approve cases and a trainee user might not.

Case security is provided at various levels within the application. Each level is geared toward securing a particular aspect of a case. Organizations can use one or a combination of the following levels of security to enable or restrict what a user can do.

Securing general case maintenance

A user's ability to do general case maintenance is set up as part of system administration by using function security. General case activity can be secured include registering a person and creating a case, approving a case, and suspending payments.

Function security governs user access to all functions accessible from the client application. A user's ability to maintain a case is governed by the user's security role, security group, and the security identifiers assigned to the maintenance functions during system administration. This data is set up in a hierarchy. The user's security role is the highest level of the hierarchy, the user's security group is at the second level, the security identifiers and case operations, which are defined by function identifiers, are at the third and fourth levels.

The hierarchy includes the protected resources that a user can access such as functions, fields, products, assessments, outcome plans, investigations, and appeals.

For more information about securing user access to all server functions, see User security profiles.

Protecting fields from general user access

Fields can be protected from general user access by using field security. Field level security determines whether users can view information in specific fields. For example, the organization might want to restrict access to a client's salary details from junior caseworkers. The client's salary details can be protected from general user access.

For more information about protecting fields from general user access, see Securing application elements.

Securing case and client information based on location

Access to case and client information can be secured based on the user's location and the location of the user's position in the organization.

Location-based security is used to authorize a user's ability to access case and client information based on their location within the organization. A user can access case information only if the user's location is successfully compared to either the location of the case owner if the case owner is a user or the location of the primary client of the case.

For more information about location-based security, see the Cúram Location Administration Guide.

Securing maintenance for specific programs and features

The application provides a level of security that allows the organization to secure case maintenance for specific programs. Program security authorizes a user to approve, maintain, create, and view program information. The purpose of program security is to provide an extra layer of security for cases that facilitate the authorization and delivery of benefits. For example, an organization might want to restrict access to certain types of programs to a certain set of users in the location that also have the required security identifiers.

Program security is set up on a product by product basis. When a user attempts certain processes that are associated with a product delivery case, the system determines whether the user has the necessary security identifiers for the secured program. This additional layer of security is also available for services, assessments, investigations, appeals, payment corrections, and outcome plans.

Securing access to sensitive case information

Sensitivity security determines user access to sensitive information by comparing the user's sensitivity level to the element's sensitivity level. Sensitivity levels are in the range 1-5 with 5 being the highest level. Sensitivity ensures that only users who can be trusted with certain information can access that information. For example, certain cases might be high profile. The data on such cases would have a high sensitivity level. Only users with the same high sensitivity level can access the case information.

Case notes are assigned a sensitivity level whereby only users with a sensitivity equal to or higher than the sensitivity level for the case note can view the note details. Extra sensitivity security is available for services and outcome plans. All services, and the actions and attachments within an outcome plan are assigned sensitivity levels. For a user to have access to the specific service or action and attachment within an outcome plan, the user must have a sensitivity level equal to or higher than the specific data.

For more information about location-based security, see the Cúram Location Administration Guide.

Notices

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