

Joint Comments from Homeless Advocacy Organizations
on Proposed Changes in the Administrative Review Process
for Adjudicating Initial Disability Claims
NPRM 05-14845

submitted to
the Social Security Administration
October 21, 2005

The National Health Care for the Homeless Council and other organizations that advocate for people experiencing homelessness (listed below) offer the following comments on the Social Security Administration’s proposed rule on the Administrative Review Process for Adjudicating Initial Disability Claims (RIN 0960-AG31), published in the July 27, 2005 *Federal Register* (20 CFR Parts 404, 405, 416 and 422).

I. Organizations endorsing these comments:

National Health Care for the Homeless Council (<http://www.nhchc.org>)
Advocacy and Training Center of Cumberland, Maryland
Corporation for Supportive Housing (<http://www.csh.org>)
National Alliance to End Homelessness (<http://www.endhomelessness.org>)
National Coalition for Homeless Veterans (<http://www.nchv.org>)
National Coalition for the Homeless (<http://www.nationalhomeless.org>)
National Law Center on Homelessness & Poverty (<http://www.nlchp.org>)
National Network for Youth (<http://www.nn4youth.org>)
National Policy and Advocacy Council on Homelessness (<http://www.npach.org>)
San Francisco Department of Public Health (<http://www.dph.sf.ca.us/default.htm>)
Volunteers of America (<http://www.voa.org>)
Washington State Coalition for the Homeless (<http://www.endhomelessnesswa.org>)
White Bird Clinic, Eugene, Oregon (<http://www.whitebirdclinic.org>)

II. Introduction

Disability precipitates and prolongs homelessness.¹ Homeless people suffer extraordinary and well-documented health risks associated with poverty, overcrowding, and poor access to health care. People without homes are mercilessly exposed to the elements, to violence, and to communicable diseases and parasitic infestations. Circulatory, dermatological, and musculoskeletal problems are common results of excessive walking, standing, and sleeping sitting up. Homelessness and malnutrition go hand-in-hand, increasing vulnerability to acute and chronic illnesses. Stresses associated with homelessness also reduce resistance to disease and account for the emergence of some mental illnesses. Homeless people experience illnesses at three to six times the rates experienced by housed people.²

There is increasing awareness of the role of medical impairment and disability in precipitating and prolonging homelessness. Homelessness itself is an indicator of functional impairment and often a

¹ A homeless person is defined as “an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing” (§330(h) (5) (A), Public Health Service Act). “... A recognition of the instability of an individual’s living arrangement is critical to the definition of homelessness” (Principles of Practice for Health Care for the Homeless grantees, Bureau of Primary Health Care Program Assistance Letter 99–12, March 1, 1999).

² Wright JD. Poor people, poor health: The health status of the homeless. In: Brickner PW, Scharer LK, Conan BA, Savarese M, Scanlan BC. *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States*. New York: WW Norton & Co., 1990: 15–31.

marker of disability. The fact that people with disabilities constitute the “chronically homeless” population in America is extremely troubling. The experience of homelessness has been found to impair the psychological functioning of homeless people, regardless of their age, gender, diagnosis, or medical/psychological history.³ Any national strategy to end and prevent homelessness must include adequate financial supports to enable persons with disabilities which limit their capacity to earn sufficient income through employment to secure housing and meet other basic needs, including health care.

Disability assistance can mitigate health risks associated with homelessness. The most important sources of assistance for Americans with disabilities are two Federal programs administered by the Social Security Administration (SSA) — Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). SSI and SSDI constitute a safety net for persons with disabilities, providing both cash assistance and eligibility for health insurance under Medicaid and/or Medicare. The timely receipt of SSI or SSDI benefits dramatically improves access to food, stable housing, and health care. Persons who qualify for SSI/SSDI are more likely than others to obtain available low-cost housing and receive priority for certain types of subsidized housing. Both the Medicaid coverage that accompanies the receipt of SSI and the Medicare benefits that follow receipt of SSDI improve access to comprehensive health care, including mental health services and addiction treatment.

By increasing access to housing and health care, disability benefits can help to mitigate health risks associated with homelessness, facilitate recovery, improve quality of life for many homeless people, and help them to resolve their homelessness. Homeless individuals with disabilities who receive comprehensive health services, intensive case management, and the means to meet their subsistence needs are much more likely to achieve stabilization, obtain permanent housing, and eventually participate in gainful employment. Expedited SSI/SSDI benefits are therefore extremely important to protect and increase economic security and to prevent and end homelessness. Nevertheless, as many as 80 percent of uninsured clients served by Health Care for the Homeless (HCH) providers are considered disabled but do not receive disability assistance under SSI or SSDI.

