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Helping Inmates Obtain Federal Disability Benefits

Serious Medical and Mental Illness, Incarceration, and Federal Disability Entitlement Programs

Field Note

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Report Highlights

Thousands of severely ill inmates are released from the Nation's prisons and jails each year. Helping them find ways to pay for medical and mental health care and living expenses is thought to be a crucial part of ensuring their successful return to the community. Some of these releasees may be eligible for disability benefits available through Federal entitlement programs, such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Medicaid, Medicare, and veterans pension or compensation funds. Making these types of benefits available to qualifying releasees as soon after release as possible is believed to be critical to preventing relapse, recidivism, and reinstitutionalization.

One way to increase the probability that benefits commence shortly after release is to file the necessary paperwork before inmates are released. Because application processes are typically complex and time-consuming, and because inmates face a number of obstacles to completing applications themselves, ill inmates are likely to fare best when qualified discharge planners assist in filing applications.

This report describes the experiences of three sites—the State of New York, the city of Philadelphia, and the State of Texas—that help prison or jail inmates prepare and file pre-release applications to initiate or restart Federal disability benefits. Through formal or informal partnerships, corrections, benefits, and healthcare professionals in these sites help inmates negotiate the applications process. Assistance may include assembling inmates' identification, financial, and health records; preparing and filing pre-release applications for benefits; monitoring the status of applications; assisting with

appeals when necessary; and working to ensure that releasees actually obtain benefits that are approved.

The sites have learned that helping offenders to obtain Federal disability benefits not only can increase offenders' access to community-based care, it can also 1) reduce the financial burden on State and local governments that fund indigent health care systems and 2) increase the number of disabled offenders who receive treatment. Site experiences suggest other important lessons regarding helping inmates to obtain benefits:

- Interagency partnerships are an essential ingredient in the benefits application process.
- Dedicating staff to benefits tasks can build expertise, improve communication, and streamline the benefits process.
- Finding ways to finance treatment and monitor releasees until benefits commence is essential to ensure that qualifying releasees actually receive benefits.
- Tracking outcomes of the benefits process is beneficial to improving procedures and sustaining program funding.
- Centralizing operations can help reduce processing delays and improve communication among partner organizations.
- Assisting mentally ill inmates and releasees can pose special challenges.

Helping inmates apply for medical and cash assistance is an important way to assist severely ill inmates who are returning to the community, but the experiences of the three sites described in this report suggest that this assistance should be viewed as only one facet of a much broader discharge plan. The benefits applications process is complicated and, if it involves SSI or SSDI, can take a long time before an eligibility determination is made. Furthermore, there is no guarantee that claims will be approved. In addition, relatively few inmates or releasees apply for benefits and, when these

benefits involve SSI or SSDI, only a small percentage of them succeed on their first try. Even releasees who ultimately qualify for and receive benefits are likely to find it challenging to avoid relapse or recidivism, unless other supports, such as case management services and housing are made available.

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Introduction

On any given day, tens of thousands of inmates with serious medical or mental health conditions are housed in Federal, State, and local correctional facilities around the Nation.[1,2] Indeed, prevalence rates for certain mental illnesses such as schizophrenia and bipolar disorder, chronic diseases such as asthma, and infectious diseases such as tuberculosis, hepatitis C, and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) are estimated to be significantly higher among prison and jail inmates than among the population at large.[3] In addition, for a major portion of these inmates regular use of drugs or alcohol has contributed to or exacerbated their health and mental health conditions.[4] Prior to incarceration, many also experienced precarious lifestyles marked by periods of homelessness, joblessness, incarceration, hospitalization, family instability, and limited or sporadic health and mental health care.[5] Some inmates who are ill have been trapped for years in a cycle of relapse, recidivism, and reinstitutionalization.

Although access to effective screening and treatment during incarceration appears to vary considerably according to jurisdiction, correctional setting, or type of illness,[6] many severely ill inmates receive assessment and care for the first time in their lives while incarcerated, and many of them are released while still receiving treatment.[7] Continuing this care after release or ensuring that proper treatment commences immediately following community reentry is important to:

- Increase the probability of positive health outcomes, prevent relapse, and, when applicable, prevent the development of drug-resistant strains of viruses;
- Prevent the spread of disease;
- Reduce the likelihood of recidivism related to illness;

- Insure the health, safety, and stability of families and communities that must assist and cope with releasees who are ill; and
- Minimize costs to community health care systems or to prison and jail health care systems should releasees return to correctional facilities.[8]

Helping ill releasees find ways to pay for medical and mental health care and to pay for living expenses is thought to be a crucial part of accomplishing these goals. Options for some releasees include disability benefits[9] available through five Federal entitlement programs:

1) Supplemental Security Income (SSI),
2) Social Security Disability Insurance (SSDI)—disability insurance benefits available through the Retirement, Survivors, and Disability Insurance (RSDI) program,
3) Medicaid,
4) Medicare, and
5) Veterans compensation or pension funds.

However, making these types of benefits available to qualifying releasees ***as soon after their release as possible*** is believed to be a key factor in their successful return to the community. Without medical benefits to facilitate access to care or an income to help pay for a place to live, releasees who are ill are thought to be at increased risk for lapses in treatment, re-hospitalization, or return to the criminal justice system.[10] Although research to determine whether having benefits improves the health and criminal justice outcomes of severely ill releasees is only now underway or being planned,[11] researchers hypothesize that releasees who obtain benefits are more likely to seek and continue care than releasees who do not.[12] Findings from a study of health care needs and use among

injection-drug users, other chronic drug users, and non-drug users, which showed that study respondents with health insurance were significantly more likely than those without insurance to report both need for and use of care, lends support to this hypothesis.[13]

Estimates of the number of severely ill inmates who may be eligible for one or more entitlement benefits at release are not readily available, but experience suggests that the pool of prospective candidates includes the following types of individuals:

- those who were receiving benefits when they entered jail or prison and had their benefits reduced, suspended, or terminated (depending on the benefit) following admission;
- those who have never applied for benefits but whose circumstances suggest that they may qualify for disability benefits;
- those who applied some time prior to incarceration but had their claims denied or closed for lack of information;
- those who entered jail or prison with applications pending; and
- those who have received benefits at some time in their lives but lost them.

Individuals in each group face unique issues with respect to obtaining benefits, but across these groups ***the probability that qualifying individuals will receive benefits shortly after release is likely to increase dramatically when benefits planning occurs during the period of incarceration and the necessary paperwork is filed before release***.

In addition, for a host of reasons, including impaired health, limited self-advocacy skills, inability to move freely while incarcerated to collect information and respond to requests from benefits agency representatives, and difficulty understanding the complexities of the benefits application process itself, ***individuals in each of these categories are likely to require assistance from qualified discharge planners in order to guarantee that benefits applications are filed and reviewed in a timely fashion***.

Depending on individual circumstances, this assistance may involve the relatively uncomplicated tasks of helping inmates to assemble identification materials (e.g., social security cards) and release papers, and contact appropriate benefits personnel prior to or immediately following release. Alternatively, the assistance may be more complicated and include preparing and filing pre-release applications for benefits on inmates' behalf, assembling their financial and health records, monitoring the status of applications, assisting with appeals when necessary, and ensuring that releasees actually obtain benefits that are approved.

Unfortunately, discharge planning for severely ill inmates, with or without the provision of assistance with obtaining benefits, is still more the exception than the rule.[14] Yet, increasingly, political leaders, corrections departments, social services agencies, community-based organizations, and researchers are turning their attention to this important issue and looking for ways to guarantee that releasees who qualify for medical and cash benefits obtain these entitlements in a timely manner.[15]

To shed light on how some jurisdictions are approaching this challenge, ***this report focuses on the experiences of three sites that help severely ill inmates prepare and file pre-release applications to initiate or restart Federal entitlement benefits (i.e., SSI, SSDI, Medicaid, Medicare, or veterans)***.[16] These include:

- **The State of New York**, whose Division of Parole has established a Memorandum of Understanding with the Social Security Administration (SSA) to file pre-release applications for SSI and SSDI for severely mentally and medically ill inmates housed in State prisons;

- **Philadelphia County (City of Philadelphia), Pennsylvania**, where individuals in the Coordinating Office for Drug and Alcohol Programs (CODAAP) of the City of Philadelphia Behavioral Health System have established an informal agreement with the Philadelphia County Assistance Office of the Pennsylvania Department of Public Welfare to

expedite access to Federal or State medical assistance for parolees from the city jail who participate in the city's Forensic Intensive Recovery (FIR) Program; and

- **The State of Texas,** where the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI), part of the Texas Department of Criminal Justice (TDCJ), has an MOU with SSA to aid inmates with mental illness, mental retardation, or physical disabilities file pre-release applications for SSI and SSDI.

Although their inmate populations and benefits assistance procedures differ, all three sites:

1) provide benefits assistance to sentenced jail or prison inmates prior to release;

2) target inmates who have been screened (and, in many cases, treated) for medical or mental illnesses while incarcerated;

3) rely on interagency partnerships to help inmates to initiate benefits claims; and

4) have several years' experience assisting inmates with benefits applications.

The report is intended to inform professionals in corrections, health and mental health care, community-based organizations, and benefits organizations about the issues involved in helping inmates with disabilities obtain medical and cash assistance. It provides information gathered from the literature on severely ill inmates and their need for benefits, Federal benefits publications and websites, telephone interviews with experts on corrections and benefits issues, and visits to the three study sites. The remaining sections provide:

- An overview of Federal policy regarding entitlement benefits, with a spotlight on inmate issues;

- A description of approaches to benefits assistance in the three study sites; and

- A discussion of lessons learned from the experiences in those sites.

For those interested in learning more about the topics discussed here, relevant resources and websites appear at the end of the report.

Federal Entitlement Benefits

This section offers a brief summary of the disability benefits components of the five Federal entitlement programs identified above.[17] It also highlights rules and regulations pertaining to the benefits for incarcerated individuals. Since the rules and regulations for each of these benefits programs are complex, those seeking detailed information about them will want to refer to the resources listed at the end of the report or contact State and Federal benefits agencies directly.

Benefits Administered by the Social Security Administration—SSI and SSDI

The Social Security Administration (SSA) administers two programs that provide monthly cash benefits to disabled individuals who meet certain criteria: Retirement, Survivors, and Disability Insurance (RSDI or Title II)[18] and Supplemental Security Income (SSI or Title XVI). Disability insurance under RSDI is commonly referred to as Social Security Disability Insurance (SSDI). For most applicants, the medical requirements and the disability determination process for SSI and SSDI are the same (see "Determining Disability" below). In order to receive disability benefits under SSDI or SSI, an applicant must meet certain non-medical criteria and must be found to have a physical or mental impairment that either has lasted, or is expected to last, for at least a

year, or will result in death. The impairment must also be so severe that the individual is unable to engage in any substantial gainful activity.

Overview of SSDI

SSDI is a program financed with Social Security taxes that have been paid by workers, employers, and self-employed persons into the Social Security Trust Fund. Individuals may be eligible for SSDI based on their own contributions or based on the contributions of a family member. Persons who are eligible based on their own work records must have accumulated a sufficient number of credits for taxable work income (usually 20 credits in the last 10 years ending with the year in which the disability occurred, although workers aged 30 or younger may qualify with fewer credits).[19] Given the focus of this report, it is important to note also that, beginning October 19, 1980, individuals who acquired their disabling impairment as a result of the commission of a felony (or "High Misdemeanor" in New Jersey) for which they were convicted are barred for life from receiving SSDI benefits *based on that impairment*, although they may have other impairments that qualify them for SSDI.[20] In addition, Federal law prohibits payment of disability benefits to SSDI applicants if drug or alcohol abuse is a contributing factor material to the determination of disability—that is, when it is the sole or primary diagnosis.[21]

Once approved for benefits, an individual may begin receiving SSDI payments in the sixth month after SSA determines that the disability began. The amounts paid vary according to the amount of the insured worker's contributions to the Social Security Trust Fund.

Overview of SSI

Unlike SSDI, SSI is a means-tested entitlement that is financed through general tax revenues and is available to aged,[22] blind, or disabled people who have limited assets and income. Recipients must be U.S. citizens or "qualified aliens."[23] Fugitive felons are not eligible for SSI, and individuals who deliberately dispose of resources in order to receive SSI may be ineligible for benefits for up to 36 months.[24] Individuals whose primary or sole diagnosis is drug or alcohol abuse are also barred from receiving SSI.[25] Since SSI is considered a benefit of last resort, SSI applicants must agree to apply for all other cash benefits to which they may be entitled (e.g., SSDI, pensions, veterans benefits) before receiving SSI.

SSI disability benefits are paid the first full month after the date a claim is filed or the date the individual becomes eligible for SSI. The Federal government pays a Federal benefit rate, which, in 2004, was $564 for disabled individuals. Rates vary across States, however, because many States supplement the Federal benefit rate according to their own rules. In addition, some individuals may have their benefits reduced if they have other income or resources.

Determining Disability

Determining eligibility for SSI or SSDI disability benefits involves five sequential steps. (See figure 1: "Five Steps to Determining Disability for SSI or SSDI.") SSA staff in the field office where a claim is filed complete ***the first step***: determining whether a person meets the non-medical eligibility criteria for benefits.

Figure 1: Five Steps to Determining Disability for SSI or SSDI

Step 1: Are you working?

- If yes, and earnings average more than $800 a month (in 2003), the claim is denied.
- If yes, but earnings average less than $800, the claim proceeds to the next step.
- If no, the application proceeds to the next step.

Step 2: Is your condition severe?

- If the condition does not interfere with basic work-related activities, the claim is denied.
- If the condition interferes with basic work-related activities, the claim proceeds to the next step.

Step 3: Is your condition on the list of disabling impairments?

- If yes, or deemed to be of equal severity as those on the list, then the claim is approved.
- If no, or not deemed to be of equal severity as those on the list, the claim moves to the next step.

