

**SUMMARY OF  
RECOMMENDATIONS**

1. **Ensure timely and accurate disability determinations for SSI/SSDI claimants who are homeless.**
2. **Ensure the adequacy of SSI/SSDI benefit amounts to meet the needs of homeless recipients.**
3. **Ensure that individuals with substance use disorders who meet current Social Security disability criteria receive SSI/SSDI benefits.**
4. **Protect and strengthen state disability assistance programs.**
5. **Strengthen employment programs for SSI/SSDI beneficiaries.**

*Any strategy to prevent and end homelessness must include adequate income and health benefits for people who have disabilities and are unable to work.*

**Disability causes and prolongs homelessness.** Nearly 16 percent of the non-institutionalized U.S. population is disabled, yet people with disabilities constitute over 40% of people who are homeless in America.<sup>1,2</sup> Diminishing affordable housing, depressed wages, higher unemployment, and decreased access to health insurance coverage over the past two decades has placed an increasing number of individuals and families with disabilities at risk of homelessness, and makes leaving homelessness more difficult as well.

**Demonstrating disability is more difficult for individuals experiencing homelessness.** Medical records and other historical documents needed to demonstrate functionality and the duration of disabling conditions are often dispersed among many emergency rooms and hospitals where those without insurance have sought care in the past. These records are often incomplete and not thorough enough in themselves to establish documentation over time, given that visits tend to be episodic. In addition, individuals with serious mental illness, developmental delay, or other cognitive impairments may not be able to remember where more permanent records may be located (e.g., the name and location of their elementary school, their primary care provider as an adolescent, etc.). Living in emergency shelters and on the street also makes retaining documentation and identification more difficult—papers are often ruined by weather, stolen or lost, or discarded by corrections officials upon arrest. All of these factors make documenting disability much more difficult.

**Disability assistance can mitigate the health risks associated with homelessness.** Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) constitute a safety net for persons with disabilities, providing cash assistance and, usually, eligibility for publicly supported health insurance (Medicaid/Medicare). Those who receive SSI/SSDI are also more likely to be eligible for low-cost housing, including supportive housing. Housing alleviates the extraordinary health risks associated with homelessness, expedites recovery, improves quality of life, and helps beneficiaries achieve stability and resume productivity.

**Barriers to accessing SSI/SSDI benefits can prolong homelessness.** Homeless SSI/SSDI claimants often are denied benefits for failure to meet the requirements of an arduous application process, rather than for lack of serious medical impairments that meet SSA disability criteria. Systemic barriers include poor access to health care, insufficient documentation of diagnosis and functional impairments by an approved medical source, remote application offices, complex application processes, disability evaluators unfamiliar with the realities of homelessness, and inconsistent implementation of SSA disability determination policy

across jurisdictions. Barriers can be exacerbated by an applicant's mental illness or by the lack of stability necessary to maintain contact, keep paperwork organized, and meet deadlines throughout the application review.<sup>3</sup>

**There are proven approaches to establishing disability that overcome systemic barriers for individuals experiencing homelessness.** Launched in 2005 with SAMHSA and HUD support, *SSI/SSDI Outreach, Access and Recovery (SOAR)* helps states and communities develop strategies and provide training to case workers who assist individuals in preparing accurate and complete SSI or SSDI applications. Outcomes for 37 states reporting to date indicate that SSI/SSDI approvals for homeless applicants averaged 73% on initial application with decisions received in an average of 91 days. SOAR efforts have helped state and local economies realize \$53,041,104 in savings.<sup>4</sup>