Declining social supports and SSI/SSDI eligibility barriers increase risk for prolonged homelessness. Welfare reform efforts and other benefit retractions of the past two decades have left an increasing number of individuals and families at risk of homelessness. Time limits and punitive consequences for noncompliance with welfare guidelines, as well as the narrowing of eligibility criteria to exclude substance use disorders as a basis for disability, have resulted in the elimination of social supports for extremely vulnerable individuals and families.

Lacking access to Federal income support and public health insurance, single adults — by far the majority of clients at most HCH projects — are forced to rely on various State-only programs, which have been cut back or eliminated in most states over the past 20 years. Federal and State disability programs and vocational rehabilitation services are similarly limited. Restricted access to SSI/SSDI benefits is exacerbated by average waiting periods of 1–3 years between application and eligibility determination, and significantly higher denial rates for homeless claimants.

³ Gonzalez EA et al. Neuropsychological evaluation of higher functioning homeless persons: A comparison of an abbreviated test battery to the mini-mental state exam. *Journal of Nervous and Mental Disease*; 189(3): 176–181, 2001.

People experiencing homelessness often fail to obtain SSI or SSDI despite the high likelihood that they would meet eligibility requirements, due to a variety of system barriers. Obstacles include lack of access to health services, insufficient documentation of functional impairments, remote application offices, lack of transportation, and complex application processes. Often barriers are intensified by the functional impairments of mental illness and the lack of personal stability necessary to see a complex application process through to completion.

A national study of homeless assistance providers and their clients conducted in 1996 found that only 11% of homeless service users received SSI and 8% qualified for SSDI.⁴ Local studies conducted since then suggest that homeless disability claimants are denied benefits at significantly higher rates than other claimants. A review of disability claims submitted to the DDS in Boston from July 2002 to September 2004 revealed that SSI/SSDI denials were 2.3 times more common than approvals for homeless individuals, while denials for housed claimants were only 1.5 times more common than approvals.⁵ An earlier study by the Homeless Subcommittee of the Massachusetts DDS Advisory Committee had found that 33% – 37% of unsuccessful disability claims submitted by homeless persons (over a 9-month period in 1998-99) were denied for lack of sufficient medical evidence or failure to keep appointments for a consultative examination.⁶

The Federal Health Care for the Homeless program, administered by the Health Resources and Services Administration, awards grants to 182 health centers that provide primary care and related services to persons experiencing homelessness. HCH providers estimated that as many as 31%–84% of their uninsured homeless clients served in FY 2000 had mental or physical impairments that should have qualified them for SSI and Medicaid; advocates attested that SSI or SSDI benefits may have been obtained for these clients with aggressive application assistance, patient advocacy, and case management.⁷

III. Comments on Proposed Changes in the Disability Determination Process

We strongly support efforts to reduce unnecessary delays for claimants and make disability determinations more efficient, so long as the new procedural requirements do not unfairly prevent those meeting the statutory definition of disability from obtaining benefits.

Our overarching concern about the proposed rule is that in attempting to simplify the disability determination process for adjudicators, it may make the process more complex and harder to negotiate for claimants — especially for those who are homeless. Proposed changes appear to favor the agency over the claimant. We fear that rigid new procedural requirements will be unfair to homeless claimants, as specified in the following comments.

⁴ Burt, Martha, et al. *Homelessness: Programs and the People They Serve: Summary Report – Findings of the National Survey of Homeless Assistance Providers and Clients*, HUD Technical Report. Washington, DC: The Urban Institute, 1999: http://www.huduser.org/Publications/pdf/home_tech/tchap-05.pdf

⁵ O’Connell JJ, Quick PD, Zevin BD, Post PA (Ed.). *Documenting Disability: Simple Strategies for Medical Providers*. Nashville: Health Care for the Homeless Clinicians’ Network, National Health Care for the Homeless Council, Inc., 2004, p. 7: <http://www.nhchc.org/DocumentingDisability.pdf>

⁶ Post, Patricia A. *Casualties of Complexity: Why Eligible Homeless People Are Not Enrolled In Medicaid*. Nashville, TN: The National Health Care for the Homeless Council, 2001, p. 61: <http://www.nhchc.org/Publications/CasualtiesofComplexity.pdf>

⁷ *Ibid.*, pp. 72–73.

