



**U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy**

ESTABLISHING ELIGIBILITY FOR SSI FOR CHRONICALLY HOMELESS PEOPLE

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Office of the Assistant Secretary for Planning and Evaluation

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PREFACE TO THE ISSUE PAPERS

In 2014, most homeless people will become Medicaid-eligible under the Affordable Care Act (ACA) of 2010 based on their low incomes. Many homeless people have complex physical and behavioral health conditions for which they seek care through frequent use of emergency rooms and inpatient hospitalization, at considerable cost in public resources.

With appropriate supportive services, inappropriate use of crisis health services can be avoided. Medicaid reimbursement is an important source of funding for many of the health, care coordination, and recovery support services that help homeless people succeed in housing and stop such inappropriate use. Among the best indicators of Medicaid's potential usefulness to homeless people once they become beneficiaries are the ways that today's providers have been able to use Medicaid to cover health care and behavioral health care for people who have been chronically homeless and are now living in permanent supportive housing (PSH).

In October 2010, the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation, contracted with Abt Associates Inc. for a study to explore the roles that Medicaid, Community Health Centers, and other HHS programs might play in providing services linked to housing for people who experience chronic homelessness through PSH. **Permanent Supportive Housing** provides a permanent home for formerly homeless people with disabilities, along with the health care and other supportive services needed to help tenants adjust to living in housing and make the changes in their lives that will help them keep their housing. It differs from group homes, board and care facilities, and other treatment programs in that most tenants hold their own leases, and keeping their housing is usually not contingent on their participating in services or remaining at a certain level of illness.

Because Medicaid is implemented through partnerships between states and the Federal Government, every state's Medicaid program is different. Medicaid is only one component of strategies that communities use to create and sustain supportive housing. It does not pay for housing costs, and Medicaid reimbursement is available only for services that address health-related issues. This study focuses on communities known to be using Medicaid to provide integrated health, mental health, and substance use services combined with housing for chronically homeless people. Other states and providers will develop new models of service delivery and reimbursement in the coming years.

The Study's First Phase: Literature Synthesis, Environmental Scan, and Site Visits

The chronically homeless people on whom this study focuses have multiple, complex, and interacting physical and behavioral health conditions. Achieving the best results for these clients and the public institutions and systems from which they get care requires effective engagement, service delivery, and care coordination. To understand how this care is currently being delivered, the research team reviewed both published and unpublished literature and drew on team members' extensive knowledge of successful programs and agencies. The result was "*Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Literature Synthesis and Environmental Scan*" (Burt, Wilkins, and Mauch, 2011). This report documents the evidence on the rationale for linking housing assistance with Medicaid-funded health services--specifically, that these services are more clinically effective while also being less expensive than avoidable emergency room use and hospitalizations.

The research team then conducted site visits to see how housing and supportive services worked together in practice. The team identified the relatively few communities in the United States with experienced providers that integrate housing with health, mental health, and substance abuse services. The team conducted site visits to three of these communities--the San Francisco Bay Area, Chicago, and the Boston-Worcester area. The communities visited are not representative; rather, they are examples. Their experiences may be helpful to policy makers and practitioners alike, as they illustrate both what can be accomplished and the many challenges and barriers that must be overcome along the way. A growing number of communities are starting to implement similar approaches.

The research team then produced four issue papers on promising practices linking health, mental health, and substance abuse services to housing assistance for the target population of chronically homeless people:

- **Paper 1**--describes three subgroups of the people experiencing chronic homelessness, and the services and housing configurations currently supporting them. *Health, Housing, and Service Supports for Three Groups of People Experiencing Chronic Homelessness*. Cambridge, MA: Abt Associates Inc., 2012. M.R. Burt & C. Wilkins.
[\[http://aspe.hhs.gov/daltcp/reports/2012/ChrHomls1.shtml\]](http://aspe.hhs.gov/daltcp/reports/2012/ChrHomls1.shtml)
- **Paper 2**--describes the ways that Medicaid is being used now and might be used in the future under provisions of the ACA to serve chronically homeless people. *Medicaid Financing for Services in Supportive Housing for Chronically Homeless People: Current Practices and Opportunities*. Cambridge, MA: Abt Associates Inc., 2012. C. Wilkins, M.R. Burt, & D. Mauch.
[\[http://aspe.hhs.gov/daltcp/reports/2012/ChrHomls2.shtml\]](http://aspe.hhs.gov/daltcp/reports/2012/ChrHomls2.shtml)

- **Paper 3**--describes innovative approaches to establishing Supplemental Security Income (SSI) eligibility. *Establishing Eligibility for SSI for Chronically Homeless People*. Cambridge, MA: Abt Associates Inc., 2012. M.R. Burt & C. Wilkins.
- **Paper 4**--looks at innovative ways that public housing agencies are supporting housing for formerly homeless people in the communities the researchers visited. *Public Housing Agencies and Permanent Supportive Housing for Chronically Homeless People*. C. Wilkins & M.R. Burt.
[\[http://aspe.hhs.gov/daltcp/reports/2012/ChrHomls4.shtml\]](http://aspe.hhs.gov/daltcp/reports/2012/ChrHomls4.shtml)

Core information about health, housing, and supportive services found in the *Literature Synthesis and Environmental Scan* is not duplicated in the briefs. Likewise, Papers 2, 3, and 4 do not repeat the information on subpopulations found in Paper 1. Each brief refers to the others or to the *Literature Synthesis and Environmental Scan* as needed.

Second Phase: Case Studies of New Strategies

The second phase of this study involves case studies of six communities that are on their way toward early implementation of the ACA's Medicaid provisions or other Medicaid-related policies and practices designed to deliver care to chronically homeless people. The study will follow the six communities through fall 2012, watching as they design and implement different strategies that involve Medicaid waivers, state plan options, and other approaches. Future reports will describe these strategies and the progress communities are making.

1. INTRODUCTION

Homeless people have two compelling reasons to seek enrollment in Supplemental Security Income (SSI): (1) obtaining a reliable income source that will help them afford housing; and (2) increasing their access to appropriate health care through "categorical" eligibility for Medicaid for people who participate in SSI.¹ Housing and health care providers also have a compelling reason to encourage their homeless and formerly homeless clients' enrollment in SSI and Medicaid: the resources from those programs can help cover the costs that providers incur for the care they offer homeless and formerly homeless people.

Most homeless people have little or no income; many have health problems, but few have a regular source of medical care. There may be several reasons for this lack of regular medical care, but one is surely that they have no health insurance. Homelessness also complicates their ability to get medical care because their whereabouts and schedule are not predictable.

When chronically homeless people first meet health care providers, they usually have more than one serious health condition. Commonly they wait until a health condition is extremely serious and then seek care at emergency rooms, which can do little but respond to the immediate crisis. Often the person has:

- No insurance or money, so no way for the provider to get reimbursed for health care.
- No housing and no way to pay for housing--so no way to follow health regimens, get aftercare, or move toward recovery from the illness or to manage the condition.
- No way to retain housing even if it is offered, unless the person gets other services.