Step 4: Can you do the work you did previously?

- If yes, the claim is denied.
- If no, the claim moves to the next step.

Step 5: Can you do any other type of work?

- If, after considering your age, education, past work experience, and transferable skills, and reviewing demands of occupations determined by the Department of Labor, the answer is yes, the claim is denied.
- If the answer is no, the claim is approved.

Source: Adapted from Social Security Administration, *How to Apply for Social Security Disability Benefits*, http://www.ssa.gov/disability.html.

- To meet the non-medical eligibility criteria for SSDI, a person must have accumulated the required number of work credits and, if working, be earning no more than $800 a month (for 2003).

- For SSI, an applicant must meet all of the requirements pertaining to resources, citizenship, living arrangement, and residence, and be earning no more than $800 a month.

- For both SSDI and SSI, if non-medical eligibility is not established, a claim is denied at that point.

Once a person's non-medical eligibility is established, a claim is forwarded to the Disability Determination Services (DDS) office in the State where it was filed for completion of ***the remaining four steps*** in the process. A DDS team consisting of a disability examiner and a medical or psychological consultant reviews the applicant's medical and mental health evidence to determine whether the individual is disabled according to Social Security law. (See figure 2: "Medical Evidence Required for Determining Disability.") The team uses the evidence provided in the application and usually gathers additional information in order to answer four questions related to the applicant and his or her disability.

1) First, the DDS team asks whether the person's medical or mental health condition is severe enough to interfere with basic work-related activities. If not, the person is deemed ineligible for disability benefits.

2) If the condition is sufficiently severe, the DDS team proceeds to the second step to determine whether the condition is included in the list of disabling impairments[26] that *automatically* qualify a person for benefits. If the condition is on the list, or if the condition is of equal severity to one that is on the list, then the person is found to be disabled and qualifies for benefits at that point.

3) If the condition is not on the list or is not deemed to be of equal severity to those on the list, then a third question is asked to determine whether the person's condition interferes with the work he or she did previously (generally, within the past 15 years). If the condition does not interfere with work completed previously, the claim is denied.

Figure 2: Medical Evidence Required for Determining Disability for SSI or SSDI

Sources: Information must be provided by one or more of the following "acceptable medical sources":

Licensed Physicians
Licensed or Certified Psychologists
Licensed Optometrists
Licensed Podiatrists
Qualified Speech-Language Pathologists

Evidence:

Medical Evidence from Treating Sources (e.g., hospitals, clinics, or other health facilities to provide a longitudinal history of impairment)

Other Evidence Regarding Ability to Function in a Work Setting

Medical Reports that include:

- Medical history
- Clinical findings
- Laboratory findings
- Diagnosis
- Treatment prescribed with response and prognosis
- Provider's opinion regarding what the claimant can do despite the impairment

Consultative Examinations by an independent source (e.g., if the treating source is unable or unwilling to complete required examinations). These are ordered at the discretion of the State Disability Determination Services office and paid for by that office.

Evidence Relating to Symptoms

- Location, duration, frequency, and intensity
- Precipitating and aggravating factors
- Type, dosage, effectiveness, and side effects of medication
- Treatments, other than medications
- Other information about the claimant's functional limitations due to the symptoms

Source: Adapted from Social Security Administration, *Disability Evaluation Under Social Security*, January 2003: 13-18.

4) If the condition does interfere with work completed previously, then the final question is asked: Can the person adjust to other work? After considering the person's age, education, past work experience, and any transferable skills, the person's claim is approved if he or she cannot adjust to other work or is denied if other work is possible.

After making the disability determination, the DDS office returns the case to the SSA field office, which notifies the applicant regarding the disability determination. If the DDS finds the claimant disabled, SSA computes the SSI benefit amount and makes arrangements to begin payments. If the claim is denied, the field office retains the file in case the applicant decides to appeal the disability determination.

SSA estimates that review of an initial disability claim can take from 90 to 120 days. If disability is denied and appeals are filed, the time until a final determination is made can be considerably longer (several years, in some cases).

The appeals process has four levels:

1) reconsideration of the evidence by a different team within the DDS office;

2) review or hearing before an administrative law judge within SSA's Office of Hearings and Appeals, who may request additional medical evidence;

3) review by an Appeals Council; and

4) the filing of a civil action with a U.S. District Court, which reviews the evidence in the case.

After a denial at one level, an applicant or representative may file an appeal to the next level within 60 days of receiving notification that the claim has been denied.

Incarcerated SSDI or SSI Recipients

Incarcerated individuals who were receiving SSDI prior to their incarceration have these benefits suspended if they are convicted and spend more than 30 continuous days in jail or prison. Individuals who are in jail awaiting trial continue to receive SSDI benefits until they are convicted and incarcerated for 30 days. Family members who were receiving SSDI benefits based on the convicted individual's work record may continue to receive benefits while the individual is incarcerated provided they are not convicted and incarcerated themselves. An individual's SSDI benefits will be restored following release, regardless of the amount of time the offender has served, once the individual files a request with SSA and the agency receives proof of the individual's release from the correctional facility.

Individuals who were receiving SSI prior to incarceration have these benefits suspended after they have served a full calendar month in jail or prison. Incarcerated SSI beneficiaries do not have to have been convicted in order to have their benefits suspended; rather, their benefits are suspended because they are housed in a public institution (e.g., prison or jail) for a full calendar month.[27] Once they are incarcerated for 12 consecutive, full calendar months, their SSI benefits are terminated. Individuals who are released after serving less than 12 consecutive, full calendar months may apply to have their benefits restored. SSA confirms their living arrangements, resources, income, and release status before restoring benefits. Individuals who serve 12 consecutive calendar months or more must reapply for benefits and resubmit non-medical and medical and mental health records for review by the SSA field office and the State DDS office.

How SSA Verifies Incarceration Status

According to SSA, most State and local corrections departments provide SSA with data on new admissions on a monthly basis. These data include inmate name, social security number, date of birth, gender, date of conviction, date of confinement, release date, and inmate status, among other things. SSA uses the data to update information on the institutional status of its beneficiaries. Since SSA benefits data are routinely shared with Federal benefits paying agencies, including State welfare agencies that oversee Food Stamps, Medicaid, and Medicare benefits, these agencies also have access to information on the institutional status of SSI and SSDI recipients and non-recipients.

SSA pays corrections departments $400 for information received within 30 days of the inmate's date of confinement or conviction, or $200 for information received between 31 and 90 days of the inmate's date of confinement or conviction.[28] In addition, SSA will provide participating correctional institutions with verification of inmates' social security numbers if such a report is requested.[29] Having accurate social security numbers can help to expedite the pre-release application process.

Pre-Release Applications for SSI and SSDI

In order to expedite the processing of applications for SSI, residents of public institutions (e.g., jails or prisons) may submit pre-release applications for benefits. ***Inmates with work histories may also submit applications for SSDI before their release.*** Individuals may make these applications even when there is no (formal or informal) pre-release agreement between the institution and SSA,[30] but pre-release agreements have

certain features designed to accelerate claims processing that make them desirable. (See figure 3: "Standard Elements of Pre-Release Agreements.") Pre-release applications are accepted when applicants 1) are in an institution, 2) appear likely to meet the criteria for SSI eligibility following release, and 3) are expected to be released 30 days following notification of potential eligibility. When an individual whose claim is medically approved is not released from the institution within 30 days of notification of potential eligibility but release is likely to occur within the one-year life of an approved application, the field office may hold the claim until release.[31] When release is unlikely within the life of the application, the field office may take final action to deny the case. [32]

If a claim is denied prior to release, an inmate or a representative may file an appeal. If a claim is medically approved prior to release, the applicant or a representative must still provide SSA with information on release status, income, resources, and living arrangement following release in order for benefits to commence.

Medical Assistance—Medicare and Medicaid

Most disabled people who receive SSDI, SSI, or some combination of the two are eligible for Medicare or Medicaid. A small group of Medicare beneficiaries with low incomes also qualify for Medicaid coverage.[33] Commonly referred to as "dual eligibles,"[34] these individuals make up about 10 percent of Medicare recipients. [35] This section provides an overview of Medicare and Medicaid and highlights issues pertaining to inmates who have received or seek coverage under one or both programs.

Figure 3: Standard Elements of Pre-Release Agreements

Pre-release agreements may be formal or informal.

They are allowed if a person:

- is in an institution;
- appears likely to qualify for disability benefits when he or she is released; and
- is expected to be released within 30 days of receiving medical approval.

The institution typically agrees to:

- notify SSA if the applicant meets the above criteria;
- provide current medical evidence and non-medical information to process the claim;
- provide information regarding release dates and update SSA if there is a change; and
- notify SSA when the individual is released.

SSA typically agrees to:

- process the claim or reinstatement as quickly as possible and
- notify the institution promptly regarding the decision on the claim.

Source: Adapted from Social Security Administration, *Understanding Supplemental Security Income 2002 Edition*, April 2002: 89.

Overview of Medicare

Individuals who have been approved for SSDI benefits generally become eligible for Medicare after a two-year waiting period. Medicare has two parts: Part A (the Hospital Insurance Program) and Part B (the Supplementary Medical Insurance Program).[36] Part A is financed mainly through payroll taxes paid by employees and employers; Part B, which is voluntary, is financed through beneficiary premiums and general revenue. Part A covers inpatient hospital services (subject to a deductible and coinsurance after the 60th day), skilled nursing facility benefits, home health visits following a hospital stay, and hospice care. Part B covers physician services, outpatient hospital services, some other services not covered by part A (e.g., physical and occupational therapists), some home health care, and medical equipment. On December 8, 2003, the President signed a bill that changed a number of features of Medicare coverage, including expanding coverage to include prescription drugs.[37]

Incarcerated Medicare Recipients

When a disabled person who has been receiving Medicare is incarcerated, Medicare coverage is suspended and does not resume until SSDI payments resume.[38] Although inmates automatically retain their Part A coverage while incarcerated, in order to retain Part B coverage they must continue to pay their premiums during the period of incarceration.[39] If Part B coverage ends because a person fails to pay premiums, he or she is eligible to re-enroll during the General Enrollment Period (January through March of each year), with some financial penalty and, generally, at a higher premium rate.[40]

Overview of Medicaid

Medicaid is a means-tested entitlement program that provides medical insurance to low-income people. It is funded jointly by the Federal government, which sets broad guidelines for its operation, and the States, which administer the program. The Federal government matches State Medicaid funding based on a formula that compares a State's per capita income to the national average. In order to receive Federal funds, States must agree to provide coverage for a set of core services[41] to individuals in certain eligibility categories. However, States have the option to expand the range of services covered and the eligibility groups within categories. As a result, there is considerable variation in Medicaid coverage across States.

To be eligible for Medicaid, an applicant must meet set financial criteria pertaining to income and resources; be a member of a group that is "categorically eligible" for benefits (i.e., children, pregnant women, adults in families with dependent children, individuals with disabilities, or the elderly); be a U.S. citizen or qualifying immigrant; and be a resident of the State where the application is filed.

Although there are a number of ways that people with disabilities may qualify for Medicaid, most do so by qualifying for SSI.[42] In 39 States and the District of Columbia, SSI recipients automatically receive Medicaid. Seven of these states require separate Medicaid and SSI applications, but, as "criteria sites," they use the SSI criteria regarding income and disability to make their Medicaid decisions. The remaining 32 of the 39 States and the District of Columbia have an agreement with SSA to have it make Medicaid decisions about persons receiving SSI benefits. In these sites, SSA will notify SSI recipients that they will hear from their Medicaid offices regarding Medicaid

acceptance. However, when SSI is denied in a State with this agreement, SSA does not determine Medicaid ineligibility. Instead, the determination is handled by the State offices designated to administer Medicaid, which notify candidates directly about the offices' decisions.

Eleven states have elected to use more restrictive eligibility standards for their Medicaid programs than those specified for SSI. They require separate SSI and Medicaid applications and make separate decisions regarding SSI and Medicaid eligibility. Nevertheless, most people who are eligible for SSI in those states are also reported to be eligible for Medicaid.[43]

Roughly 20 percent of individuals with disabilities qualify for Medicaid through some means other than SSI eligibility.[44] In particular, States may opt to offer Medicaid coverage to a number of other groups of individuals with disabilities. For example, 36 States have opted to create "medically needy" groups for disabled people with high medical expenses.[45] Other States provide Medicaid access to the working disabled whose earnings disqualify them for SSI but are still low enough to qualify for Medicaid. A number of other types of disabled individuals may qualify for Medicaid, depending on the State.[46]

Disabled individuals who receive Medicaid have a wide range of physical and mental conditions, such as severe mental illness, cerebral palsy, cystic fibrosis, Downs Syndrome, mental retardation, or HIV/AIDS.[47] Medicaid excludes some impairments, such as drug addiction and alcoholism, as qualifying conditions.[48]

Incarcerated Medicaid Recipients

Individuals who received Medicaid prior to incarceration are generally barred from receiving Federal Medicaid payments during the period of incarceration, but Federal law does not require that Medicaid eligibility be terminated due to incarceration.[49] In practice, however, most states terminate Medicaid eligibility for people who are incarcerated, which means they must have their benefits reactivated after release.[50] When a person's Medicaid eligibility is tied to his or her SSI eligibility, reinstatement of Medicaid benefits following release depends on the person's SSI status at the time of release (i.e., whether SSI benefits have been suspended or terminated). For these individuals, Medicaid will be restored once SSI eligibility is restored. For individuals whose SSI benefits have been terminated, Medicaid restoration will occur only after a lengthy reapplication process to restore SSI. Once SSI is reinstated, the Federal government will provide up to three months of retroactive payments for Medicaid-covered services that individuals receive while waiting for SSI approval following release.[51] When a person's Medicaid eligibility is not tied to SSI, Medicaid eligibility is supposed to be reevaluated by State authorities before eligibility is denied.[52] Reportedly, however, these re-determinations often do not occur,[53] and there may be long delays before Medicaid is restored.