Part 405, Subpart B—Initial Determinations

§405.101 Quick disability determination process

Comments:

While the proposed process may expedite benefits for some claimants, it is unlikely to alleviate existing barriers for many of those who are homeless, for the following reasons:

- **Obtaining medical evidence of impairments for homeless claimants within the 20-day limit is usually impossible.** Medical records of claimants who have seen multiple providers in several jurisdictions usually are not readily available. This requirement would be especially difficult for persons with mental illness or other impairments with symptoms that are difficult to document, and for persons with learning problems secondary to language barriers, educational limitations, or undiagnosed learning disabilities limiting capacity to work.

While we applaud the idea of processing applications quickly, in our experience most homeless claimants are unable to provide medical evidence of their impairments quickly enough to enable them to benefit from Quick Disability Determination, as proposed. We are concerned that the 20-day limit is virtually impossible for homeless claimants to meet.

- **Expedited disability determination is needed for all homeless claimants.** For the reason just specified, most homeless claimants would continue to rely on the regular disability determination process. Would quicker approval of more cases with well-documented claims enable faster and more accurate decisions on claims considered during the regular disability determination process? Would referral of cases not approved by a Quick Disability examiner to another examiner in a different unit delay rather than expedite initial decisions for these claimants?

Recommendations:

- **Consider homelessness per se as an indicator of functional impairment in disability determinations, at every level of consideration.** All claims filed by homeless persons should be flagged at all levels of consideration to trigger expedited disability determination due to urgency of need. This would be consistent with the President's goal of ending chronic homelessness. The fact that all disability claims filed by Katrina survivors are flagged for expedited consideration demonstrates that the proposed process is feasible. Social Security, in special circumstances, has long flagged cases; the agency has the administrative capacity to promptly implement such a process.
- **We recommend data collection so that SSA can measure the impact of these proposed rules on homeless claimants nationwide.** The flagging of SSI/SSDI claims filed by homeless persons should be accomplished by adding a check-off box to the SSA application form and a "homeless" field to DDS and SSA datasets. This would enable the agency to track the progress of claims submitted by homeless individuals electronically and to monitor for disparities in outcomes for homeless versus non-homeless claimants (e.g., in allowance rates, average wait between application and final disposition including appeals, etc.), in all regions of the United States. Such data tracking would support the Presidential initiative to end homelessness in ten years.

- **Require all State Disability Determination Services to set up a Homeless Unit** (as in the Boston DDS) or designate individuals familiar with homeless claims to act as a resource for providers in the field and to expedite decisions on these cases.
- **Provide more and better training to medical providers in the field** — not just to the national network of medical, psychological, and vocational experts consulted by DDS. Allow medical providers to have access to this expertise.
- **Expand the definition of qualified medical evidence providers.** Homeless people often do not have access to physicians or psychologists, or may not be willing to see them, but have frequent contact with other licensed health professionals (e.g., clinical social workers, nurse practitioners, physician assistants, nurse clinicians). We therefore recommend that SSA accept diagnoses from these licensed health practitioners as well.
- **Include advocates or community representatives on the Disability Program Policy Council.** Without input from persons who are knowledgeable about the obstacles to Federal disability assistance that special populations (including people experiencing homelessness) encounter, policies will continue to be made that are impossible for them to follow. It is essential that the Disability Program Policy Council include representatives who are familiar with the life situations of people with disabilities who are homeless or at risk of becoming homeless.

Part 405, Subpart C—Review of Initial Determinations by a Reviewing Official

Comment:

- **Under the proposed process, claimants would have no opportunity for communication with the Reviewing Official (RO).** When adjudicators have the opportunity to communicate with claimants, it gives them a more complete basis for determining disability. The explicit objective of this policy is “to ensure to the maximum extent possible the accuracy and consistency—and thus the fairness—of determinations made at the front end of the process.” However, a paper-only review, with no opportunity for communication between the RO and the claimant will not achieve this objective.

§405.210 How to request review of an initial determination.