If formerly homeless people are covered by insurance, they get better care. The public agencies that provide the health, behavioral health, and other supportive services that help keep formerly homeless people in housing also have a much easier time remaining fiscally solvent if their clients are covered by insurance that can reimburse them for much of the care that clients need.

¹ SSI is a means-tested "welfare" program, designed to supply income to poor people who qualify on the basis of being aged, blind, or disabled. Eligibility for SSI does not depend on past employment. People who are age 65 or older and who meet the income and other non-medical requirements for eligibility do not have to prove that they are disabled. For persons who are blind or disabled and between the ages of 18-64 to be approved, they must be unable to engage in "substantial gainful activity" (i.e., to work and make \$1010 or more per month in 2012; \$1690 if blind).

Income from SSI helps formerly homeless people pay rent and have some money for living expenses, although those who receive SSI benefits have incomes well below the federal poverty level. Most permanent supportive housing (PSH) for formerly homeless people offer deep rent subsidies, but many rely on the tenant to pay some rent. SSI gives tenants the resources to pay their shares, with the rest of the rent usually covered by a subsidy such as a Housing Choice Voucher, project-based Section 8, or a Shelter Plus Care subsidy or by grant resources through the U.S. Department of Housing and Urban Development's Supportive Housing Program. Without income from SSI, many homeless people cannot afford to live in a community and be stably housed.

In 1996, the last time that national data were available, only 11 percent of *all* homeless people reported income from SSI, and only 8 percent from Social Security Disability Insurance (SSDI) benefits (Burt et al., 1999).²

In 2014, virtually all homeless and formerly homeless people will become eligible for Medicaid, but SSI will remain as important for chronically homeless people in the future as it is now. This is because the new Medicaid coverage for homeless and formerly homeless people will likely be for a relatively limited package known as “benchmark” or “essential” services. This service package is likely to contain more restrictions than “full” Medicaid and thus be less likely to cover the array of services that many formerly homeless people need. SSI eligibility, in contrast, renders beneficiaries categorically eligible for “full” Medicaid now and will still do so after 2014. In addition, many formerly homeless people will continue to need SSI income to help them pay for housing and other expenses.

Unfortunately it is not easy to establish eligibility for SSI. SSI eligibility is limited to those below certain income levels who are 65 or older, blind, or disabled. The Social Security Administration (SSA), which administers SSI, follows a five-step procedure to determine disability:³

- Step 1: Is the person working? If the person is working and earns more than \$1,010 a month in 2012, she or he won't be eligible.
- Step 2: Is the person's condition severe? The condition for which the person is claiming disability must interfere with basic work-related activities.

² Unlike SSI, which is means-tested, SSDI is an “insurance” program, designed to provide an income to persons who have worked and paid Social Security payroll taxes for a sufficiently long time but who have become disabled and can no longer work. The two programs use the same criteria for establishing that a disability exists, but have different rules for a number of other things, such as the amount of monthly stipend, how soon benefits start after enrollment, and which health insurance program a person qualifies for. SSI qualifies a person for Medicaid in most states; SSDI qualifies a person for Medicare in all states, but coverage does not begin until 24 months after the person enrolls in SSDI. Some people who get SSDI are still poor enough to qualify for SSI as well, which also means they can participate in both Medicaid and Medicare. These people are called “concurrent beneficiaries” in relation to SSI/SSDI, and “dual-eligibles” in relation to their sources of health care payment. Their status poses some challenges related to getting appropriate health and behavioral health care, as discussed in Wilkins, Burt, and Mauch (2012).

³ Adapted from information supplied by SSA at <http://www.ssa.gov/dibplan/dqualify5.htm>.

- Step 3: Is the condition found on the list of medical conditions? These are conditions that SSA considers so severe that they automatically mean that the person is disabled and thus eligible for SSI. If the conditions are not on the list, SSA must determine whether their severity is equal to that of conditions that *are* on the list. This is the situation many homeless people face. If the condition is judged to be as severe as a list condition, the person is eligible. If it is severe, but not as severe as a list condition, then the process goes to Steps 4 and 5.
- Step 4: Can the person do the work he or she did previously?
- Step 5: Can the person do any type of work? The answers to Steps 4 and 5 must be no for a finding of disability to be established.

Establishing eligibility on the basis of age or blindness is comparatively easy. Likewise, some medical conditions do not require any assessment of function, as long as testing and laboratory results adequately establish the condition. These conditions include pancreatic cancer and most other cancer listings, respiratory impairments, some cardiac impairments, and digestive system impairments. But a functional assessment *is* often required for medical conditions common among homeless people, including musculoskeletal, neurological, and mental impairments. For these conditions, proving a level of functional impairment sufficient to qualify as “disabled” in SSA terms often is not at all easy.

When talking to people in the field who have the responsibility to help homeless people qualify for SSI, one usually hears that the disability determination process takes many months and more often than not ends in failure, at least for the first application. The success rate on first application for all applicants, homeless or not, was 31 percent in 2010, and appeals are currently taking an average of about a year to complete.⁴ The rate is lower for homeless people, with only 10-15 percent succeeding on first application if they apply on their own without help from case workers or advocates (Dennis et al. 2011).

Challenges facing SSI applicants include completing the entire application, getting access to existing documents, inadequacy of existing documentation, and the fact that some diagnoses are harder to document than others. Documenting disability when substance abuse might be a contributing factor is especially difficult.

Nor do the challenges stop for homeless people once they become SSI beneficiaries. Troubled as they often are by mental illnesses and other disabling conditions, coupled with uncertain location and related unreliability of getting mail, homeless people often miss notices to present themselves for continuing disability review procedures and end up dropped from the rolls.

⁴ 2010 SSI Annual Statistical Report. Pub. No. 13-11827. Washington, DC: SSA, August 2011.

SSI is suspended when a person enters an institution such as a state hospital, jail, or prison for a full calendar month; if the stay lasts more than 12 consecutive months, SSI benefits are terminated and the individual must reapply. SSI recipients who are temporarily in institutions for medical care may continue to receive their benefits during the first three full months to maintain the home or living arrangement to which they would return. A physician must certify to SSA via letter that the recipient will be medically confined for 90 consecutive days or fewer. However, if an SSI recipient is in a hospital, skilled nursing facility, intermediate care facility, or nursing home and Medicaid is paying more than 50 percent of the cost of services provided to the individual, the maximum federal payment to the individual is reduced to \$30 a month.

Excellent guides and technical assistance materials already exist to help professionals working with homeless people develop successful SSI applications. Two primary sources of this information are the National Health Care for the Homeless Council (NHCHC) (<http://www.nhchc.org>) and Substance Abuse and Mental Health Services Administration's (SAMHSA's) SSI/SSDI Outreach, Access, and Recovery (SOAR) Technical Assistance Center website (<http://www.prainc.com/SOAR>). Rather than duplicating such information, this brief introduces the issues related to establishing SSI eligibility for homeless people, summarizes relevant material from the NHCHC and SOAR websites, and describes findings from site visits completed for this project to the Boston, Chicago, and San Francisco Bay areas, and from ancillary contacts in Los Angeles and Maine.

We look at the challenges related to establishing eligibility one at a time, then review some of the approaches being used to help homeless people apply successfully. These approaches work for initial applications, appeals and reinstatement of benefits, so we do not discuss reinstatement separately.