As discussed below, a few State and local jurisdictions have found ways to ensure that Medicaid benefits commence as soon after release as possible. For potential SSI recipients, a key method involves filing pre-release applications for SSI benefits (described above) or, for recipients with suspended SSI benefits, ensuring that SSA receives the information necessary to reinstitute benefits at release. In addition,

some individuals have worked directly with State offices responsible for administering Medicaid to ensure that jail inmates' benefits are not terminated[54] or, as in the case of the Philadelphia program described in this report, to facilitate access to coverage soon after release.

Veterans Benefits

The Department of Veterans Affairs (VA) offers an array of benefits to veterans who have been discharged from active military service under other than dishonorable conditions. Because of their relevance to disabled veterans who are released from prison or jail, VA health, compensation, and pension benefits are discussed in this section.[55]

Health Care

The VA offers a variety of hospital and outpatient health care benefits to enrolled veterans in eight priority categories who meet specific service, disability, or income requirements.[56] Two of these categories include enrolled veterans with nonservice-connected disabilities or noncompensable service-connected disabilities (e.g., those receiving compensation for inactive tuberculosis) who agree to pay co-payments for services.[57] In addition, the VA provides health care to veterans who are not enrolled with the VA but "1) have a service-connected disability of 50 percent or more; 2) want care for a disability that the military determined was incurred or aggravated in the line of duty, but which the VA has not yet rated, during the 12-month period following discharge; or 3) want care for a service-connected disability only." [58] Veterans who qualify for VA health benefits may also qualify for Medicare or Medicaid, depending on

their circumstances. ***Veterans who are confined in Federal and State prisons or local jails may not receive VA health benefits while incarcerated, but they retain their eligibility for benefits during their confinement***.

Compensation

Some disabled veterans receive monthly cash assistance through disability compensation benefits. Compensation is paid "to veterans who are disabled by injury or disease incurred or aggravated during active military service."[59] The amount of compensation that a veteran receives depends on his or her disability "rating," which is a percentage determined by the VA according to a specified ratings schedule.[60] Compensation may also be paid for a spouse, child, or dependent parent when the disability rating is 30 percent or more. In 2003, monthly compensation payments for veterans with no dependents ranged from $106 for those with a 10 percent rating to $2,239 for those with a 100 percent rating.[61]

Veterans who were receiving compensation prior to incarceration continue to receive payments if they are awaiting trial or are convicted only of a misdemeanor. If they are convicted of a felony and incarcerated for more than 60 days, their compensation is **reduced** ***as follows:*** if their disability rating was 20 percent or higher prior to incarceration, their rating is reduced to the 10 percent disability rate; if they had a 10 percent rating, their monthly payment is cut in half (i.e., $53 for 2003).[62] When applicable, incarcerated veterans may apply to have eligible dependents receive any amounts not paid to the veteran. Overpayments of compensation due to not notifying the

VA regarding a person's incarceration result in the loss of payments until overpayment amounts are recovered.

Disability Pensions

Pension benefits are available to veterans with non-service-related injuries who are permanently and totally disabled.[63] Pension recipients who are disabled must have had 90 days or more of active military service, at least one day of which was during a period of war, and their disability cannot be the result of willful misconduct. The amount of a person's monthly pension payment is determined after consideration of other sources of income. Because a qualified veteran's total income (i.e., pension plus other income) cannot exceed a level set by Congress, disability pension amounts can vary substantially across individuals.

Pension benefits are suspended after conviction for a misdemeanor or felony and 60 days of incarceration. Dependents may receive a portion of the benefits while the person is incarcerated. Again, if overpayments occur because of failure to notify the VA regarding incarceration, payments cease until the overpayment is recovered.

Pension or Compensation

Some veterans are eligible for both pension and compensation benefits but may not receive them simultaneously. They may choose the benefit that ensures them the most income and have the option to switch their election if their circumstances change. For example, an incarcerated, convicted veteran who is eligible for both compensation and pension benefits, and who was receiving pension benefits prior to incarceration

because they were higher than his compensation benefits, may switch to receiving compensation payments while incarcerated since his pension benefits end following conviction and incarceration. After release, he may switch back to receiving pension benefits if they still offer the highest payment.

How the Department of Veterans Affairs Verifies Conviction and Incarceration Status

Through a Memorandum of Understanding, SSA forwards the corrections data it receives to the Department of Veterans Affairs, which uses the information to suspend or reduce benefits (depending on the benefit) for incarcerated veterans who were receiving benefits payments prior to incarceration.[64] Staff in the Department of Veterans Affairs' Benefits Delivery Center in Hines, Illinois, sort the SSA data by region and forward the beneficiary information to the department's regional offices for verification. Regional office staff are then responsible for verifying information on incarceration (e.g., conviction status, length of stay, misdemeanor vs. felony), updating information on incarceration status in the department's benefits delivery database, and corresponding with incarcerated veterans about any changes in their benefits status due to their conviction and incarceration.

Applications and Adjustments During Incarceration

While incarcerated, veterans may apply for benefits or request information that will help expedite benefits claims. For instance, veterans who received compensation benefits prior to incarceration may request a review of their disability rating or pension status, or request benefits payments for dependents. In addition, veterans who did not

receive benefits prior to incarceration may apply for physical examinations to determine eligibility for compensation or pension benefits and may apply for compensation benefits, so that these benefits can begin during incarceration, or apply for pensions, so that these benefits may begin immediately upon release. They may also request that the VA research their military records to determine periods of service or discharge status for determining pension eligibility. These actions can expedite new claims, which, reportedly, can take nine months or more to process.[65]

Reinstating Benefits That Are Suspended or Reduced During Incarceration

To reinstate benefits that were suspended or reduced during incarceration, the VA must receive official notice of release, which usually occurs when the released veteran applies at a regional veterans office to have his or her benefits reinstated. ***Corrections officials may facilitate the reinstatement process*** by forwarding information to the relevant VA office. Compensation or pension payments are paid effective the date of release as long as an application for benefits has been made within one year after release. When applications are made more than a year after release, benefits will be effective the date of application. In some cases, the VA may schedule a medical examination to determine if a releasee's condition has improved, a change that could result in modification or termination of benefits.

Benefits Strategies for Inmates in Three Sites

The following site profiles describe efforts in three jurisdictions to assist inmates with benefits applications prior to release from prison or jail. The profiles review how

each of the sites became involved in the benefits application process, the partnerships and staffing arrangements that support the process, procedures that have been developed for filing applications, and the results of these efforts. The experiences of the three sites show that ***arranging for severely ill offenders to qualify for Federal entitlements not only facilitates access to community-based care but can also 1) reduce the financial burden on State and local governments that fund indigent health care systems and 2) allow community-based service providers to increase the number of disabled offenders served.*** Nonetheless, to varying degrees the sites have learned that helping offenders obtain benefits can be a challenging enterprise. (See figure 4: "Challenges in the Benefits Application Process.")

Benefits Strategies for Prison Inmates in New York State

This section highlights two initiatives in the State of New York designed to assist prison inmates with entitlement benefits.

Pre-Release Applications for SSI/SSDI for Severely Ill Inmates

Since 1988, the New York State Division of Parole has had a Memorandum of Understanding (MOU) with SSA to support pre-release applications for SSI and SSDI benefits. The original MOU, which had few specific protocols, was updated in 2000 to include a more formalized application process and additional partners. In addition to the Division of Parole and SSA, the partnership now includes medical relations staff of the Division of Disability Determination in the State's Office of Temporary and Disability

Figure 4: Challenges in the Benefits Application Process

Program participants in the three sites identified a number of challenges to the benefits applications process.

- **Staff Resistance.** Some staff and professionals may resist assisting inmates because they feel that offenders do not deserve this type of assistance. Because corrections staff, including contract medical and mental health staff, may not view benefits planning as part of their job descriptions, they may resist participating in the process because it places additional burdens on their time. Parole officers may not assign high priority to having parolees apply for or obtain benefits.

- **Applicant Impairments.** Illiteracy, language barriers, and health and mental health conditions can make it difficult for severely ill offenders to participate effectively in the application process. Illness may also impair their memory of prior treatment.

- **Offender Resistance.** Inmates may refuse to participate in making pre-release applications for SSI or SSDI only to discover after release that they cannot support themselves or obtain care. Parolees who have obtained pre-release approval for benefits may not follow through with obtaining benefits following release.

- **Disability Determination Delays.** Even when applications for SSI or SSDI are filed prior to release, applications review can take a long time. As a result, benefits may not start for weeks or months after release.

- **High Rates of Denial for SSI.** Initial SSI applications are often denied, which necessitates appeals that produce significant delays. If releasees do not have help filing appeals following release or cannot be located, they may lose the opportunity to obtain benefits.

- **Lack of Information.** Medical and mental health records necessary to substantiate the nature and duration of disability may be difficult to obtain because offenders typically have seen multiple health care providers in the community. In addition, correctional records may be inaccurate or incomplete.

- **Inability to Locate Releasees.** Even if they receive medical approval prior to release, releasees who cannot be located are likely to have their SSI or SSDI applications closed for lack of important information.

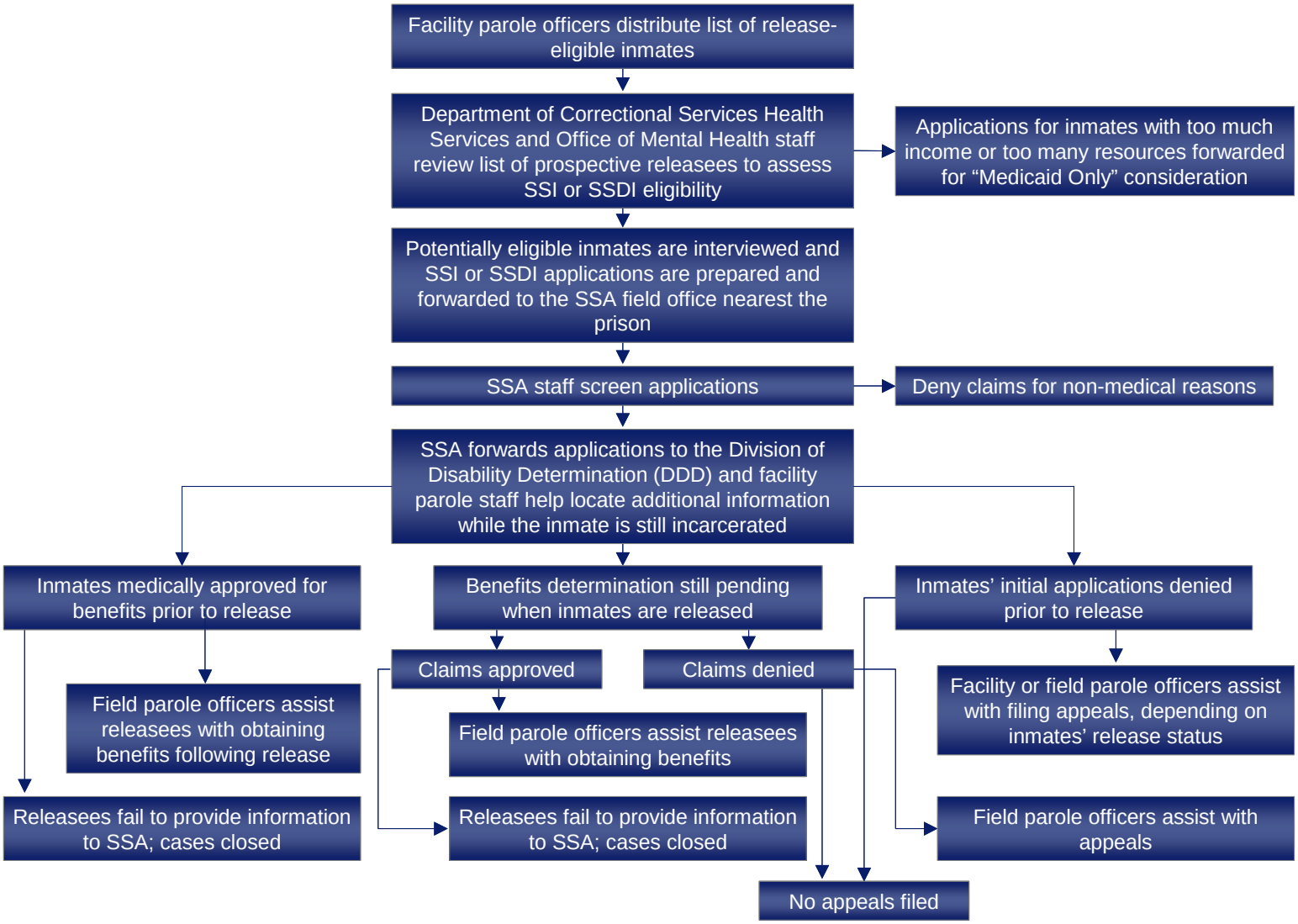
Assistance, the State Office of Mental Health, which provides inmates with mental health care and discharge planning, and the Department of Correctional Services' Health Services, which provides medical care to inmates. Following the signing of the updated MOU, Parole, SSA, and Disability Determination staff offered statewide training on the process, procedures, forms, and decision-making steps required for its effective implementation. In addition, to bolster its participation and become a more active partner in the discharge planning process, SSA identified contacts in each of its field offices who could respond to questions from parole, mental health, and corrections staff.

The multi-stage application process outlined in the revised MOU involves identifying severely medically and mentally ill inmates eligible for SSI or SSDI benefits prior to release, completing and filing paperwork, filling in information to ensure the applications are complete, and monitoring outcomes once the completed applications have been submitted to SSA. (See Exhibit 1: "New York's Processing of Pre-Release Applications for SSI and SSDI.") No additional State or Federal funding has been provided to accomplish any of these tasks.