Comment:

- **Requiring that new evidence be submitted with an appeal request could impose a higher burden on homeless claimants.** It often takes longer to obtain sufficient evidence of medical impairments for individuals who are homeless than for other claimants. The mobility of people without stable housing, their complex medical and psychosocial histories, and inadequate access to health care complicate the task of obtaining medical records or other documentation of impairments from providers in multiple jurisdictions. The uninsured homeless individual typically has received health care through an elaborate and fragmented array of multiple and disconnected emergency room visits in many different locations, too often never seeing the same doctor twice. Such discontinuity of care complicates the compilation of a complete clinical record. Educational limitations, linguistic barriers, and cognitive impairments present additional challenges in gathering evidence, particularly for claimants who experience chronic homelessness.

- **ROs need clinical as well as legal expertise.** The proposed rule indicates that SSA plans to hire attorneys as Federal Reviewing Officials. While attorneys have significant expertise in the legal requirements for SSI eligibility, they are not necessarily familiar with the clinical nuances that can be significant to determining disability.
- **Impact of eliminating reconsideration on homeless claimants is unclear.** Social service providers and advocates have had some success in obtaining allowances of homeless claims at reconsideration. Currently, before the requests for reconsideration are rejected, advocates have the opportunity to call and find out what information is missing from SSI/SSDI claims. Would they be able to do so with the Reviewing Official?

Recommendations:

- **Qualifications of ROs:** Federal Reviewing Officials should include both attorneys and qualified clinicians.
- **Interaction between claimant advocates and ROs:** Advocates should be able to communicate informally with ROs to find out what information is missing from pending disability claims.

§ 405.220 Procedures before a reviewing official.

Comments:

- **Would national network consultants be sufficiently knowledgeable about the complex medical and psychosocial conditions of claimants who are homeless?** The proposed rule states that the RO can obtain more evidence and must consult with a medical or psychological expert affiliated with the national network if he or she disagrees with the DDS decision or if the claimant submits new evidence. Standards that define the medical and psychological expertise necessary for experts to qualify for participation in the national network are to be developed in consultation with the Institute of Medicine. Whatever their professional credentials may be, our concern is that national network consultants may have little understanding of the complex medical and psychosocial conditions characteristic of homeless claimants or the structural barriers they face in meeting basic needs.

Example: Henry has been homeless for the past 15 years. When he is unable to get regular food and shelter, sometimes it is because he is so depressed that he has no energy to do anything. Sometimes it is because the soup kitchens available to him are only open at certain times and he can't get there. In addition, if he doesn't get to the shelter by 2:30 p.m. and stand in line, he won't get a bed. Understanding the homeless service infrastructure as well as Henry's medical and psychosocial history would mean that experts could differentiate ADL issues that relate to access, to his illness, and to both.

- **Who would actually make this decision?** The Reviewing Official (RO) or the Federal Expert Unit (FEU)/national network expert? If the claimant submits new and material medical evidence, the RO must "consult" with the FEU/NN expert. If the RO disagrees with the initial decision and wants to allow the claim, an FEU/NN expert must evaluate the evidence to determine the severity of the impairment(s). Does this create a bias towards affirming the initial decision? Different adjudicators have different points of view. Why is it necessary for the RO to consult a FEU/NN expert to evaluate the claim? The proposed process seems to add steps to the first appeal rather than reducing them.

- **Need for training of SSA/DDS workers:** There is currently no standard training for SSA or DDS workers that addresses the special needs of homeless claimants. Insensitivity of eligibility workers and evaluators to the difficulties encountered by individuals who are homeless in negotiating the disability determination process while meeting basic needs often creates additional barriers for these claimants.

Recommendations:

- **Qualifications of national network members:** Professional credentials and understanding of the disability determination process are necessary but insufficient criteria for the expertise of national network (NN) members. NN experts should also be required to demonstrate understanding of claimants with special needs (including those who are homeless).
- **Training of SSA/DDS personnel:** All personnel involved in SSA applications and disability determinations should receive training designed to increase their understanding of SSI/SSDI claimants and beneficiaries with special needs, including those who are homeless. Although some district offices or State DDS may conduct trainings, currently there is no national training program for SSA/DDS personnel.

Part 405, Subpart D—Administrative Law Judge Hearing

General concern:

- **Do these provisions impose a disproportionate burden for homeless claimants?** Our concern is that proposed changes related to hearings before an administrative law judge (ALJ) would impose procedural barriers that prevent eligible homeless people from getting benefits and prevent ALJs from making accurate decisions.

§405.315 Time and place for a hearing before an administrative law judge.