2. THE CHALLENGE OF ESTABLISHING SUPPLEMENTAL SECURITY INCOME

To qualify for SSI on the basis of disability, one must be able to document a **diagnosis** that fits into one of SSA's medical listings of impairments. Further, a person must have had the condition associated with the diagnosis for at least a year or be anticipated to have it for at least a year (**duration**). In addition, the condition must meet SSA's definition of **disability**, and this is the hardest eligibility criterion to prove. SSA defines a disabled adult as:

"...an individual [age 18 or older] who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months..."

(42 U.S.C. §1382c(a)(3)(A); 42 U.S.C. §423(d)(1)(A))

And:

"...one must have a severe impairment(s) that makes you unable to do your past relevant work or any other substantial gainful activity that exists in the national economy."

20 CFR 404.1505(a)

"Disability" is a legal and administrative term rather than a medical one. SSA determines that a person is impaired enough to qualify for benefits based on medical evidence, against the standard that the person is not able to "engage in substantial gainful activity" (i.e., to work and make \$1010 or more per month in 2012; \$1690 if blind). SSI eligibility is documented by medical records, doctors' statements based on medical records, and other evidence about a claimant's impairment(s), restrictions, daily activities, and efforts to work, including statements by the claimant him or herself.

Physical conditions are the easiest to document--if one is a paraplegic, the diagnosis is clear, as is duration. However, disability may still be in question, as many paraplegics work and support themselves.

Most doctors are trained to diagnose and treat the condition but not to consider or document differing levels of functional impairment that might lead SSA to determine that a person cannot work. Having two or more conditions complicates the issue further: individually, neither may cause serious impairment, but their combined impact may be considered an acceptable basis for eligibility.

Mental conditions and impairments are less straightforward than physical conditions, in part because of the inherent difficulties of diagnosing accurately and in part because the conditions themselves are often cyclical, with periods when the person may function well and others when functioning is severely impaired. As described

below, substance use conditions raise even more difficult issues. The chronically homeless applicant for SSI typically has multiple health conditions: some form of mental illness, some level of substance use, and some physical ailments or conditions. Therefore he or she has issues with all three criteria: diagnosis, duration, and disability. It can be challenging to document how long a person's incapacity due to the combination of these conditions has lasted or is expected to last, and to establish disability if no single condition does so definitively.

Documenting impairment is not a simple process for anyone, and being homeless makes it even harder. Homeless people have more problems assembling the documentation needed to complete their applications, and state Disability Determination Services (DDS) have more difficulty reaching homeless people to obtain needed additional information.⁵ A recent guide to help clinicians assist their patients to apply for SSI describes the problem (Post et al., 2007, p. 2):

Local studies...suggest that homeless disability claimants are denied benefits at significantly higher rates than other claimants, often for failure to negotiate the arduous application process rather than for lack of severe medical impairments that meet SSA disability criteria. A review of disability claims submitted to the Disability Determination Services in Boston from July 2002 to September 2004 revealed that SSI/SSDI denials were 2.3 times more common than approvals for homeless people, while denials for housed claimants were only 1.5 times more common than approvals (O'Connell et al., 2007, footnote 6, p.9). An earlier study by the Homeless Subcommittee of the Massachusetts DDS Advisory Committee had found that over one-third of unsuccessful disability claims submitted by homeless persons (over a nine-month period in 1998-99) were denied for lack of sufficient medical evidence or failure to keep appointments for a consultative examination (Post, 2001, 61).

Before turning to strategies being developed in local communities to help chronically homeless people enroll in SSI, we look briefly at some of the issues just described: obtaining the information needed to establish eligibility, the adequacy of medical records for establishing eligibility, and the issue of disabilities related to drug addiction and alcoholism (DA&A).

2.1. Accessing Existing Information

SSA requires that the documentation to establish diagnosis, duration, and disability come from acceptable medical sources, which are usually charts or records made by doctors or letters from doctors detailing the contents of those charts and records. If such evidence is not readily available--and it usually is not to chronically homeless people acting on their own--SSA may require an applicant to get a "consultative examination" to

⁵ Local SSA field offices receive applications, check to assure they are complete and determine whether the applicant is eligible based on SSA's non-medical criteria. They then forward the application to the state Disability Determination Services office, which determines medical eligibility. The DDS reports its recommendation to SSA and SSA notifies the applicant of its decision.

document the claimant's impairment(s). Because doctors who do not know and have no history with the applicant usually perform these examinations, they are considerably less likely than the applicant's own health care providers to be able to observe and document type, level, and duration of functional impairments, so the applicant is very likely to face denial of benefits.

Further complications arise because homeless people do not always go to the same provider for care or present with the same issues. They may also forget about some sources of care or fail to tell case workers about them, so documentation from those sources will never enter the application record. Most homeless people's lack of a medical home or continuous primary care practitioner relationship complicates the effort to access the comprehensive information needed for SSI applications.

Officially, for medical records maintained at clinics or hospitals under a claimant's name, Social Security number, or other identifying information, SSA's policy is to request all evidence available from those treating facilities to evaluate impairments, from the time at which a claimant alleges that his or her impairment began. In practice, though, getting enough of the right information about an applicant into SSA's hands to lead to a timely and positive decision is a serious challenge. This was emphasized by all of the people with whom we spoke about SSI eligibility processes during site visits, as well as people with whom we have been discussing these issues for years in communities throughout the country.

The most frequently heard challenges to successful SSI/SSDI applications from health care practitioners, case workers for homeless SSI/SSDI applicants, attorneys working on SSI/SSDI claims, and sometimes representatives of local SSA offices include:

- **Assembling evidence for the duration of medical conditions**--Homeless people tend to use whatever health care provider is available when their need is urgent. They also move between communities and forget where they have received care, further complicating information retrieval. Records of the health care that chronically homeless people have received, and for what conditions, are often scattered among various clinics and hospitals and not easy to assemble. Further, the applicant for SSI may not have sought or received care for some conditions, especially mental illnesses. The doctor currently treating the applicant and being asked to document his or her health conditions(s) and their impact on functioning may have seen the applicant for only a few weeks or months--not enough to attest to a condition's duration or to understand all of the patient's conditions and how they may interact to affect functioning.

If the applicant's current doctors or health care facilities have not known a client for a year or have no records of the particular diagnoses in question going back that far, they can only attest to the length of time they have known the client in connection with the particular diagnoses. Many providers told us that their clients

have to enter care and continue to attend a particular clinic, get services, and wait as long as it takes for the clinic to be able to certify that the required duration of their disabling condition has been met. If the health facilities involved are part of a larger health care system--say a county system with one or more hospitals and several clinics--SSI applicants may have received services for their condition(s) from more than one, and some of those services may go back far enough to document the required duration. But if those records are not electronically retrievable--and they usually are not--applicants may need to wait to apply until they have been in care long enough for their current primary care doctor to be able to document disabling condition(s) that have lasted or are likely to last at least a year.