Identifying Candidates

Each month, facility parole officers prepare a list of inmates who are eligible for parole or other statutory release.[66] The officers share the list with staff of the Department of Correctional Services Health Services and the Office of Mental Health at each facility, who convene regular meetings to discuss the release planning needs of the inmates on the list who are also receiving prison-based health or mental health services. Staff review the medical, mental health, and financial histories of the inmates to determine which inmates

Exhibit 1: New York's Processing of Pre-Release Applications for SSI and SSDI



may qualify for SSI or SSDI. Those inmates whose income or resources are determined to exceed the SSI eligibility limits are referred to the New York State Department of Health Office of Medicaid Management for "Medicaid Only" consideration. Staff then prepare SSI/SSDI applications for inmates who appear likely to qualify for them.

Completing Applications and Monitoring Outcomes

Facility parole or mental health staff meet with the inmates to complete applications and compile relevant institutional medical and mental health records. Completed applications, which may be submitted up to 120 days prior to the anticipated release date, are sent by facility parole officers or Office of Mental Health staff to the SSA field office in the county near the prison where the prospective releasee is housed. SSA staff review each application and, in the event that an inmate is ineligible on the basis of non-medical criteria (e.g., resources, alien status), notify the facility parole officer designated as the contact person on the application. All applications that meet the non-medical criteria are forwarded to the Division of Disability Determination (DDD), where an assigned reviewer corresponds with the facility parole officer or mental health staff person to ensure that institutional documentation is complete (e.g., that lab work is completed) and, when necessary, requests medical or mental health records from the community at large.

If a medical (i.e., disability) determination is made prior to release pending SSA's confirmation of living arrangement, resources, and income following release, facility parole officers inform the inmate of the decision and the steps he or she must take following release to activate benefits. If an inmate is not released within 30 days of

medical approval of the claim, the MOU stipulates that SSA may disallow the claim. But since favorable medical decisions are viable for 12 months, SSA may reinstate the claim without the inmate's filing a new application if the inmate is subsequently released within the 12-month window. When an application is denied prior to an inmate's release, the facility parole officer is instructed to inform the inmate of his or her right to appeal and may assist with filing the necessary paperwork.

Post-Release Activities

The facility parole officer is responsible for notifying SSA of the inmate's confirmed release date (no earlier than one week prior to release), the releasee's residential address, and the field parole office's address and phone number. In turn, SSA is charged with contacting the SSA field office nearest the releasee's address and forwarding the inmate's file to the office. In the event that a medical determination is pending, DDD will also be notified regarding the location of the field parole office responsible for supervising the applicant.

At release, the facility parole officer forwards information on the status of the application and SSA contact information to parole field offices. Field agents are then charged with providing assistance to ensure that eligible inmates obtain benefits. Field agents are expected to:

1) monitor applicants who have received medical approval to make sure they make contact with SSA and local social service agencies responsible for Medicaid to complete the process and begin receiving their benefits,

2) assist applicants with pending claims to ensure that DDD and SSA staff have all of the information they require, and

3) assist with appeals if pre-release claims have been denied.

Outcomes

Parole officials estimate that between 200 and 400 pre-release applications are submitted annually.[67] Although data on outcomes are not maintained, anecdotal evidence from staff involved in the program suggests that a significant portion of these applications are denied. The high denial rate is not surprising, given that State DDD records indicate that statewide only about 38 percent of initial claims for SSI are approved.[68] Still, it is useful to consider some of the reasons that inmate applications are denied.

- Some applicants cannot be located following release (e.g., because they fail to appear at their designated parole office, move from their approved residences, or are not under parole supervision). In these cases, even if applicants have been medically approved by DDD prior to release, their cases will be coded as "whereabouts unknown" by SSA and then closed for lack of information regarding resources, income, and living arrangements.

- Many releasees leave institutions while their applications are still under review by DDD, reportedly because release dates cannot always be anticipated accurately 120 days in advance of release. This is especially true for parole violators—one-third of new admissions to New York's prison system—who often move through the system quickly with little time for discharge planning before release. Their applications are often filed 60 days or less before release. In these cases, if DDD officials cannot find them following release to obtain additional documentation (e.g., consultative exams), or if their field parole officer does not make entitlements a priority, applications may be closed for lack of information.

- Reportedly, it is not uncommon for applications to be denied because applicants are not qualified aliens.

- Other applications may fail because important medical records are not complete enough to determine disability according to SSA specifications or are not obtained in a timely fashion. One problem is that inmates cannot always accurately recall their medical or mental health histories; even those who do remember may have records that are difficult to obtain because the records are in multiple locations (within the community or

within the correctional system). In these instances, cases may be closed, or SSA may require that new applications be filed to address missing information.

- Sometimes the documentation provided by prison medical staff or mental health staff is not sufficient to determine both the level of impairment and the effect of the impairment on employability.

- The high rate of turnover and reassignment among parole officers can mean that individuals listed as points of contact on applications and in supporting documentation may not be available when DDD or SSA questions need to be answered.

- Applicants whose initial claims are denied may refuse to appeal, preferring, instead, to apply for State-funded public assistance, which is available to some individuals who have been denied SSI.

The Division of Parole is working to address some of these issues by providing written directives to all of its institutional and field agents to reinforce the importance of the pre-release application process. In addition, the division has designated Program Services staff located in its central office in Albany to assist SSA and DDD staff when they cannot locate the parole agent listed on an application or a pre-release applicant following release. Finally, DDD staff are now working in conjunction with other partners on a pilot project to develop training protocols for medical and mental health staff at two prisons to ensure that mental health and medical exams and corresponding paperwork meet the requirements for disability determination.

Working With Incarcerated Veterans

In 1986, the New York State Department of Correctional Services (DOCS) created the Incarcerated Veterans Program to address the unique needs of incarcerated veterans. The program's goals include helping participants become aware of their

entitlements, benefits, and community resources; providing them with access to veterans service providers in the community; and preparing them for community re-entry. Through informal partnerships with an array of agencies, including the U.S. Department of Veterans Affairs, the New York State Division of Veterans Affairs, the State Department of Labor, the State Small Business Development Center, and local veterans groups and organizations, the DOCS has worked to identify incarcerated veterans at admission, or shortly thereafter, offer them services during incarceration, and assist in their transition to the community.

The Incarcerated Veterans Program has three service levels.

- Level I services, which include providing information on entitlements and helping inmates secure military records, upgrade discharges, and request benefits, are offered by designated DOCS staff at all general confinement facilities.

- Level II services (offered at four correctional facilities) include counseling services to help with personal and readjustment problems and reentry planning (e.g., securing personal documents, identifying community resources, developing release plans).

- Veterans in Level III Residential Services, which are offered in three institutions, are housed together for a period of at least six months and receive in-depth individual and group counseling and comprehensive release planning.

Representatives from partner agencies visit the veterans programs at each institution to provide information, training, and assistance, as necessary. In particular, staff from the two Veterans Integrated Service Networks (VISN) in the State meet with prison inmates, monitor when veterans will be released, and alert regional VA staff across the State when an inmate is returning to the community.

Although neither the DOCS nor the VA maintains data on inmate benefits applications or reinstatements, the multi-tiered program is thought to be an important tool for helping veterans learn about entitlements and for expediting many aspects of the benefits application process. Learning about benefits is important since many veterans who participate in the program reportedly believe they lose their right to entitlements if they commit a crime. Also, completing many of the steps in the application process during incarceration (e.g., records checks, rating reviews) helps to expedite the benefits process for new applicants and for those who received benefits prior to incarceration.

The City of Philadelphia's[69] Approach to Benefits for Forensic Intensive Recovery Program Clients and Other Jail Inmates

Since 1993, the Coordinating Office for Drug and Alcohol Abuse Programs (CODAAP) of the City of Philadelphia's Behavioral Health System has administered the Forensic Intensive Recovery (FIR) Program, which provides behavioral health treatment, case management, and vocational services to individuals released via early parole or re-parole from the Philadelphia Prison (local jail) System. The program is one of several criminal justice treatment initiatives in the city, whose community-based partners include:

- CODAAP,
- the Pennsylvania Department of Public Welfare (DPW),
- the Defender Association,
- Community Behavioral Health,
- the Office of Mental Health,
- the Philadelphia Prison System,
- the District Attorney's Office,
- Pre-Trial Services,
- the Sheriff's Office,
- the Adult Probation and Parole Department,

- the Municipal Court,
- the Court of Common Pleas, and
- the Deputy Managing Director for Criminal Justice Population Management.

Inmates with substance abuse disorders who have served at least half their minimum sentences, have six months to a year left on their sentences, and pose no threat to the community are referred to FIR's Clinical Evaluation Unit by the Defender Association's Social Work Department. Candidates are screened while incarcerated, and those who qualify for program services are recommended for early parole. If approved for FIR, clients are released to residential or intensive outpatient treatment programs.

Originally intended to reduce jail crowding by providing a minimum of 250 community-based treatment slots, and funded initially with city grant money totaling $3.3 million, FIR now serves 1,300 participants and has a total budget of $20 million. Federal and State medical assistance dollars,[70] which support the treatment services of 66 providers across the city, are the major sources of funding. Less than one fifth of the budget ($3.6 million) comes from city funds and State grants, which support the salaries of a Medical Assistance Coordinator who helps inmates apply for benefits, clinical evaluators, case managers, vocational education staff, and supervisors.

A key reason for the dramatic increase in the size of the FIR program, despite virtually static core funding and cuts in other funding sources over the years the program has operated, is that program managers have found ways to facilitate client access to medical assistance. In 1999, realizing that medical assistance could play a significant role in defraying program costs, CODAAP staff met with staff at the Philadelphia County Assistance Office, which is operated by the Pennsylvania Department of Public Welfare

(DPW) and is responsible for the administration of cash, food stamps, Medicaid, and energy assistance benefits, to discuss ways to improve the medical assistance application process for FIR participants. Their efforts resulted in significant changes in the existing medical assistance applications process and dramatic increases in the number of FIR clients covered.

Streamlining Medical Assistance Claims for FIR Clients

Under the application system that existed in 1999, FIR clients were released without medical assistance.[71] Individual treatment providers were responsible for transporting clients to one of 19 different full-service, county assistance offices to initiate benefits claims. The system not only increased the risk of client flight, it also interrupted treatment. In addition, it required considerable DPW staff time, since multiple visits were often necessary before eligibility was established and because multiple DPW workers were involved in the decision-making process. Moreover, it took between 30 and 45 days for clients to enroll initially in Medicaid and up to 90 days more to enroll in Community Behavioral Health, the non-profit managed care component of the Behavioral Health System created by the city that pays for substance abuse and mental health treatment for individuals eligible for medical assistance.[72] Until Community Behavioral Health enrollment was complete, FIR's program managers had to pay for client care with Behavioral Health Special Initiative (BHSI) monies—State funds allocated for indigent residents who are not eligible for medical assistance—which severely drained available resources and limited the number of clients who could be served by the program.

Through an informal agreement, CODAAP, FIR, the Defenders Association, and the Philadelphia County Assistance Office staff devised a method to streamline the applications process and reduce the drain on Behavioral Health Special Initiative funds. Three concepts formed the foundation of the multi-faceted reform. One was centralizing the applications process in just one of the city's 19 County Assistance Office locations. A second was to complete benefits applications while FIR candidates were still incarcerated. The third was to designate a Medical Assistance Coordinator at FIR to help inmates complete applications and a single Income Maintenance Caseworker at the Philadelphia County Assistance Office to review the applications.

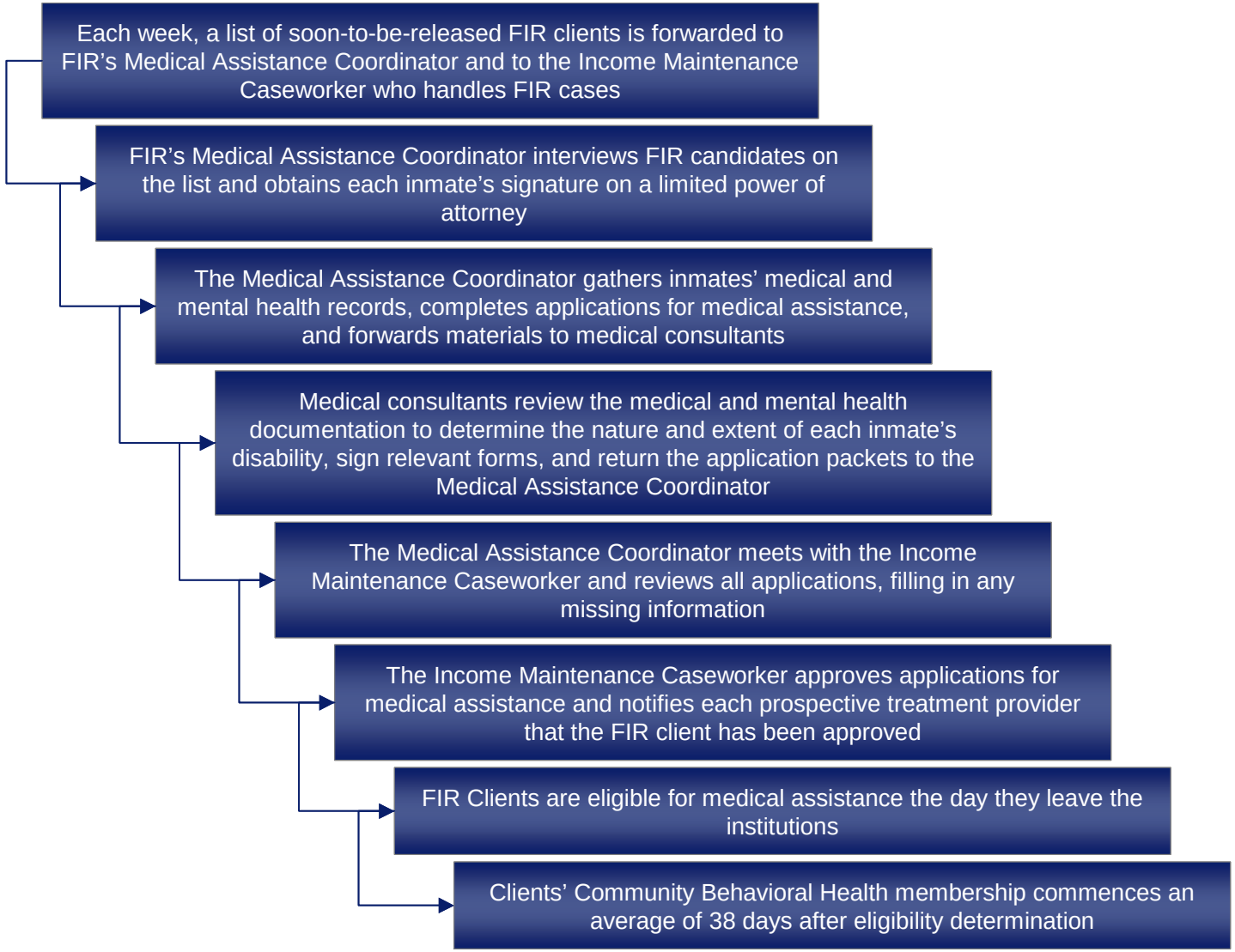
The system that emerged from the discussion (see Exhibit 2: "Weekly Processing of FIR Clients' Medical Assistance Applications") has been operating since 2000 and includes the following steps:

1. **Identifying Soon-to-Be-Released Candidates.** Every Thursday, staff in the Defenders Association Social Work Department fax or e-mail a list of approved FIR clients who are scheduled to be transferred to treatment the following week to FIR's Medical Assistance Coordinator and the Income Maintenance Caseworker designated by DPW to handle all FIR applications for medical assistance.