Comment:

- **Hearing scheduled within 90 days of request:** We welcome the explicit expectation that ALJ hearings will be held within a specified period (90 days) following the claimant's request for a hearing. However, as this is not required by law, how will it be enforced? If hearings continue to be held 1–2 years following requests, what will be done to correct this?

§405.331 Submitting evidence to an administrative law judge.

Comment:

We are concerned that the proposed process may impose a disproportionate burden for homeless claimants and prevent administrative law judges from making accurate decisions. Many new time limits make the process overly complicated.

- **Time limit for submitting evidence before an ALJ hearing:** The proposed rule would require that evidence be submitted 20 days before an ALJ hearing. This short timeframe would limit the ability of advocates to take on cases for homeless claimants, which often require significantly more time to gather evidence. (See comment under §405.101, page 5, and SSI/SSDI eligibility barriers noted on page 3.)

- **Time limits with no “good cause” extension:** (e.g., 10 days to object to time/place of hearing or issues in hearing notice, 10 days to submit new evidence after a hearing, 10 days to ask ALJ to vacate dismissal) Homeless claimants typically have complex medical and psychosocial conditions that interfere with their ability to meet rigid deadlines. The proposed time limits are excessively rigid for this population. Ability to get a favorable decision may be impacted by the time available to develop the case. If an advocate gets the case two weeks before the hearing, a longer time after the hearing may be required to develop the case. The additional time limits seem primarily intended to reduce the number of hearings, which could harm claimants.

Compounding this concern is the wide disparity, from community to community, in the availability of legal assistance to poor people. In some communities, free or low-cost legal assistance is not available at all. As with other kinds of assistance, lack of transportation can also be a barrier. The proposed deadlines would be difficult for homeless claimants to meet without assistance from an advocate—optimally someone experienced in disability law and the special circumstances of homeless claimants.

Recommendation:

- **All time limits for claimants should have “good cause” exceptions,** with special considerations clearly specified.

§405.370 Decision by the administrative law judge.

Comment:

- **Requirement that ALJ address RO decision in a *de novo* hearing:** This seems to undercut the ability of an ALJ to have a *de novo* hearing. Is it realistic to expect that this will lead to impartial new decisions? The main purpose of a *de novo* hearing is to take a fresh look at all evidence. Our concern is that looking at prior evidence already judged to be insufficient might bias this process.

§405.373 Requesting consideration of new and material evidence.

Comments:

- **“Limited circumstances”** under which new and material evidence could be submitted after a hearing are confusing and insufficient, as currently specified.
- **Closing the record after the ALJ issues a decision** (Closing the Record, Supplementary Information, Pages 43596–43597): This requirement would be too burdensome for claimants. New clinical information frequently becomes available when individuals with disabling conditions are re-hospitalized, receive additional treatments, and/or develop new or exacerbated impairments. Claimants should be allowed to have this new information considered as evidence of disability even after an ALJ has issued a decision. SSA should balance administrative efficiency with fairness to claimants.
- **Reopening a prior application:** Under the current rule, SSA can re-open an SSI application for any reason within any year or within 4 years for Title II, often resulting in retroactive benefits which claimants can use to pay off debts, make a down-payment on an apartment, or qualify for Title II benefits. Under the new regulations, reopening could only be

requested within six months for two situations: (1) clerical error in computation of benefits or (2) clear error on the face of the evidence.

Reopening a prior application can be very important for people who clearly meet the disability standard but were unable to adequately articulate their claim in the first application, were unable to obtain evidence, or have an impairment that is difficult to diagnose. For many persons with chronic conditions, including undiagnosed mental impairments, serial applications are filed instead of appeals. Limiting the opportunity to re-open a prior application will negatively affect homeless claimants, many of whom have such conditions. Re-applying affects back payments for SSI claimants and Medicare eligibility for SSDI claimants. The fact that people who are homeless often have difficulty receiving written communications makes this requirement particularly burdensome and unfair.

Recommendation:

- **Retain current policy.** We recommend that consideration of new and material evidence be allowed following an ALJ decision. We support retaining the current rules on reopening a prior application.
- **Address communication barriers.** SSA should make greater efforts to contact claimants than merely send letters. Written communications are not sufficient for displaced persons, particularly those with cognitive impairments and/or literacy problems. These issues are not addressed in the proposed rule.

Part 405, Subpart E—Decision Review Board

§405.410 Selecting claims for Board review.