- **Incorporating information from the people who know the applicant best--** Often, the people who know the applicant best are outreach staff or case workers in homeless assistance agencies. They may write letters supporting an SSI application and include the facts about duration and functional impairment as they know them. While these “third party” letters are not “medical evidence” they can be helpful and are considered by SSA and DDS though not as highly as evidence that comes from an “acceptable medical source.”
- **The cost of retrieving medical records and other documentation--** Sometimes there are charges for copying and sending medical records and other documentation. Homeless applicants rarely have the resources to pay these charges.
- **Communications between SSA offices and homeless applicants--** SSA staff often have questions about an application and try to contact the applicant to resolve those questions or ask for additional information. Homeless people may be difficult to contact, and their applications may be denied if they continue to be unavailable to SSA staff and the needed information is not provided. Having a representative (a case worker or attorney facilitating the application) authorized to communicate with SSA about the application can avert many denials that occur for this reason.
- **Ignorance or confusion about past applications (successful and unsuccessful) for SSI/SSDI--** We frequently heard from case workers and advocates that before coming for help, many of their homeless clients had already tried to apply for SSI/SSDI on their own. Case workers and advocates sometimes find that their clients’ chances of success in their current application improve considerably once information on past applications or enrollment is discovered, though clients may not be able to remember the information or provide it.

2.2. Adequacy of Existing Information

Even if successfully retrieved and assembled, existing documentation may not provide the information needed. Basic problems include:

- Doctors do not know what information SSA needs to see in order to make a determination of disability and approve an application.
- Doctors do not habitually focus on the impact of a patient's condition(s) on functioning, but this is important for establishing disability for some conditions.
- What doctors write in their notes following routine health care interactions often does not have anything to do with documenting impairment levels for SSA. Their notes may be difficult to interpret with respect to functioning, and that can make it less likely that SSA will approve the applicant for SSI.

A doctor in Boston's Health Care for the Homeless Program (BHCHP) offered us an example from his own experience: "When I see a patient with end-stage renal failure and the person is holding her own, I will probably write 'doing well' in the case notes. What I really mean is, 'doing as well as can be expected, considering she's dying and hasn't the energy to leave her house for anything but dialysis,' but that's not what I write down." If the first comment is what the SSA reviewers see, they are likely to deny the claim unless they also see the test results that accompany the doctor's notes. If the doctor instead says "what he really means" as noted above, the claim is more likely to be approved. People interviewed in several of the communities visited for this project are making special efforts to help doctors understand what they need to write in medical charts to help patients with these severe disabilities qualify for SSI.

2.3. Substance Use and "Material Contribution"

Disabling conditions wholly or partly attributable to drug addiction and alcoholism (DA&A, in SSA terminology) have been controversial since Congress established the SSI program in 1972. Over the more than two decades--from program inception to the end of benefits on January 1, 1997 for people whose substance use was "material" to their disability--the role of substance use in determining eligibility for SSI has been a complicating factor in disability decisions.

Philosophical issues were matters of regular discussion, including whether recipients of SSI could work if they would only stop their substance use and, therefore, were therefore not disabled; why the government should be "enabling" people's addictions by giving them a monthly check; and the continuing absence of good linkages to treatment. The final straw was extraordinary growth in DA&A beneficiaries (and therefore costs) in the 1990s: from under 20,000 when the decade began, to almost 170,000 in 1996. Hunt and Baumohl (2003) discuss several factors that probably contributed to this phenomenal enrollment growth, one of which was an SSI Outreach

Project mounted by SSA that was *explicitly designed* to let people with mental illnesses and substance use disorders know that they were eligible and help them qualify.⁶ It was quite successful (Livermore, Stapleton, and Zueschner, 1998). In 1996 Congress directed SSA to end SSI/SSDI eligibility in cases where DA&A was material to the person's disability (Public Law 104-121, Section 105).

Drug addiction and alcoholism can have devastating effects on people's health, contributing to the development of chronic conditions where there were none before. These effects include permanent damage to many bodily systems and may also entail impaired cognitive and mental functioning. The 1996 statutory change that terminated SSI/SSDI eligibility for people whose drug addiction or alcoholism is material to their disability was not intended to disqualify people who have disabling co-occurring impairments. People with substance use disorders who present sufficient medical evidence of impairment that meets SSA disability criteria are entitled to SSI/SSDI regardless of current alcohol or drug use (Post et al., 2007). Denials of eligibility have nevertheless been widely reported to occur at the initial stage of disability determination, and fewer than half of these denials are reversed on appeal. A National Health Care for the Homeless Council guide offers the best coverage of issues related to DA&A, along with many useful approaches to overcoming the barriers to establishing eligibility (Post et al., 2007).

⁶ Hunt and Baumohl (2003) introduces a double issue of *Contemporary Drug Problems*, 30(1-2), 2003 that is devoted entirely to the results of "the SSI study." The SSI study was a 2-year longitudinal inquiry into what happened to the people who lost benefits when, on January 1, 1997, SSA acted on a Congressional directive to terminate benefits for almost 170,000 existing beneficiaries with a DA&A-related impairments, and to stop approving SSI applications for people with such conditions.

3. APPROACHES TO INCREASING THE SUCCESS OF SUPPLEMENTAL SECURITY INCOME APPLICATIONS

Agencies that serve chronically homeless people might be able to cover many of their health-related costs if their clients were on Medicaid, so one would expect them to routinely help clients qualify for SSI. However, quite a few agencies serving homeless people, including major health care providers such as hospitals, do not mount active campaigns to help them obtain disability benefits. From what we learned during site visits for this study to the Boston, Chicago, and San Francisco Bay areas, the reasons differ by setting.

- **Primary care settings.** Most health care environments such as clinics and hospitals do not help homeless patients apply for SSI. The application process is complicated, lengthy, and, in their experience, prone to failure. Even though most such agencies are Medicaid providers and it would ultimately be in their financial interest to obtain Medicaid reimbursement for the care they give homeless patients, they will not, or cannot, spend the staff resources needed to support SSI applications. In part, the availability of federal and state funds to pay for services reduces the incentive for providers to assist with SSI applications. This may change over time with the implementation of ACA.
- **PSH providers.** Many PSH providers are not Medicaid providers themselves and are not partnering with any Medicaid provider. They have decided against trying to become Medicaid providers, wanting to avoid lengthy turnaround times for reimbursement and the risk of having charges disallowed. These PSH providers do not have the expertise to help tenants develop SSI applications that are likely to be successful, nor do they have access to the medical records that could help them do so.

Instead of making SSI applications part of their own missions, many health care and PSH providers rely on legal advocacy organizations to assist people with SSI applications. In some communities (e.g., San Francisco) nearly all of the SSI application support work is done by the staff of legal advocacy organizations. Even where homeless service-providers have received training and help their clients with SSI applications (e.g., Heartland Health Outreach (HHO) in Chicago) they usually turn to legal advocacy organizations to take on the more complicated cases.

In this section, we discuss three broad strategies for increasing the success of SSI applications: case worker training (including development of specialized staff roles), legal advocacy, and system changes. These strategies are not at all mutually exclusive. Communities intent on improving success rates for SSI applications often do several at

once as well as sequentially. But each *could* be used without the others, so we discuss them here separately.