2. **Interviewing Inmates and Obtaining Limited Power of Attorney.** The Medical Assistance Coordinator interviews the inmates on the list and obtains each inmate's signature on a limited power of attorney that allows the Medical Assistance Coordinator to gather the necessary documentation for the application and appear before the Income Maintenance Caseworker on the inmate's behalf.

3. **Determining Disability.** The Medical Assistance Coordinator gathers inmates' medical and mental health records, completes applications for medical assistance, and forwards the applications to one of two psychiatrists paid contractually by FIR. The medical consultant reviews the application materials and documentation and signs the Employability Assessment Form, which documents the nature and extent of an individual's disability and is used to determine eligibility for medical assistance. Approximately 28 cases are processed weekly.

Exhibit 2: Weekly Processing of FIR Clients' Medical Assistance Applications



4. **Meeting with the Income Maintenance Caseworker to Start Eligibility.** Each week, the Medical Assistance Coordinator meets with the Income Maintenance Caseworker at the designated DPW office and reviews all applications for the week. The Income Maintenance Caseworker identifies any missing information (which, reportedly, occurs rarely) and completes authorization for medical assistance. The Income Maintenance Caseworker then sends notices of eligibility to the treatment facilities and to the applicants.

5. **Starting Eligibility the Day of Release.** FIR participants are eligible for medical assistance the day they are released from jail, although they must still wait for their Community Behavioral Health membership to be effective, which takes an average of 38 days. During that time, Behavioral Health Special Initiative funds are used to pay for treatment services but, because months have been shaved off the eligibility and enrollment process, a larger portion of Behavioral Health Special Initiative funds is available to support additional FIR clients.

Outcome of FIR's Modified Medical Assistance Process

Streamlining the medical assistance application process has had positive outcomes for the FIR program and for providers. For one thing, it has resulted in a dramatic increase in the number of clients receiving medical assistance. Of the 2,329 applications for medical assistance acted upon by DPW between July 1, 2000, and October 11, 2002, 97 percent were approved for eligibility.[73] Between fiscal years 2000 and 2001, the percentage of FIR clients receiving medical assistance more than doubled from 38 percent to 90 percent. In addition, shifting responsibility for benefits applications to a single benefits case manager and completing applications prior to release has significantly reduced the client flight rate, as well reduced disruption in treatment associated with filing applications after release. Also, assigning a single DPW staff person to process FIR claims, and having that person coordinate with a single

Medical Assistance Coordinator, has reduced the amount of time that DPW staff must spend processing applications and has helped to standardize applications review.

Obtaining Cash Assistance for FIR Clients

FIR's program administrators made a conscious decision to make obtaining medical assistance their top priority. They recognized that it can take months or years to complete the review of SSI applications for which many FIR clients may not qualify because substance abuse is their primary diagnosis. Rather than having clients' medical coverage depend on an SSI determination, they made applying for medical assistance the priority and made obtaining cash assistance a goal to pursue only after medical assistance has been obtained.

After approving clients' medical assistance eligibility, the Income Maintenance Caseworker continues to track FIR cases unless and until clients apply for cash assistance or food stamps. At that point, the file is transferred to the Philadelphia County Assistance Office nearest the location where the client is residing. Following transfer, if treatment providers have not already done so, Disability Advocacy Program workers assigned to district offices by DPW are available to assist disabled individuals with applications for SSI or SSDI, if appropriate. (At the time of release, roughly 10 percent of FIR clients are thought to be eligible for SSI due to a primary mental health diagnosis. After release, others are identified as the severity of their mental illness becomes more apparent.) Disability Advocacy Program workers interview clients, gather medical and mental health documentation, and assist clients with appeals. If necessary, Disability Advocacy Program workers also coordinate with the State Bar Association to have pro

bono attorneys represent clients before administrative law judges. Pennsylvania also provides general assistance welfare funds for low-income clients who do not qualify for SSI or Temporary Assistance to Needy Families (TANF).[74] While the disability requirements for general assistance funds are less stringent than for SSI, because monthly payments are also much lower, clients fare better financially when they qualify for SSI.

Other Endeavors Related to Benefits for Jail Inmates

The benefits strategy that has been applied so successfully with FIR clients is now being used to assist severely mentally ill inmates who qualify for early release. With a three-year grant from the Pennsylvania Commission on Crime and Delinquency, the city's Office of Mental Health/Mental Retardation is now screening jail inmates who are severely mentally ill (i.e., schizophrenic, bi-polar) and have a co-occurring substance abuse disorder. A behavioral health case manager screens clients, recommends them for early release to the community, arranges community placements for them, and helps them with benefits applications. Mirroring FIR's medical assistance process, the case manager is alerted by the Defenders Association Social Work Department when program candidates are nearing release and helps them complete applications for medical assistance. These applications are then reviewed by the Income Maintenance Caseworker assigned by DPW to review FIR applications so that, when possible, benefits eligibility starts the day of release. The grant, which began in June 2002, involves identifying 50 clients per year. Although this represents just a fraction of the 1,400 inmates in the Philadelphia Prison System who are estimated to have mental health diagnoses, the

project is identifying gaps in services and helping to create mechanisms for transferring offenders with mental illness to community care whenever possible.

Finally, the city is expanding its focus on benefits in yet another way. Working with SSA, city planners are exploring how to expedite the reinstatement of inmates' suspended SSI benefits. They have outlined a plan in which case workers at the jail will help inmates whose benefits have been suspended by contacting SSA 30 days before inmates are released to apply for reinstatement, verify social security numbers, and confirm eligibility. Immediately prior to release, SSA staff will interview inmates over the phone to update information regarding resources, living arrangements, and income. As soon as the inmate is released, jail staff will fax the release form to SSA, which will then initiate benefits. It is hoped that this process will help releasees by eliminating their need to file for benefits following release and reducing the likelihood that they will misplace important paperwork. The process also appeals to social security staff because it will eliminate the need for them to request verification of release and prevent security problems that might arise during face-to-face encounters with releasees.

The Texas Correctional Office on Offenders With Medical or Mental Impairments (TCOOMMI)[75]

The Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) was created and funded by the State legislature in 1987 to address the needs of juvenile and adult offenders with mental illness, mental retardation, or developmental disabilities. Subsequently, the legislature expanded TCOOMMI's mandate to include offenders who are terminally ill or elderly, or have serious medical conditions or physical disabilities. TCOOMMI is composed of 31 members—21

represent state agencies and community-based organizations, and 10 are appointed by the Governor. The council is supported by a 20-person staff that is housed within the Texas Department of Criminal Justice (TDCJ), which manages the operation of the State's prison, parole, and State jail[76] systems.

Most of TCOOMMI's $16.6 million annual budget is used to pay for contracts with 36 local Mental Health and Mental Retardation Agencies and with the Texas Department of Human Services. Contract staff provide transitional support to incarcerated, special needs clients and case management and other services to clients under criminal justice supervision in the community. TCOOMMI pays for case management services for indigent clients in the community who are medically or mentally ill. It also pays for medications and outpatient mental health care for mentally ill clients. State or local dollars fund the remaining service needs of indigent clients in the community.

Improving Procedures for SSI and SSDI Applications

After a decade of administering TCOOMMI programs, staff realized that there was a need to develop a consistent and effective process to aid special needs offenders in applying for social security, medical, and other benefits. Experience demonstrated that there was considerable variation in the processing of parolees' and probationers' SSI and SSDI applications, with some applications being denied inappropriately because some SSA reviewers incorrectly believed that individuals under criminal justice supervision were not entitled to benefits. In addition, the submission of applications prior to release was typically limited to the few inmates whose work histories allowed them to apply for

SSDI or whose illnesses were terminal. Most TCOOMMI participants were instructed to wait until after release to file their benefits applications, which generally resulted in a three- to four-month delay before they heard whether the applications were approved. Releasees with severe mental illness were especially vulnerable during this period, frequently failing to stabilize in the community when they lacked an income and medical assistance. Also, Federal benefits were critical to help offset the huge drain that releasees placed on State and county indigent resources, which were stretched to their limit. Moreover, staff realized that additional clients could be served if Federal entitlements were available to cover some or all of the cost of services paid by TCOOMMI.

Believing strongly that TCOOMMI clients who received medical and cash assistance shortly after release would be less likely to require emergency hospitalization or to reoffend to obtain income, staff approached the legislature for authorization to launch a pilot program to aid inmates with benefits applications prior to release. In July 1999, the legislature authorized TCOOMMI to initiate a Social Security Pilot Project. The Texas Department of Criminal Justice and SSA signed an MOU to process inmates' pre-release applications for SSI/SSDI. The MOU specifies that applications for Social Security benefits may be filed 90 days prior to an offender's scheduled release date and applicants may receive medical approval of their applications prior to release. Since Texas is a state that has an agreement with SSA to have the SSI application serve as an application for Medicaid, individuals approved for SSI are automatically approved for Medicaid.

Operating the Benefits Pilot

The Pilot Project targets adult inmates with special needs who are eligible for one of two types of TCOOMMI services: Medically Recommended Intensive Supervision (MRIS) or Continuity of Care (COC).

- **MRIS** is an early parole program for inmates who are sentenced to serve non-aggravated felonies and who are elderly, physically handicapped, mentally ill, terminally ill, or mentally retarded, or have a condition requiring long-term care. MRIS inmates must be approved by the Texas Board of Pardons and Parole and must not be deemed a threat to public safety. Following the preparation and approval of a treatment plan, MRIS inmates must be housed in a medically suitable placement under the care of a physician. TCOOMMI staff are required to report to the Parole Board on the medical and placement status of all MRIS releasees on a quarterly basis.

- **TCOOMMI's Continuity of Care** program offers formal pre- and post-release planning and aftercare services to inmates and releasees[77] who have priority Axis I psychiatric diagnoses[78] or are mentally retarded, physically handicapped, terminally ill, HIV positive, or elderly. TCOOMMI contracts with staff of local Mental Health Mental Retardation Agencies or the Texas Department of Human Services to provide COC services throughout the State. TCOOMMI's COC network ensures that the majority of inmates with special needs are screened while incarcerated and then released to treatment services in the communities in which they will be living, thereby avoiding disruption in their health and mental health services. Twenty-seven contracted COC workers are assigned to assist inmates in nearly all Texas Department of Criminal Justice facilities in the State.

Twelve full- or part-time benefits eligibility specialists who are under contract to TCOOMMI through local Mental Health Mental Retardation Agencies or the Texas Department of Human Services assist inmates eligible for COC or MRIS services with all applications for Federal entitlements (e.g., SSI, SSDI, Food Stamps, AIDS medications, veterans benefits).

Benefits Pilot sites include 20 TDCJ units that house inmates who are eligible for COC services and have a priority Axis I diagnosis or are medically fragile, and 34 units that house medically fragile inmates eligible for MRIS. These pilot units are located in a combination of prisons, Substance Abuse Felony Punishment Facilities,[79] or State jails.

Up to 120 days prior to an inmate's projected release date, TCOOMMI staff notify a benefits eligibility specialist that an inmate from a target unit is scheduled for release. (See Exhibit 3: "Processing Inmates' Pre-Release Applications for SSI and SSDI.") The eligibility specialist contacts SSA to verify the inmate's social security number, citizenship, and current benefits status. He or she then meets with the inmate at the correctional facility, completes a pre-screening questionnaire to determine if the offender will have difficulty obtaining or maintaining employment, receives permission from the inmate to initiate an SSI/SSDI application, and obtains signatures on release of information documents.