Comment:

- **Concerns about selection of claims for review:** SSA doesn't have a good track record in selecting ALJ decisions for review. For example, the Bellmon reviews in the 1980's selected ALJs with too high a percentage of favorable decisions. How will SSA ensure that an "equal share" of favorable and unfavorable decisions will be selected? SSA said they would review decisions where errors are likely. Would cases involving co-occurring substance use disorders or disabling conditions for which an objective test is not available to demonstrate disability be over-selected for review?
- **Due process concerns:** Decisions might be made solely on the basis of a computerized profile, rather than on an individual claimant's characteristics. Predictive screening tools would be used to select cases with a high likelihood of error. Who will select the screening criteria? Proposed procedures are complicated and would increase the bureaucratic complexity of the disability determination process.

Part 404, Subpart P—Determining Disability and Blindness

§404.1520a Evaluation of mental impairments:

Comment:

- **(e) documenting application of the technique** needs clarification. Rules propose using a "standard document" to record "how we applied the technique." It is not clear what the term

“technique” refers to. What “standard document” will be used “to record the presence or absence of the criteria and the rating of the degree of functional limitation” at every level of adjudication? Forms currently used for consultative evaluations do not sufficiently capture relevant evidence. Issues often arise with respect to evaluation of functional impairment for people with mental illness. Such evaluations don’t allow for the variability in symptoms and functioning that are part of serious and persistent mental illnesses.

Recommendation:

- **Allow for narrative explanation to fully describe functional impairment.** If SSA is going to use a standard document to evaluate functional impairment, this document should not be simply a checklist, but should allow for clarification, explanation, and exceptions—i.e., more of a narrative explanation. The checklists or fill-in-the-blank questions used in the current ADL form do not capture the nuances—and therefore the severity—of functional impairment in people with serious mental illness.

The Work Opportunity Initiative (Supplementary Information, page 43592):

Comment:

- **Demonstration projects:** Several SSA demonstration projects are designed “to provide supports and services to beneficiaries that will enable them to maximize their self-sufficiency and potentially enter or reenter the workforce” (<http://www.ssa.gov/disabilityresearch/demos.htm>). Yet all but one of these projects — the Homeless Outreach Projects & Evaluation (HOPE) — are designed for SSDI beneficiaries alone. More homeless people are eligible for SSI than for SSDI. Why haven’t more demonstration projects been initiated to provide accelerated benefits and early interventions to SSI claimants and beneficiaries?

Recommendations:

- Implement more demonstration projects that assist SSI claimants and beneficiaries with return to work and expedited benefits including Medicaid coverage.
- Make permanent the HOPE project and/or other procedures to expedite benefits for persons experiencing homelessness, developed in conjunction with their advocates. Implement additional programs with collaborating organizations that will allow more homeless people to enroll in SSI.

III. Conclusion

Our broad intent is to make Federal disability programs (SSI and SSDI) more accessible to homeless claimants who are likely to qualify for benefits, and to assure that all severely impaired individuals with complex medical and social needs have access to Federal disability benefits as quickly as possible, whether or not they are experiencing homelessness. While it is appropriate to deny a claim because the evidence establishes that the individual does not meet the statutory definition of disability, it is wrong to deny benefits to an otherwise eligible, disabled individual who falls between procedural ‘cracks’ or who is unable to submit relevant evidence because of procedural limitations.

The heterogeneity of SSI/SSDI claimants is not taken into account in the proposed rule or under current policy. Special considerations are needed especially for SSI subgroups, including homeless claimants and beneficiaries. Increasing numbers of SSI applicants are individuals experiencing homelessness, many of whom have mental impairments with co-occurring disorders (chemical dependency and other chronic, disabling conditions). Federal and State officials making decisions on these claims must have a solid understanding of the impact that these conditions and homelessness *per se* have on ability to work. SSA/DDS officials should be actively engaged in removing unnecessary procedural impediments that prevent claimants who meet the statutory definition of disability from qualifying for Federal assistance. Yet SSA proposes no additional responsibilities for its staff or contractors to assist claimants who clearly cannot navigate the current or proposed disability determination process. This remains our central concern.

As health care providers and advocates for displaced people, we are eager to work with SSA and with State Disability Determination Services to design and implement disability determination processes that meet the complex medical and social needs of severely impaired people who are homeless, and in so doing, to provide them with the financial and health security that is essential to their resolution of homelessness.