3.1. Case Worker Training and Specialization

Staff of homeless assistance agencies who work with chronically homeless people are often expected to help them apply for SSI. Without special training, such staff may be only slightly more successful than homeless people themselves in completing an application that SSA will approve on initial submission.

Case workers need to know precisely what information SSA is looking for, and what specific facts to include for different disabling conditions. They also need to know where to get the relevant information, and how to access it.

Case workers across the country have learned by doing, but systematic efforts also exist to train case workers. We look at the outcomes of one major effort of this type--the SAMHSA's SSI/SSDI SOAR initiative--which began in 2005 and continues today. A variation on the theme of case worker training is development of specialized staff whose *only* job is to help people apply for disability benefits. We look at three examples of specialized staff--in Portland, Maine, in Chicago, and in Los Angeles.

3.1.1. Results of SOAR

SOAR is designed to improve access to SSI and SSDI for people who are homeless or at risk for homelessness and who also have a disabling condition, specifically mental illness or co-occurring mental illness and substance use disorders. SOAR works at two levels. At the systems level, SOAR offers technical help and strategic planning assistance to bring social service providers, advocates for the homeless, and state and local public agencies together to modify existing practices. At the direct care level, SOAR trains staff in participating states who will then train others--case managers, social workers, and other staff working with homeless people--to give them the information and skills needed to help their clients get SSI or SSDI (Dennis, Lassiter, Connelly, and Lupfer, 2011). The training curriculum, *Stepping Stones to Recovery*, was developed specifically to train case workers to assist with SSI/SSDI applications (Perret and Dennis, 2009).

Fourteen states began participating in SOAR participation in 2005, 11 more in 2006, and ten in 2007. A formal evaluation of SOAR's first three years (Kauff et al., 2009) selected six states--three from each of the first 2 years--for in-depth case studies of the SOAR implementation process. The evaluation collected evidence on the number of SSI/SSDI applications submitted by SOAR participants and their rates of success. Rates of submission and success in the six case study states varied considerably. In the five case study states for which the evaluators were able to get information on

applications submitted and their rates of success, the number of submitted applications ranged from 20 to 187, and rates of success ranged from 26 percent to 100 percent.⁷

By the end of 2011, 48 states had received SOAR training and technical assistance and most had projects functioning in at least some communities. Outcomes as of June 2011 for the 44 states that had projects with at least 1 year's experience, and that could supply data, show that cumulatively these projects had submitted almost 15,000 applications since 2006, of which on average 71 percent were approved on initial application, ranging from 48 percent to 100 percent

Time to decision from receipt of the application at an SSA office averaged 101 days and ranged from 33 days to 234 days). Even the least successful of these projects, at 48 percent approval on first application, achieved a three-fold improvement on the average rate of 10-15 percent that homeless applicants experience when they do not get help with their applications.

The best performance by a SOAR project was Philadelphia's Homeless Advocacy Project. It obtained 99 percent approval in an average of 32 days for 742 applications over a period of 4 years. At the other end of the spectrum were projects that achieved 67 percent approval in 136 days, 61 percent approval in 156 days, and 58 percent approval in 133 days. Evidence from the SOAR implementation study (Kauff et al., 2009) suggests that both approval rates and time to decision were helped by support from SSA and DDS directors who modified their practices to reduce bottlenecks and increase communication with clients' advocates.

3.1.2. Promising SOAR Practices

SOAR training and technical assistance are well-established a website (<http://www.prainc.com/SOAR>) and technical assistance center sponsored by SAMHSA. Numerous documents available through this website describe SOAR techniques and promising practices for improving the success of SSI applications. We limit ourselves in this brief to listing the practices discussed by Dennis, Perret, Seaman, and Wells (2007) and Perret and Dennis (2009):

- **Focus on initial applications.** Do not wait for an application to fail and then rely on an appeal--doing so may add months or years to the process. Assemble the right documentation at the beginning.
- **Become an applicant's representative.** By having an applicant complete an SSA-1696 form, a case worker may become the applicant's representative, legally entitled to speak for the applicant, receive mail, and appear at SSA offices as needed, whether the applicant can be located or persuaded to come in or not.

⁷ See <http://www.prainc.com/cms-assets/documents/52889-944292.2011-outcomes-summary-031212.pdf>.

This form allows two-way communication between the case worker and SSA and between the case worker and DDS.

- **Avoid consultative examinations if at all possible.** Get the proper medical documentation from the applicant's source of treatment before submitting an application. It rarely helps the applicant if SSA asks for a consultative examination.
- **Work closely with hospitals and other health care providers.** Close relationships help get the proper records. They also enable cross-training, so that case workers know what records are likely to contain, and medical staff learn what SSA is looking for and can start providing appropriate documentation, especially of functional impairment.
- **Reach out to medical records departments.** Medical records are often lengthy, highly detailed, and difficult to extract. Case workers need to know what information they might contain and how to ask for and get what they need without receiving masses of irrelevant material.
- **Establish ongoing communication with SSA and DDS.** Both SSA and DDS can set up procedures that substantially enhance the odds that a homeless person's application will more smoothly and expeditiously through the disability determination process. Options include:
 - Flagging applications from homeless people,
 - Establishing a special person or unit that handles applications from homeless people,
 - In big cities, designating particular local SSA offices that will handle all applications from homeless people, and
 - Reserving one or more days a month during which a particular SSA office will work only with homeless people.

Informal arrangements also exist (e.g., building a personal relationship with a particular SSA staff member), who expedites all applications from homeless people if he knows they are coming. But formal ones are better, as they survive changes in staffing.

- **Create a summary report.** Write a report or letter that pulls out and organizes all the relevant facts and document the functioning of the individual as it relates to his or her ability to work, and have an acceptable medical source sign it.

3.1.3. Specialized Staff

Many communities took steps on their own to facilitate the SSI application process for homeless people, often before SOAR began. Establishing positions for staff specializing in SSI applications is an important strategy. As will be seen in our three examples, all of which began before SOAR,⁸ specialized staff and units employ many of the “promising practices” just described to increase their chances of success.

- **Portland, Maine Department of Human Services.** More than a decade ago, the City of Portland began funding a position within its Department of Human Services that is specifically responsible for helping people qualify for SSI/SSDI. The same staff person has occupied the position since its creation and is very successful for a number of reasons, not least of which is her tenure in the position. A large proportion of the people she assists are homeless. She spends a lot of time with potential applicants to get extensive detail about their illnesses, treatment, and work histories. She develops trusting relationships with clients, and they disclose information to her that they might not otherwise reveal on applications.

It takes her about 2 weeks to pull together the information needed for the SSI/SSDI application. During a potential applicant’s first visit, they complete an assessment form, set up visits to health care providers and anyone else the applicant needs to see, and arrange a meeting for filing the application. All of these appointments are scheduled very close together. She also establishes herself as a client representative and uses her office address as a mailing address for all applications. This helps her stay on top of communications and information requests from SSA so these do not get lost or ignored. Longstanding collaborative working relationships with the local SSA and state DDS offices are another important element in how this position functions. Local SSA staff are very cooperative and appreciate the way this position functions to smooth out the application process.