Depending on the nature of the inmate's disability, eligibility specialists work with prison mental health or medical staff to compile institutional documentation for disability applications. In addition, the eligibility specialist checks automated Mental Health and Mental Retardation and Department of Human Services records to ascertain whether those agencies ever treated the applicant prior to incarceration. This records check is facilitated by a State statute that allows certain State and local agencies, and certain individuals contracted by those agencies, to exchange medical or psychiatric information regarding special needs inmates without a release of information from the inmates.[80] Whenever possible, the eligibility specialist also gathers records from any community-based providers the inmate saw prior to incarceration. The eligibility

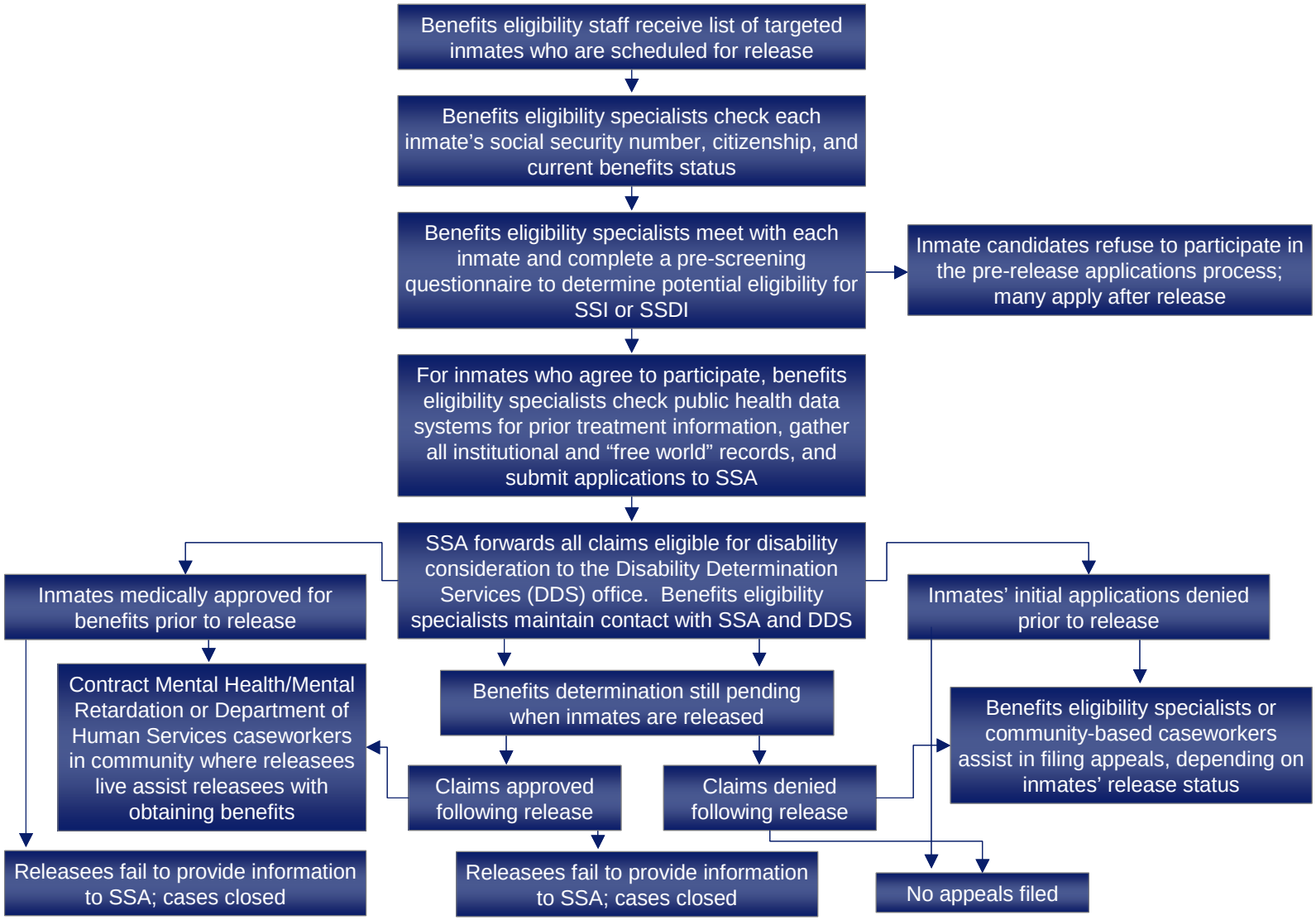
specialist then submits the application packet, including medical and mental health documentation, to SSA, monitors the review status of the application, and, if benefits are denied while the applicant is still incarcerated, assists inmates with appeals.

After filing a claim, the eligibility specialist keeps SSA informed regarding the inmate's release status, release date, and any changes in the applicant's expected post-release address or telephone number. The eligibility specialist also maintains contact with the Disability Determination Services examiner assigned to the case to assist with obtaining any additional information (e.g., mental status exams, consultative exams) the agency may require to complete its review. In addition, TCOOMMI staff in Huntsville are available to field questions and provide assistance should eligibility specialists be unavailable when a Disability Determination Services request is made.

Following release, an individual's file is transferred to the Mental Health and Mental Retardation Agency or Department of Human Services office nearest the area where the offender will reside. In most cases, an eligibility specialist or Continuity of Care caseworker at that location is assigned to monitor the SSA application, which includes providing additional information if the claim is open, assisting with appeals if the claim has been denied, or ensuring that the offender takes the necessary steps to have benefits begin (e.g., report to SSA so they may confirm income, resources, and residence; report to the Department of Human Services to start Medicaid).

Data on the filing and decision status of benefits applications (including data on inmates who refuse to submit applications) are reported to TCOOMMI staff and entered daily into a computer file. TCOOMMI staff then prepare statistical tables and distribute benefits status reports to the Mental Health and Mental Retardation Agencies and

Exhibit 3: Processing Inmates' Pre-Release Applications for SSI and SSDI in Texas



regional Department of Human Services staff who will provide services to clients following release. Weekly, monthly, and quarterly reports on the status of applications managed by eligibility specialists in each contracting agency are also forwarded to TCOOMMI's director, who can use the information to assess how different agencies and contractual staff are handling their responsibilities for the benefits process.

Outcome of the Pilot Project

TCOOMMI's benefits data show that the pilot project has succeeded in helping inmates obtain social security benefits, but the data also reveal that the task is challenging. Of 1,686 individuals referred to benefits eligibility specialists in the first nine months of fiscal year 2002, 1,076 (64 percent) did not submit applications to SSA.[81] Most refused to apply.[82] Reportedly, some believe they are capable of working; others do not feel they are ill enough to warrant receiving benefits; and still others do not want the perceived stigma of being welfare recipients. However, once released, many reportedly apply for benefits because they realize that their expectations were unrealistic or their views were naive. Unfortunately, they lose precious time and money because of the delay. The data also show that of the 610 cases processed by SSA in the first nine months of fiscal year 2002, 297 (49 percent) were approved, 232 (38 percent) were denied, and 81 (13 percent) were awaiting a decision.[83] Finally, the data reveal that application success rates vary across benefits eligibility specialists. One specialist had a 92 percent approval rating in fiscal year 2002.[84] Keys to his success seem to be his attention to detail, ability to obtain supporting medical examinations or documentation, and responsiveness to Disability Determination Services requests for additional

information. TCOOMMI has capitalized on his acumen by having him train other benefits specialists around the State.

Anecdotal evidence suggests that by improving procedures and staffing arrangements, the Benefits Pilot has helped inmates and staff alike.

- What was once a reactive process with few standards and relatively ad hoc identification of potentially eligible inmates is now a proactive one, with a system for identifying candidates, written procedures, dedicated staff, and measurable outcomes.
- Filing applications prior to release means that more inmates now have benefits when they leave institutions than in the past.
- Having dedicated eligibility specialists prepare benefits applications and gather medical records has reduced the burden on prison medical staff that once had sole responsibility for preparing the applications and sometimes felt overwhelmed at having benefits tasks added to their numerous treatment responsibilities.
- Because eligibility specialists screen prospective applicants, provide considerable medical and mental health documentation with the applications, and offer prompt support if questions arise during the review process, Disability Determination Services processing of inmate applications is reportedly more efficient than in the past.
- Finally, even when it is difficult to find applicants following release, TCOOMMI's tracking procedures are usually very effective and most applicants are located.

Obtaining Benefits for Severely Ill Inmates: Lessons from the Sites' Experience

The experiences of the three study sites suggest six important lessons regarding efforts to assist inmates with benefits applications.

1) Partnerships keep the process alive.
2) Dedicating staff has rewards.
3) Filling gaps until benefits commence is essential.
4) Tracking outcomes is beneficial.
5) Centralizing operations reduces delays and improves communication.
6) Assisting mentally ill offenders poses special challenges.

Partnerships Keep the Process Alive

Regardless of whether the benefits applications process is outlined in a formal MOU, as it is in Texas or New York, or operates through informal agreement, as it does in Philadelphia, ***many agencies, organizations, and individuals are necessary to ensure that applications for severely ill offenders do not fall through the cracks***. Because multiple decision makers are involved in determining disability, the process is facilitated when all parties work together. Involving all relevant decision makers also creates the opportunity for communication about the strengths and weaknesses of the applications process. Indeed, as a result of this type of information sharing, New York is launching its pilot project to have State Division of Disability Determination staff train prison mental health and medical staff on ways to improve the documentation they provide. Also, because many benefits claims are still open when inmates return to the community, it is important that all of the parties that work with offenders before and after release are involved in making sure that processing of applications continues following release.

Dedicating Staff Has Rewards

Both TCOOMMI and FIR staff have seen that ***there are significant advantages to funding eligibility staff whose sole function is to help offenders access benefits***. For example, since the primary burden of gathering medical and mental health documentation has shifted from correctional staff to the benefits eligibility specialists in Texas, medical staff are reportedly more willing to assist in preparing applications. In addition, being able to specialize means that TCOOMMI's benefits staff are able to submit application

packets that contain more information (i.e., including both institutional and community-based records) than in the past, which is thought to have accelerated the review process. In Philadelphia, having dedicated staff has shifted responsibility for seeking benefits from multiple providers and numerous disability examiners to just one Medical Assistance Coordinator and one Department of Public Welfare examiner. This has not only streamlined the process but, as noted earlier, has resulted in improved security and treatment outcomes for program participants. In addition, dedicated staff can concentrate on filling gaps in documentation without having to postpone their other institutional responsibilities. Finally, having dedicated staff increases the likelihood that there will be strong working relationships with disability decision makers who can rely on a quick response to their requests for assistance.

Filling Gaps Until Benefits Commence Is Essential

Filing pre-release applications for benefits is not a panacea. As experiences in the three study sites demonstrate, many severely ill inmates who are approached about benefits applications leave prison or jail with little likelihood that benefits will commence soon after release. Some inmates, as TCOOMMI staff have witnessed, refuse assistance prior to release; many first-time applicants leave correctional facilities before applications processing is complete; some, as the experience in New York demonstrates, have their cases closed because their whereabouts are unknown; and still others have their initial applications denied. ***Both TCOOMMI and FIR staff address the gap in benefits after release by using their own program dollars to pay for services during the period between a client's release and the start of benefits***. Program funding also supports

clients who are ultimately denied benefits. Any jurisdiction that seeks to prevent relapse and recidivism by ensuring that severely ill releasees receive medical and cash assistance soon after release should have similar mechanisms for funding treatment and providing other support until benefits payments commence.

Tracking Outcomes Is Beneficial

Developing outcome data on the benefits process serves several important functions. For one thing, data can provide feedback on the success of staff efforts and identify areas where policy changes may be warranted. In Texas, TCOOMMI staff are able to assess which contract agencies and eligibility specialists are succeeding in obtaining benefits and use the information to improve overall performance (e.g., through staff training). In contrast, in New York, where data on social security applications are not maintained, staff assume that their efforts are largely unsuccessful, which makes it difficult for them to sustain enthusiasm for filing applications. Benefits data can also be used as a means of demonstrating a program's ability to secure entitlement dollars that offset program costs. This type of information has been used to persuade sources of government funding in both Philadelphia and Texas to continue to support program services.

Centralizing Operations Reduces Delays and Improves Communication

Sites have discovered that ***there are benefits to centralizing the processing of medical and cash assistance claims***. As described earlier, partners in FIR's medical assistance application process discovered that, by centralizing the processing of benefits

claims, they could reduce the number of individuals involved in decision making and significantly reduce the amount of time until eligibility is confirmed and enrollment in the medical assistance managed care organization occurs. Faced with having cases closed because inmates cannot be located following release, staff in New York's Division of Parole have also centralized processing of post-release requests for information by identifying individuals in Albany whom SSA and Division of Disability Determination staff may contact with questions regarding releasees. Staff anticipate that this will help reduce processing delays and denials by making it easier for benefits professionals to receive assistance when they need it. With a similar goal in mind, staff in TCOOMMI's Huntsville, Texas, office are available to field questions and provide assistance to SSA and DDS examiners across the State.

Assisting Mentally Ill Offenders Poses Special Challenges

Program participants in New York and Texas who prepare applications for prison inmates noted that ***assisting mentally ill inmates with benefits applications is especially challenging***. Indeed, data on TCOOMMI filings show that in fiscal year 2002, 47 percent of the SSI or SSDI applications that were filed for mentally ill offenders were denied compared to 38 percent of the medical claims.[85]

Individuals in both sites suggested that disability determination staff appear more cautious about approving benefits for mentally ill inmates than they are about approving inmates with a medical illness. Program and benefits staff offered the following possible explanations:

1) There are fewer objective criteria for diagnosing mental illness than for diagnosing medical illness.

2) There is a common perception that some offenders feign mental illness to obtain more favorable treatment while incarcerated.

3) When applicants have co-occurring substance abuse disorders and mental illness, it is difficult to determine which is the primary diagnosis.

4) Mentally ill offenders can appear stable in a correctional setting because they comply with treatment and live in a structured environment where sources of external disruption (e.g., lack of housing, drug use) are largely eliminated. As a result, it is difficult to use their behavior in prison as evidence that, following release, they will be unable to engage in gainful activities.

Program staff perceive that it is easier to have applications approved when the applicant has a history of mental health treatment in the community, but they noted that, because of illness and long periods of incarceration, inmates frequently cannot remember whom they saw for treatment in the community. In addition, it is not unusual for an offender's first documented treatment to occur while incarcerated.

Final Thoughts

Helping inmates apply for medical and cash assistance is an important way to assist severely ill inmates who are returning to the community. But, as the experiences of the three sites described in this report make clear, ***such assistance should be viewed as only one facet of a broader discharge plan.*** The applications process is complicated; if it involves SSI or SSDI, it can take a long time to complete. And there is no guarantee that claims will be approved. In addition, as the numbers presented in this report demonstrate, relatively few inmates or releasees apply for benefits and, when these benefits involve SSI or SSDI, only a small percentage of them succeed on their first try. Even releasees who ultimately qualify for benefits are likely to find it challenging to

avoid relapse or recidivism unless other supports (e.g., case management services, housing) are made available.

Finally, it is important to note that, although Philadelphia's FIR program targets sentenced jail inmates, none of the strategies described in this report is designed to assist persons who are *detained* in local jails. Developing ways to inform them about the benefits application process and ensuring that incarceration does not cause jail detainees to lose benefits unnecessarily are among the issues that still need to be addressed.

Resources

The following Federal agencies and programs may provide additional information regarding obtaining benefits for severely ill inmates and releasees.

Federal Agencies

The National Institute of Justice (NIJ)
810 Seventh Street N.W.
7th Floor
Washington, D.C. 20531
Telephone: 202-514-6205
URL: http://www.ojp.usdoj.gov/nij

The Centers for Disease Control and Prevention (CDC)
1600 Clifton Road
Atlanta, GA 30333
Telephone: 404 639-3534 / 800 311-3435
URL: http://www.cdc.gov

The Social Security Administration
Office of Public Inquiries
Windsor Park Building
6401 Security Blvd.
Baltimore, MD 21235
Telephone: 1-800-772-1213
URL: http://www.ssa.gov

The Centers for Medicaid and Medicare Services
7500 Security Blvd.
Baltimore, MD 21244-1850
Telephone: 1-877-267-2323
URL: http://www.cms.gov

The Department of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420
VA Benefits Phone Number: 1-800-827-1000
URL: http://www.va.gov

Programs Described in This Report

New York State Division of Parole
Program Services
97 Central Avenue
Albany, NY 12206
Telephone: 518-473-5572

City of Philadelphia Behavioral Health System
Coordinating Office for Drug and Alcohol Abuse Programs
1101 Market Street
Suite 800
Philadelphia, PA 19107
Telephone: 215-685-5425

Texas Correctional Office on Offenders with Medical or Mental Impairments
8610 Shoal Creek
Austin, TX 78757
Telephone: 512-406-5406

Endnotes

[1] Jails are locally administered correctional facilities that house unsentenced inmates and sentenced inmates who typically serve terms of one year or less for violations of State laws. State prisons typically house inmates sentenced to terms in excess of one year for violations of State laws. Federal prisons house inmates sentenced to incarceration for violations of Federal laws.

[2] Roughly one-third of State prison inmates and one quarter of Federal prison inmates surveyed in 1997 reported having some physical impairment or mental condition, with older inmates and women most likely to report a health problem. (See Maruschak, Laura M., and Allen J. Beck, "Medical Problems of Inmates, 1997," *Bureau of Justice Statistics Special Report*, NCJ 181644,Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, January 2001: 1.) Thirty-seven percent of jail inmates surveyed between October 1995 and March 1996 reported that they had "a physical, mental, or emotional condition, or difficulty seeing, learning, hearing or speaking." (See Harlow, Caroline Wolf, "Profile of Jail Inmates, 1996," *Bureau of Justice Statistics Special Report*, NCJ164620, Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, April 1998: 11.) At mid-year 1998, an estimated 16 percent of State prison inmates, 7 percent of Federal prison inmates, and 16 percent of inmates in local jail reported either a mental condition or an overnight stay in a mental institution. (See Ditton, Paula M., "Mental Health and Treatment of Inmates and Probationers," *Bureau of Justice Statistics Special Report*, NCJ174463, Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, July 1999: 1.)

[3] For example, the number of HIV-positive inmates who were released from prisons and jails in 1996 is estimated to be between 98,000 and 145,000, with an estimated 39,000 of them having AIDS; 1.3 to 1.4 million inmates are estimated to have been infected with hepatitis C; and 566,000 inmates with latent TB infection are estimated to have been released that year. (See Hammett, Theodore M., Patricia Harmon, and William Rhodes, "The Burden of Infectious Disease Among Inmates and Releasees from Correctional Facilities," paper submitted to the National Commission on Correctional Health Care, Chicago, Illinois, May 2000.) Prevalence estimates for certain infectious and chronic diseases and mental illnesses are reported in National Commission on Correctional Health Care, Report to Congress, Volume 1, *The Health Status of Soon-To-Be-Released Inmates*, Washington, D.C.: U.S. Department of Justice, National Institute of Justice, 2001: 15-28. For information on the prevalence of HIV/AIDS in prisons, see Maruschak, Laura M., "HIV in Prisons, 2000," *Bureau of Justice Statistics Bulletin*, NCJ196023, Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, October 2002. Prevalence rates of schizophrenia and major affective disorders among jail inmates are estimated to be two to three times higher than in the general population. (See Teplin, Linda, "The Prevalence of Severe Mental Disorder Among Male Urban Jail Detainees: Comparison with the Epidemiologic Catchment Area Program," *American Journal of Public Health*, June 1990: 663-669.)

[4] Two reports by the Bureau of Justice Statistics offer information on the regular drug use of inmates in general. (See Mumola, Christopher J., "Substance Abuse Treatment, State and Federal Prisoners, 1997," *Bureau of Justice Statistics Special Report*, NCJ172871, Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, January 1999: 8; and Harlow, Caroline Wolf, "Profile of Jail Inmates, 1996," *Bureau of Justice Statistics Special Report*, NCJ164620, Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, April 1998: 1.) Chitwood et al. review the research literature documenting the acute and chronic health problems presented by sustained use of illicit drugs, including pulmonary complications, endocrine abnormalities, seizures, stroke, hepatic dysfunction, HIV/AIDS, and tuberculosis. (See Chitwood, Dale D., et al., "A Comparison of the Need for Health Care and the Use of Health Care by Injection-Drug Users, Other Chronic Drug Users, and Nondrug Users," *American Behavioral Scientist*, Vol. 41, No. 8, May 1998: 1108.); Abram, Karen, and Linda Teplin, "Co-Occurring Disorders Among Mentally Ill Jail Detainees," *American Psychologist*, October 1991: 1036-1045.

[5] According to results of inmate surveys conducted by the Bureau of Justice Statistics, mentally ill inmates were more likely than other inmates to report criminal histories involving three or more offenses; unemployment in the month prior to arrest; family histories of incarceration and alcohol or drug use; periods of homelessness during the year preceding arrest; having been under the influence of drugs or alcohol when committing their incarceration offense; past physical or sexual abuse; and alcohol dependence. (See Ditton, Paula M., "Mental Health and Treatment of Inmates and Probationers," *Bureau of Justice Statistics Special Report*, NCJ174463, Washington, D.C.: U.S. Department of Justice, Bureau of

Justice Statistics, July 1999.) Regarding life circumstances of inmates with HIV/AIDS, see Roberts, Cheryl A., et al., *Discharge Planning and Continuity of Care for HIV-Infected State Prison Inmates as They Return to the Community: A Study of Ten States*, Final Report, Atlanta, Georgia: U.S. Department of Health, Centers for Disease Control and Prevention, December 2001: 1-2.

[6] National Commission on Correctional Health Care, Report to Congress, Volume 1, *The Health Status of Soon-To-Be-Released Inmates*, Washington, D.C.: U.S. Department of Justice, National Institute of Justice, 2001: 29-34. Mentally ill jail inmates were less likely to receive mental health treatment than mentally ill inmates in State and Federal prisons. (See Ditton, Paula M., "Mental Health and Treatment of Inmates and Probationers," *Bureau of Justice Statistics Special Report*, NCJ174463, Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, July 1999: 9.) See also, Human Rights Watch, *Failure to Provide Discharge Services*, New York: Human Rights Watch, October 2003; Roberts, Cheryl, et al., *Discharge Planning and Continuity of Care for HIV-Infected State Prison Inmates as They Return to the Community: A Study of Ten States*, Final Report, Atlanta, Georgia: U.S. Department of Health, Centers for Disease Control and Prevention, December 2001.

[7] National Commission on Correctional Health Care, Report to Congress, Volume 1, *The Health Status of Soon-To-Be-Released Inmates*, Washington, D.C.: U.S. Department of Justice, National Institute of Justice, 2001: xvii.

[8] Ibid., 2.

[9] This report focuses on the majority of inmates and releasees with disabilities who are not elderly and must meet certain disability requirements in order to qualify for benefits. In general, elderly individuals (as defined by the program) do not have to establish disability in order to qualify for benefits.

[10] Griffin, Patricia A., *Maintaining Medicaid Benefits for Jail Detainees with Co-Occurring Mental Health and Substance Use Disorders*, Delmar, New York: The National GAINS Center for People with Co-Occurring Disorders in the Justice System, Summer 1999/Revised Spring 2002:1; Koyanagi, Chris, *Finding the Key to Successful Transition from Jail to the Community*, Washington, D.C.: Bazelon Center for Mental Health Law, March 2001: 1; National Commission on Correctional Health Care, Report to Congress, Volume 1, *The Health Status of Soon-To-Be-Released Inmates*, Washington, D.C.: U.S. Department of Justice, National Institute of Justice, 2001: 51; Council of State Governments, *Criminal Justice/Mental Health Consensus Project*, New York: Council of State Governments, 2002: 162.

[11] Researchers at the National GAINS Center for People With Co-Occurring Disorders in the Justice System in Delmar, New York, are studying offenders with mental illness who are released from the Pinellas County, Florida, Jail to ascertain whether releasees with medical benefits fare better than releasees who do not. The Texas Council on Mental Impairments (TCOOMMI) plans to study whether its clients who have benefits are less likely to recidivate than clients who do not.

[12] For example, researchers who have studied programs for HIV-infected inmates returning to the community argue that continuity of care is more likely to occur if clients receive assistance with applications for medical benefits prior to release. (See Roberts, Cheryl A., et al., *Discharge Planning and Continuity of Care for HIV-Infected State Prison Inmates as They Return to the Community: A Study of Ten States*, Final Report, Atlanta, Georgia: U.S. Department of Health, Centers for Disease Control and Prevention, December 2001: xi.); National Commission on Correctional Health Care, Report to Congress, Volume 1, *The Health Status of Soon-To-Be-Released Inmates*, Washington, D.C.: U.S. Department of Justice, National Institute of Justice, 2001: xvii.

[13] Chitwood, Dale D., et al., "A Comparison of the Need for Health Care and the Use of Health Care by Injection-Drug Users, Other Chronic Drug Users, and Nondrug Users," *American Behavioral Scientist*, Vol. 41, No.8, May 1998:1112, 1117.

[14] Human Rights Watch, *Failure to Provide Discharge Services*, New York: Human Rights Watch, October 2003; Roberts, Cheryl, et al., *Discharge Planning and Continuity of Care for HIV-Infected State Prison Inmates as They Return to the Community: A Study of Ten States*, Final Report, Atlanta, Georgia: U.S. Department of Health, Centers for Disease Control and Prevention, December 2001: ii-iii.

[15] Council of State Governments, *Criminal Justice/Mental Health Consensus Project*, New York: Council of State Governments, 2002: 162; Human Rights Watch, *Failure to Provide Discharge Services*, New York: Human Rights Watch, October 2003; Roberts, Cheryl, et al., *Discharge Planning and Continuity of Care for HIV-Infected State Prison Inmates as They Return to the Community: A Study of Ten States*, Final

Report, Atlanta, Georgia: U.S. Department of Health, Centers for Disease Control and Prevention, December 2001; McVey, Catherine C., "Coordinating Effective Health and Mental Health Continuity of Care," *Corrections Today*, August 2001: 58-62; Griffin, Patricia A., *Maintaining Medicaid Benefits for Jail Detainees with Co-Occurring Mental Health and Substance Use Disorders*, Delmar, New York: The National GAINS Center for People with Co-Occurring Disorders in the Justice System, Summer 1999/Revised Spring 2002; Koyanagi, Chris, *Finding the Key to Successful Transition from Jail to the Community*, Washington, D.C.: Bazelon Center for Mental Health Law, March 2001; National Commission on Correctional Health Care, Report to Congress, Volume 1, *The Health Status of Soon-To-Be-Released Inmates*, Washington, D.C.: U.S. Department of Justice, National Institute of Justice, 2001: 51.

[16] These sites were identified through a review of existing literature on correctional healthcare and the need for benefits, and through telephone interviews with researchers and practitioners familiar with these issues. Telephone interviewees were identified through the literature review and recommendations from other interviewees. Following site identification, each site was visited for a period of two to three days, and key decision makers and staff were interviewed either individually or in small groups.

[17] Although both adults and children may be eligible for benefits under these programs, this report focuses on incarcerated adults.

[18] To be eligible for RSDI benefits, a worker must be age 62 or older, or disabled, or blind, and have sufficient work credits.

[19] Working individuals may earn up to four credits per year, depending on annual earnings. The amount of earnings required for a credit increases each year as wages increase. See Social Security Administration, *Understanding Supplemental Security Income*, April 2002: 58.

[20] 20 C.F.R. Section 404.1506. For example, someone who is shot during the commission of a felony for which he or she is convicted and who suffers paralysis as a result of the shooting may not collect SSDI for the impairment, although he or she may be eligible for SSI for the impairment. Rules regarding SSDI benefits and any impairment that develops or is aggravated while serving a sentence for a felony committed after October 19, 1980, are also discussed in this section.

[21] 42 U.S.C. 423 (d)(2)(C).

[22] For SSI, aged persons are defined as those 65 or older. Aged persons who are disabled do not have to prove disability to qualify for SSI, although they must meet other eligibility requirements.