These components together establish continuity of contact (with applicants and with the SSA offices). As a result, the whole process takes approximately 3 months to get SSA’s initial decision from the time the person first appears and asks for assistance. Portland’s approval rate for initial applications is about 42 percent, compared with 10-15 percent for homeless people nationally who apply on their own without case workers or advocates. Over 50 percent of 2008 applications were awarded initially and did not need to go to appeal and a hearing. Furthermore, most applications from Portland that go to a hearing do ultimately get approved. This staff person also does reinstatement applications

⁸ SOAR is just starting in Maine, years after the specialized position was established. HHO had an SSI specialization before SOAR and became a SOAR trainer because it was already experienced. Antecedents of the Benefits and Entitlements Services Team (B.E.S.T.) in Los Angeles began around 2003.

for people who have lost their benefits because they either did not appear for necessary appointments or were institutionalized or incarcerated.

Portland's staff person provides training to shelter staff, case managers, and representatives from other agencies to help them identify people who are likely to qualify for SSI and not refer people to her office who have little chance of qualifying, as this leads to disappointment all around. The largest sources of referrals for assistance are the county General Assistance office, Portland's homeless access and resource center, refugee services, and Healthcare for the Homeless and mental health care providers. About 80 percent of people initially referred for assistance with SSI applications actually submit applications.

- **Chicago, HHO.** HHO has been doing SSI eligibility work for years, and has a standardized procedure for case workers to use, as well as a person with extensive experience whose job it is to supervise preparation of SSI applications. Staff members have also attended SOAR training and help train case workers in other agencies. HHO staff think SOAR is a good model, but that everything depends on local relationships. In their case, one SSA office in Chicago is very helpful and they use it as much as possible. HHO is in a good position to help its clients establish eligibility because, as a Federally Qualified Health Center (FQHC) and behavioral health care provider, it has access to a lot of the medical information needed. Not only does it have its own health records for the client, but Cook County Hospital is cooperative in sending over records for care received there. Many patients served by Cook County Hospital come to HHO for continuing care once they leave the hospital or emergency room, rather than explicitly for the purpose of establishing benefits eligibility, but their relationship with HHO helps HHO determine their eligibility for benefits.
- **Los Angeles, B.E.S.T. collaboration of public and private agencies.** B.E.S.T. began on July 1, 2009, following at least 5 years during which the Los Angeles County Department of Health Services (DHS) developed very successful benefits advocacy techniques and practices, including a streamlined approach to data retrieval.⁹ During the time a person is enrolled in the B.E.S.T. project, an integrated services team works together to document eligibility for disability benefits and coordinate the SSI/SSDI application process. The same team also coordinates direct health and behavioral health care. B.E.S.T. is based at the Center for Community Health, located in Skid Row and run by JWCH Institute, an FQHC offering integrated medical, behavioral health, dental, eye, and clinical pharmacy services. The Institute has served the homeless Skid Row population for a long time. The team includes JWCH staff, staff from county public agencies, and non-profit service-providers.

B.E.S.T. assists participants in all aspects of the SSI/SSDI application process, including tracking the clients' whereabouts, obtaining identification, providing

⁹ Described below in Section 3.2, on "System Change."

transportation, and managing retrieval of health and mental health records. Local SSA offices and California DDS are crucial partners in the B.E.S.T. project. A June 15, 2011 report indicated that, in the 16 months between December 1, 2009 and March 31, 2011, 863 participants were enrolled in B.E.S.T. Of the 503 applications submitted to SSA for these enrollees, 393 had received a decision and 110 were still being reviewed when the report was written. An additional 83 applications were being prepared for submission. Of the 393 with decisions, 334 (85 percent) were approved on first application, with an average length of time from submission to approval of 50 days. This compares favorably with SOAR outcomes, which in 2010 were 73 percent approvals and 90-day average time from submission to approval. The average total time from enrollment in B.E.S.T. to SSA approval was 120 days.¹⁰

3.2. System Change

We noted above that, for facilitating application review, it is better to have formal agency commitments to cooperation, rather than just personal relationships between case workers and eligibility technicians, although such relationships can be helpful as well. Not only will formal commitments survive staffing changes, but agencies that have formally agreed to work together will also be more likely to examine agency procedures and work together to modify any that are found to be counter-productive.

SOAR offers technical assistance to help states and communities improve the application process by changing their systems. SOAR brings social service-providers, advocates for the homeless, and state and local public agencies together for this purpose. The SOAR evaluation (Kauff et al., 2009) identified the structural and systems factors that seemed to affect the likelihood that initial SSI applications would succeed. They include support in SSA and DDS offices from the top levels through supervisory support for case managers or dedicated benefit specialists; structured interagency communication; and data collection on outcomes. As with all new service efforts that require collaboration across multiple government levels, agencies, and people (Burt and Spellman, 2007), SOAR goals are attained to the extent that implementers at all levels commit themselves to the work involved in changing their “standard operating procedures,” and follow-through on those commitments.

We focus on two examples of ways that agencies worked to improve medical data retrieval, and the medical data itself, in Los Angeles and Boston.

¹⁰ Personal communication, Elizabeth Boyce, Los Angeles County Chief Executive Office, June 15, 2011. During the same reporting period, B.E.S.T. also closed 277 cases before an application could be submitted; of these, 108 could not be found and had had no contact with B.E.S.T. for at least 30 days, 64 were found to be ineligible, and 105 were closed for other or unrecorded reasons.

3.2.1. Accessing Medical Documentation

One of the major stumbling blocks for SSI applications for homeless people is the difficulty in documenting the duration and extent of disabling conditions. Homeless people usually do not have a “medical home” and seek medical care at the facility most convenient to them at the time they need care. Records are scattered in many facilities. Rarely has the medical professional being asked to complete SSI/SSDI documentation known the person long enough to be able to report that a condition has existed for a long time at a high level of functional impairment.

To improve this situation, in the early 2000s the Los Angeles County DHS assigned two highly experienced registered nurses to retrieve the needed documentation from the county’s many public health care facilities. DHS runs the county’s seven public hospitals and related clinics. All DHS hospitals use the same data software, “Affinity,” but each hospital has its own computer system and its own system for assigning patient numbers, none of which are linked or integrated across hospitals. For several years the nurses had to go to each hospital to search its patient records and then retrieve relevant data.

In June 2008, DHS succeeded in getting the nurses efficient access to all of the Affinity systems, by locating seven computers (one for each system) in one central place. This “computer room” greatly facilitated the process of verifying when and where people got care, and for what, although nurses still have to go to paper records to retrieve case notes. The new structure of data access made it a lot easier for the nurses to get the data for the case managers in various public and non-profit programs that were helping homeless people complete their SSI/SSDI applications. This capability sped up the process *and* provided the exact information to show when the person’s disabling condition(s) began.

B.E.S.T. is responsible for facilitating the Los Angeles County Department of Public Social Services (DPSS) as it works to move more than 10,000 disabled General Relief recipients onto SSI. To support this process, central data rooms have recently been established in two more county hospitals as part of extensive countywide efforts to qualify more homeless people for SSI. Ten nurses are now stationed at DPSS, DHS’s county hospitals, and the county jail to facilitate client recruitment and data retrieval to support SSI applications.