[23] See Social Security Administration, *Understanding Supplemental Security Income*, April 2002: 9-11, for more information on "qualified aliens."

[24] Ibid., 12. A fugitive felon is someone who is fleeing to avoid a trial on a felony charge, fleeing to avoid jail or prison after a felony conviction, fleeing to avoid custody after a felony conviction, or in violation of a condition of probation or parole.

[25] See Program Operations Manual System (POMS) DI 90070.050A-1. An individual cannot be found to be disabled for purposes of SSI eligibility if drug or alcohol abuse is a contributing factor "material" to his or her disability determination.

[26] See Social Security Administration, *Disability Evaluation Under Social Security*, January 2003: 19-154, for a full listing of impairments for adults age 18 and over and the criteria for determining whether the impairments are severe enough to prevent a person from performing any gainful activity. This book is also known as the "Blue Book."

[27] There are circumstances under which residents of public institutions other than prisons and jails (e.g., nursing homes) may receive SSI payments. See, for example, Social Security Administration, *Understanding Supplemental Security Income*, April 2002: 88.

[28] See Questions About: "Prisoner Rules," Question 14: "How does Social Security determine whether a facility is eligible for $200 or $400?" at www.ssa.gov.

[29] E-mail communication from Judith Sale, program analyst, Social Security Administration, November 24, 2003.

[30] Social Security Administration, *Understanding Supplemental Security Income*, April 2002: 89.

[31] See Program Operations Manual System (POMS) DI 23530.001, D4.

[32] Ibid.

[33] The Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Prescription Drugs*, Washington, D.C.: The Henry J. Kaiser Family Foundation, October 2002: 1.

[34] Dual eligibles are defined on the Medicare website as "persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid." See www.medicare.gov/Glossary. There is also a separate set of individuals who qualify for Medicaid assistance to pay their Medicare premiums.
[35]The Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Prescription Drugs*, Washington, D.C.: The Henry J. Kaiser Family Foundation, October 2002: 1.
[36] Centers for Medicare and Medicaid Services, *Your Medicare Benefits*, Washington, D.C.: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, April 2003: 3. Medicare is a Federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).
[37] H.R. 1, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.
[38] Koyanagi, Chris, *Finding the Key to Successful Transition from Jail to the Community*, Washington, D.C.: Bazelon Center for Mental Health Law, March 2001: 8.
[39] See Questions About: "Prisoner Rules," Question 15: "What happens to my Medicare when my checks stop because I go to jail?" at www.ssa.gov.
[40] Ibid.
[41] Mandatory services include physicians' services, laboratory and x-ray services, inpatient hospital services, outpatient hospital services, early and periodic screening, diagnostic, and treatment services for individuals under age 21; family planning services and supplies; Federally-qualified health center services; Rural Health Clinic services; nurse-midwife services; certified pediatric nurse practitioner or family nurse practitioner services; nursing facility services, and home health care services for those entitled to nursing facility services. For discussion of mandatory and optional services under Medicaid, see Schneider, Andy, et al., *The Medicaid Resource Book*, Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, July 2002: 49-80.
[42] According to a recent report by the Kaiser Commission on Medicaid and the Uninsured, 78 percent of people with disabilities who receive Medicaid do so because they qualify for SSI. The Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Role for the Disabled Population Under Age 65*, Washington, D.C.: The Kaiser Family Foundation, April 2001: 1.
[43] Koyanagi, Chris, *Finding the Key to Successful Transition from Jail to the Community*, Washington, D.C.: Bazelon Center for Mental Health Law, March 2001: 6.
[44]The Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Role for the Disabled Population Under Age 65*, Washington, D.C.: The Kaiser Family Foundation, April 2001: 1.
[45] See Program Operations Manual (POMS) SI 01715.020, *List of State Medicaid Programs for the Aged, Blind and Disabled*, at http://policy.ssa.gov/poms.nsf.
[46] For a discussion of the pathways to Medicaid eligibility for low-income individuals with disabilities, see Schneider, Andy, et al., *The Medicaid Resource Book*, Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, July 2002: 17-32.
[47] The Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Role for the Disabled Population Under Age 65*, Washington, D.C.: The Henry J. Kaiser Family Foundation, April 2001: 2.
[48] Ibid.
[49] Social Security Act, Section 1905 (a) (A) and 42 U.S.C. Section 1396 (d)(a)(27)(A) as cited in Koyanagi, Chris, *Finding the Key to Successful Transition from Jail to the Community*, Washington, D.C.: Bazelon Center for Mental Health Law, March 2001: 7.
[50] Lackey, Cindy, Senior Policy Analyst, Council of State Governments, *Final Result of State Medicaid Agencies Survey* in a memorandum to Fred Osher, Director of Center for Behavioral Health, Justice and Public Safety, New York: Council of State Governments, October 16, 2000 as cited in Koyanagi, Chris, *A Better Life—A Safer Community, Helping Inmates Access Federal Benefits*, Washington, D.C.: Bazelon Center for Mental Health Law, February 2003: 9.
[51] Koyanagi, Chris, *Finding the Key to Successful Transition from Jail to the Community*, Washington, D.C.: Bazelon Center for Mental Health Law, March 2001: 7.
[52] 42 C.F.R. Section 435.916 as cited in Koyanagi, Chris, *Finding the Key to Successful Transition from Jail to the Community*, Washington, D.C.: Bazelon Center for Mental Health Law, March 2001: 7.

[53] Koyanagi, Chris, *Finding the Key to Successful Transition from Jail to the Community*, Washington, D.C.: Bazelon Center for Mental Health Law, March 2001: 7.
[54] Griffin, Patricia A., *Maintaining Medicaid Benefits for Jail Detainees with Co-Occurring Mental Health and Substance Use Disorders*, Delmar, New York: The National GAINS Center for People with Co-Occurring Disorders in the Justice System, Summer 1999/Revised Spring 2002.
[55] According to the Bureau of Justice Statistics, 225,700 (12 percent) of the inmates housed in Federal and State prisons or local jails in 1998 reported prior service in the United States Armed Forces. (See Mumola, Christopher J., "Veterans in Prison or Jail," *Bureau of Justice Statistics Special Report*, NCJ 178888, Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, January 2000: 1.) An exact count of how many of these inmates would qualify for veterans health or disability benefits is not available.
[56] See http://www1.va.gov/elig/page.cfm?pg=1 for information on eligibility categories.
[57] Department of Veterans Affairs, *Federal Benefits for Veterans and Dependents*, Washington, D.C.: Department of Veterans Affairs, 2002: 7. See also http://www1.va.gov/elig/page.cfm?pg=1.
[58] Department of Veterans Affairs, *Federal Benefits for Veterans and Dependents*, Washington, D.C.: Department of Veterans Affairs, 2002: 6.
[59]Ibid., 16.
[60] Total (100 percent) disability ratings for compensation are made based on the rating schedule or, when the rating schedule does not apply, on the basis of unemployability.
[61] See http://www.vba.va.gov/bln/21/Rates/comp01.htm for 2003 compensation amounts.
[62] Department of Veterans Affairs, *Federal Benefits for Veterans and Dependents*, Washington, D.C.: Department of Veterans Affairs, 2002: 18.
[63] Ibid., 20. Pension benefits are also available to "veterans of a period of war who are aged 65 or older and meet service and income requirements, regardless of current physical condition."
[64] Information obtained through a telephone interview with Paul Trowbridge, Department of Veterans Affairs, Central Office, Washington, D.C., October 29, 2003. The department began receiving data from SSA in June 2002. Each month, there are roughly 700 matches between the SSA and veterans databases nationwide, but there is a fairly high percentage of individuals who have been identified previously.
[65] The Bazelon Center for Mental Health Law, *Federal Benefits for Individuals with Serious Mental Illnesses Who Have Been Incarcerated: Fact Sheets about Veterans Benefits, Temporary Assistance for Needy Families (TANF), Food Stamps*, Washington, D.C.: Bazelon Center for Mental Health Law, January 2002: 4.
[66] Inmates who are terminally ill and eligible for compassionate release (early parole) are also eligible to file pre-release applications for benefits.
[67] Although there are no data on the number of individuals with serious medical or mental health disabilities who are released annually from New York prisons, the 200 to 400 who are targeted for benefits assistance probably represent a small percentage of the total who might qualify for these services each year given the large number of individuals released from New York's prisons annually. For example, in 2002, 16,941 inmates (with and without significant medical and mental health disabilities) were released from the New York State Prisons. Data on the number of releasees in 2002, provided in a personal communication from Don Little, guidance specialist, Office of Guidance and Counseling, State of New York Department of Correctional Services, November 13, 2003.
[68] E-mail communication from Thomas Malvey, Director of Policy, New York Division of Disability Determination, October 14, 2003. Following appeal, the acceptance rate increases to over 60 percent.
[69] The city of Philadelphia is also referred to as Philadelphia County.
[70] It is important to note that Pennsylvania offers two types of medical assistance to low-income residents with disabilities. One is the Federal-State Medicaid program described in an earlier section of this report, which provides assistance to low-income individuals with disabilities lasting 12 months or more whose primary diagnosis is not substance abuse. The other is a solely state-funded medical assistance program for low-income individuals with temporary disabilities (i.e., lasting less than 12 months) or with primary diagnoses of substance abuse disorder. Those with disabilities resulting from substance abuse disorders are entitled to a 9-month lifetime medical assistance benefit. Many FIR participants receive State-funded medical assistance; others receive support from the Federal-State Medicaid program. However, regardless

of the source of the medical assistance dollars, the process by which FIR clients obtain medical assistance (i.e., filing applications with the Department of Public Welfare) is the same.

[71] Medical assistance beneficiaries in Pennsylvania maintain their benefits until they serve a full calendar month in prison or jail. After that, the Department of Public Welfare is notified and medical assistance benefits are terminated. Although some FIR clients released from the Philadelphia Prison System into behavioral health treatment have a prior history of receiving medical assistance, a large majority (approximately 90 percent) was not receiving medical assistance at the time of incarceration. Information communicated via e-mail by Barry Savitz, Assistant Health Commissioner, City of Philadelphia, May 16, 2004.

[72] In 1997, Philadelphia County was one of five counties in Pennsylvania that converted to a managed care system for administering medical assistance funds.

[73] *The Philadelphia Partnership: Collaboration Between the Behavioral Health System and the Criminal Justice System*, handout provided by Barry Savitz, Assistant Health Commissioner, City of Philadelphia, September 8, 2003.

[74] Approximately half of all states offer state-funded cash assistance for individuals who do not qualify for Temporary Assistance for Needy Families (TANF). Telephone conversation with Amy Hirsch, Supervising Attorney, Community Legal Services, Inc., Philadelphia, Pennsylvania, January 2, 2003.

[75] Effective September 1, 2003, the Texas Council on Offenders with Mental Impairments (TCOMI) became the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI).

[76] State jails house offenders who are convicted of certain categories of non-violent felony offenses (e.g., property crimes and low-level controlled substances offenses). The maximum length of stay for a single offense may not exceed two years. Repeat offenders may receive overlapping State jail sentences up to three years in duration (www.tdcj.state.tx.us/definitions/definitions-home.htm).

[77] Specified release types include parole, mandatory supervision, flat discharge, State jail probation, Intermediate Sanction, and Substance Abuse Felony Punishment.

[78] Axis I (Clinical) Disorders include schizophrenia and other psychotic disorders, mood disorders, and anxiety disorders. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, Washington, D.C.: American Psychiatric Association, 2000: 27-28.

[79] The Texas Department of Criminal Justice website defines a Substance Abuse Felony Punishment Facility as "a secure residential program that provides substance abuse treatment and counseling to non-violent felony offenders whose substance abuse problem contributed significantly to their committing a crime. Upon completion of the program, the offenders are returned to community supervision, parole, or mandatory supervision." www.tdcj.state.tx.us/definitions/definitions-home.htm, February 13, 2003.

[80] See the Texas Health and Safety Code, "Exchange of Information," Chapter 614, Section 614.017. The law has been amended to allow additional agencies to participate in information sharing. See 77(R) SB 661, Texas Code at http://t1o2.tlc.state.tx.us. In 2003, the Texas legislature further amended the language in Section 614.017 to make information sharing regarding special needs offenders mandatory rather than permissive. In so doing, TCOOMMI has been granted a waiver from privacy regulations specified in the Federal Health Insurance Portability and Privacy Act (HIPPA), effective April 1, 2003, and may continue to share medical and mental health information regarding special needs offenders. E-mail communication from Dee Kifowit, Director, Texas Correctional Office on Offenders with Medical or Mental Impairments, October 8, 2003.

[81] Texas Council on Offenders with Mental Impairments, *The Biennial Report of the Texas Council on Offenders with Mental Impairments*, Austin, Texas: TCOMI, 2003: 27.

[82] Fifty-eight percent of those whose applications were not processed in fiscal year 2002 refused to apply. Among the remaining 42 percent, applications were not processed because inmates' release dates changed, they had detainers pending, they were not qualified aliens, they were transferred out of a pilot facility, or they died. Information provided on May 10, 2005, in an e-mail communication from Kelly Davis, TCOOMMI Program Specialist.

[83] Ibid. For Federal fiscal year 2003, the overall initial allowance rate for SSI/SSDI applications (SSI only, SSDI only, and combined SSI/SSDI) was 38.5 percent, substantially below the 49 percent approval rate for TCOMI clients reported in State fiscal year 2002. (State allowance rate data were provided in an e-mail

from Bruce Rollman, Director of Special Projects, Disability Determination Services, Texas Rehabilitation Commission, Austin, Texas, February 9, 2004.)

[84] Texas Council on Offenders with Mental Impairments, *The Biennial Report of the Texas Council on Offenders with Mental Impairments*, Austin, TX: TCOMI, 2003: 27.

[85] These figures are included in a statistical table prepared by TCOOMMI staff on January 28, 2003.