3.2.2. Improving the Medical Documentation Itself

Doctors are not usually thinking about documenting functional impairments when they make entries in medical charts. Yet for certain medical conditions common among homeless people, including mental illnesses, documentation of functional impairments is exactly what SSA needs to see in medical records before it can establish a finding of disability. In Los Angeles, DHS has found that recently-begun SOAR training plus improved data retrieval helps case workers in homeless assistance agencies to prepare successful SSI applications. However, case worker training is not enough. Even if case

workers are able to access medical documentation, hospital records often do not provide the specific information that SSA needs before it can approve an application.

The DHS nurses stationed at county hospitals use the data retrieval structure just described to access billing records, which give them service use and diagnosis, along with a few other important facts. Notes in client medical records are not automated, so DHS nurses retrieve medical records and make hard copies of essential information. They also go one step further. Especially for recent treatment, they are able to contact attending physicians, clarify their perception of a patient's condition and needed treatment, and have the physicians enter relevant notes into the case record. This updated record then becomes the documentation sent to SSA. The further advantage of these practices is that attending physicians gradually become aware of what they need to include in their medical notes, so the hard copy records are slowly improving.

BHCHP staff members invest significant effort in getting clients covered by SSI because of both the income stream and the Medicaid coverage that comes with SSI. BHCHP prepares medical documentation for SSI determination, and has become quite proficient at documenting conditions and functional impairments to comport with federal regulations, thus enabling its clients to qualify for SSI in short timeframes and with high rates of acceptance on first application. BHCHP's director and other clinicians whose experience has helped them develop techniques of successful medical documentation and have codified their recommendations in a highly informative and detailed guide disseminated by NHCHC (O'Connell et al., 2007).

O'Connell and colleagues recommend two basic strategies to support applications for disability benefits:

1. Refer explicitly to medical criteria for disability specified in the SSA's Listing of Impairments.
2. For patients whose impairments do not meet or equal the level of severity specified in a medical listing, document activities the patient can and cannot do. This strategy is most effectively accomplished in collaboration with a multi-disciplinary clinical team that includes a social worker and/or vocational counselor.

Recommendations for clinicians and health care agencies often suggest that a multi-disciplinary team be involved to cover some of the employment/impairment history elements and acknowledge that complying with these recommendations will be time-consuming. The payoff will be improved patient-provider relationships and clinical outcomes, as well as financial support for patients and Medicaid coverage for health care provided. The manual advises clinicians and agencies to:

- **Understand the disability determination process** for SSI/SSDI and how medical evidence is used at each stage.

- **Understand the criteria DDS uses** for each condition to determine that it is disabling; use the SSA publication *Disability Evaluation Under Social Security* (“The Blue Book”), which explains what SSA must see to find that a disability exists.
- **Write a letter** explaining the assessment of the patient’s impairment. SSA privileges information from “the treating source” above other medical sources; failure to provide a letter will likely mean that SSA will ask for a consultative examination, which rarely leads to approving an application.
- **Build an ongoing relationship with the state DDS agency**, whose staff may be willing to tell you what evidence they need for particular conditions to support a determination of disability.
- **Train all medical professionals** to routinely record and highlight the existence of important criteria for each Blue Book listing relevant to the patient, as they do for vital signs.
- **Expand traditional educational and occupational history-taking** to include how long jobs were held, what activities they entailed, what patients are and are not able to do now, current means of support, why they are unemployed or homeless, literacy level, education completed, and type of education.
- Whenever possible, **document a longitudinal history of the patient’s functional capacity**, including difficulties with activities of daily living, tasks it is difficult for the patient to do, special barriers that exist, and (in)ability to sustain employment for a regular work week (6-8 hours a day, 5 days a week).

3.3. Legal Advocacy

It sometimes takes a lawyer to move a chronically homeless person’s SSI application through to approval. Advocacy organizations such as Health and Disability Advocates (HDA) in Chicago take on the more complicated SSI application cases, often involving appeals and hearings. Even organizations that routinely help clients with their initial application for SSI often do not do appeals. These organizations may send clients needing to appeal an SSA decision to a legal aid organization with resources to support staff that help people who need to appeal. HDA, for instance, has a private three-year foundation grant that supports an experienced lawyer and a social worker devoted completely to SSI applications. The project has about 100 cases open at any given time. Some organizations using the SOAR approach refer persons who need to file an appeal to legal services. Other SOAR providers are increasingly filing requests for reconsiderations and hearings on their own. They use the same techniques they have used for initial applications, and they are experiencing considerable success. In 2011, 33 states reported that their SOAR case managers were working on appeals. SOAR

case managers had filed nearly 2,000 appeals as of June 2011 with a 66 percent approval rate in an average of 159 days.¹¹

HDA staff recommend that health care organizations try to ensure that clients have already taken some steps toward collecting information and, if possible, have filed an initial application before they are referred. Ninety-five percent of the people HDA sees have tried to apply for SSI or had received it at one time and fell off the rolls for one reason or other. The first thing the project staff do is to get a release from the client (SSA-3288) to get all information on past claims or benefits from SSA. They also get an earnings record from electronic sources. Often this search yields enough evidence of disability to proceed directly to filing for reinstatement and back benefits or to making an initial application. It takes staff 1.5 hours to complete the paperwork once the information is in hand. HDA's efforts are supported by an extremely cooperative employee in one SSA office, who provides the SSA history information immediately in response to an SSA-3288 and also lets HDA project staff fill out the application with the client and then bring it in, if the client is unwilling or unable to go to the office.

If the case is clear-cut--say a clear history of mental illness treatment and related impairment, no substance abuse, and a long history of homelessness--project staff file for presumptive eligibility and often get it. This success results from a special arrangement that project staff have with SSA. There is some talk of having one staff person in each local SSA office in Chicago designated as the eligibility technician who handles all applications from homeless people, but this is not yet a reality. HDA staff feel they could succeed with many more presumptive eligibility filings if there were trained partners in each SSA office.

However, of the 100 cases open at a time, only 12-20 a year are of the type that can lead to a presumptive eligibility determination. If initial search procedures have not yielded *any* evidence of disabling conditions in medical records, project staff get staff from caregiving organizations to document conditions and related functional impairments, interview family members about severe cognitive impairments and other conditions, and also pay for new assessments to obtain specific test results. Project staff help clients to apply for Medicaid even before their SSI application goes in, so they will be insured immediately once they get SSI. (In Illinois, qualifying for SSI does not automatically lead to Medicaid enrollment; a separate application is needed even though SSI beneficiaries are categorically eligible.) They also help clients with transportation, linkages to needed services, and similar activities, all of which takes time. While staff are usually quite successful at achieving approvals, the number of people they can serve (100 a year) is very small in relation to the number of chronically homeless people in Chicago who need this level of support to qualify for SSI.

¹¹ See <http://www.prainc.com/cms-assets/documents/52889-944292.2011-outcomes-summary-031212.pdf>.

4. CONCLUSIONS AND IMPLICATIONS

SSI is extremely important for chronically homeless people now and will continue to be so even after the vast majority of chronically and other homeless people become eligible for Medicaid in 2014. SSI provides income that lets people contribute to rent, thereby greatly increasing the odds that they will become stably housed. And SSI will continue to establish its beneficiaries' *categorical* eligibility for Medicaid after 2014, thereby qualifying them for full Medicaid benefits that will likely cover more of the care they need than the basic benefits available through state "benchmark" Medicaid plans.

The National Health Care for the Homeless Council and SAMHSA's SOAR Technical Assistance Center have done excellent jobs of identifying the challenges of helping chronically homeless people qualify for SSI and of offering approaches and techniques to help medical and other practitioners overcome these challenges. NHCHC materials are directed toward practitioners in Health Care for the Homeless programs, which are authorized and partially supported by U.S. Department of Health and Human Services' Bureau of Primary Health Care in the Health Resources and Services Administration. SOAR is directed to anyone serving persons who are homeless or at risk of homelessness who may also have mental illnesses or other disorders that may co-occur with mental illness.

Even though these resources are available and fairly widely advertised, some Health Care for the Homeless programs and other Health Centers and agencies that provides health and behavioral health services to chronically homeless people and PSH tenants have not yet put them into practice. Partnerships among the agencies that provide housing and support services to formerly chronically homeless people are one way to improve this population's access to health care of all types. Joint training to facilitate enrollment in SSI is one important element for these partnerships, but the larger task will be reconfiguring existing resources or finding new resources to staff SSI outreach and application assistance.

REFERENCES

- Baumohl, J., J.A. Swartz, and R.D. Muck (eds.). 2003. The multi-site study of the termination of Supplemental Security Income benefits for drug addicts and alcoholics. *Contemporary Drug Problems*, 30(1-2): 1-537.
- Burt, M.R. and B E. Spellman. 2007. Changing Homeless and Mainstream Service Systems: Essential Approaches to Ending Homelessness. Chapter 2 (pp. 2-1 through 2-46) in D. Dennis, G. Locke, and J. Khadduri (eds.), *Toward Understanding Homelessness: The 2007 National Symposium on Homelessness Research*. Washington, DC: Department of Health and Human Services and Department of Housing and Urban Development.
<http://aspe.hhs.gov/hsp/homelessness/symposium07/burt> or
<http://www.huduser.org/portal/publications/homeless/p2.html>.
- Burt, M.R. and C. Wilkins. 2012. *Health, Housing, and Services Supports for Three Groups of Chronically Homeless People* (Issue Paper 1).
<http://aspe.hhs.gov/daltcp/reports/2012/ChrHomls1.shtml>.
- Burt, M.R., C. Wilkins, and D. Mauch. 2011. *Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Literature Synthesis and Environmental Scan*. Washington, DC: Assistant Secretary for Planning and Evaluation, Department of Health and Human Services.
<http://aspe.hhs.gov/daltcp/reports/2011/ChrHomlr.htm>.
- Burt, M.R., L.Y. Aron, T. Douglas, J. Valente, E. Lee, and B. Iwen. 1999. *Homelessness: Programs and the People They Serve: Findings of the National Survey of Homeless Assistance Providers and Clients*. Washington, DC: U.S. Interagency Council on Homelessness.
<http://www.huduser.org/portal/publications/homeless> and
<http://www.urban.org/publications/310291.html>.
- Dennis, D., M. Lassiter, W.H. Connelly, and K.S. Lupfer. 2011. Helping adults who are homeless gain disability benefits: The SSI/SSDI Outreach, Access, and Recovery (SOAR) program. *Psychiatric Services*, 62(11): 1373-1376.
http://www.prainc.com/SOAR/library/pdfs/SOAR_Psych_Services_2011.pdf.
- Dennis, D., Y. Perret, A. Seaman, and S.M. Wells. 2007. *Expediting Access to SSA Disability Benefits: Promising Practices for People Who Are Homeless*. Delmar, NY: Policy Research Associates, Inc. <http://www.prainc.com/SOAR>.
- Hunt, S.R. and J. Baumohl. 2003. Drink, drugs, and disability: An introduction to the controversy. *Contemporary Drug Problems*, 30(1-2): 9-76.

- Kauff, J., J. Brown, N. Altshuler, N. Denny-Brown, and E.S. Martin. 2009. *Findings from a Study of the SSI/SSDI Outreach, Access, and Recovery (SOAR) Initiative*. Washington, DC: U.S. Department of Health and Human Services. <http://aspe.hhs.gov/hsp/10/SOAR>.
- Linkins, K.W., J.J. Brya, and D.W. Chandler. 2008. *Frequent Users of Health Services Initiative: Final Evaluation Report*. Oakland, CA: Corporation for Supportive Housing. <http://documents.csh.org/documents/fui/FUHSIEvaluationReportFINAL.pdf>.
- Livermore, G., D. Stapleton, and A. Zueschner. 1998. 8 lessons from case studies of recent program growth in five states. Pp. 249-274 in K. Rupp and D. Stapleton (eds.), *Growth in Disability Benefits: Explanations and Policy Implications*, Kalamazoo, MI: W.E. Upjohn Institute for Employment Research.
- O'Connell J.J., B.D. Zevin, P.D. Quick, S.F. Anderson, Y. Perret, and M. Dalton (P.A. Post, (ed.)). 2007. *Documenting Disability: Simple Strategies for Medical Providers*. Nashville, TN: Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council. <http://www.nhchc.org/DocumentingDisability2007.pdf>. This guide updates an earlier version by many of the same authors and integrates the material available separately as Post et al., 2007 related to substance use disorders and co-occurring impairments.
- Post, P.A., Y. Perret, S. Anderson, M. Dalton, and B. Zevin. 2007. *Documenting Disability for Persons with Substance Use Disorders & Co-occurring Impairments: A Guide for Clinicians*, Nashville, TN: National Health Care for the Homeless Council, Inc. <http://www.nhchc.org/DAAguide.pdf>.
- Post, P.A. 2001. *Casualties of Complexity: Why Eligible Homeless People Are Not Enrolled In Medicaid*. Nashville, TN: The National Health Care for the Homeless Council: 72–73. <http://www.nhchc.org/Publications/CasualtiesofComplexity.pdf>.
- Public Law 104–121, Section 105. DAA provisions in the Contract with America Advancement Act of 1996. http://www.socialsecurity.gov/OP_Home/cfr20/404/404-0000.htm.
- Perret, Y., and D. Dennis. 2009. *Stepping Stones to Recovery: A Case Manager's Manual for Assisting Adults Who Are Homeless, with Social Security Disability and Supplemental Security Income Applications*. 3rd edition. HHS Pub. No. SMA 09-4208. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. <http://www.prainc.com/SOAR/training/manual/SteppingStonesMan.pdf>.
- Wilkins, C., M.R. Burt, and D. Mauch. 2012. *Medicaid Financing for Services in Supportive Housing: Current Practices and Opportunities* (Issue Paper 2). <http://aspe.hhs.gov/daltcp/reports/2012/ChrHomIs2.shtml>.

CHRONIC HOMELESSNESS PERMANENT SUPPORTIVE HOUSING VOUCHER DEMONSTRATION EVALUATION DESIGN OPTIONS

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Health, Housing, and Service Supports for Three Groups of People Experiencing
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People: Current Practices and Opportunities

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