**People experiencing homelessness want to work, but federal disability programs contain disincentives to re-enter employment.** Surveys conducted in 2007 and 2009 in Sacramento found that nearly 90% of people who are experiencing homelessness want to work.<sup>5</sup> Another study conducted in 2010 by the Health Care for the Homeless in Baltimore resulted in similar findings (86%).<sup>6</sup> Job loss or inability to return to the work can be a result of a number of factors including economy, disability, poor health, lack of job skills, and limited supply of low-skill jobs. Those who find themselves out of work rely on a number of systems to regain stability. However, the lack of coordination among support systems is preventing many people who have disabilities from transitioning to meaningful careers. The Government Accountability Office (GAO) found work participation by people with disabilities to be difficult in part because of the patchwork of disability programs in the United States that lack coordination or a unified set of goals.<sup>7</sup> The GAO identified 20 federal agencies that administer almost 200 programs for people who have disabilities with most programs having unique rules, definitions, and applications.<sup>8</sup> Such poorly integrated services and supports have provided a disincentive to work because a disabled individual's health care and even housing could be compromised if he/she was to begin working. We support the strategies contained in the Federal Strategic Plan to Prevent and End Homelessness to improve coordination and integration of employment programs.<sup>9</sup>

## Disability, Employment & Homelessness Recommendations in Detail

### 1. **Ensure timely and accurate disability determinations for SSI/SSDI claimants who are homeless.**

Waiting periods between initial application and eligibility determination that average 1 to 3 years are especially devastating for homeless claimants. To expedite disability assistance for persons likely to be eligible for SSI or SSDI, the National Health Care for the Homeless Council urges Congress and the Administration to pursue the following changes:

- **Ensure better cooperation among the Social Security Administration (SSA), State Disability Determination Services (DDS) and community initiatives nationwide to expedite disability benefits for eligible homeless claimants.** Encourage SSA to flag all applications from individuals who are homeless so as to expedite processing at the DDS. Encourage all DDS agencies to establish a Homeless Claims Unit with designated examiners responsible for processing SSI/SSDI claims filed by homeless persons and for expediting disability determinations for such claimants. Direct SSA to consider repeated episodes or extended periods of homelessness as an indicator of functional impairment. Encourage SSA field offices to develop partnerships with community health and social services providers to help homeless people with SSI/SSDI applications.
- **Revise the SSA Homelessness Plan to incorporate lessons learned from HOPE,<sup>10</sup> the SSI/SSDI Outreach, Access & Recovery (SOAR) Project,<sup>11</sup> and the Baltimore SSI Outreach Project and increase support for these initiatives.**<sup>12</sup> Demonstration projects have confirmed policies and procedures that can improve allowance rates at initial consideration, and expedite access to SSI/SSDI for applicants who are homeless. Successful strategies include: (1) educating SSA and DDS staff about

issues related to homelessness; (2) designating SSA and DDS staff to assist homeless claimants; (3) ensuring that all such applications are flagged for expedited processing; (4) tracking outcomes of applications from homeless applicants separately from those of other applicants; and (5) developing processes to ensure that eligibility determinations are made as soon as possible. Such strategies should be incorporated into a revised SSA Homelessness Plan that includes timelines for implementation. By implementing these strategies, SSA could improve approval rates while reducing waiting periods for homeless claimants. Indeed, the SOAR program has resulted in a 73% approval rate at initial application with an average processing time of 91 days.<sup>13</sup>

- **Ensure prompt decisions at the administrative law judge hearings level.** Case backlogs are resulting in delays of 22 months or longer to get a hearing. Encourage efforts to expedite and improve the accuracy of disability determinations at initial consideration (exemplified by the SOAR initiative) which can reduce these backlogs. Whenever possible, SSA Offices of Disability Adjudication and Review should conduct "reviews on record" to avoid in-person hearings and to obtain quicker decisions on relevant claims.
- **Add homelessness with diagnosed schizophrenia to criteria for Presumptive Disability**, which would allow claimants to receive six months of benefits pending determination of their eligibility for extended benefits. Homelessness is an indicator of the extent of functional impairment among people with schizophrenia. Whereas the national incidence of homelessness is less than one percent, 20 percent of people with schizophrenia are homeless.<sup>14</sup> SSA should develop special SSI eligibility determination processes for claimants who are homeless and who have serious mental illness, and train designated SSA claims representatives to respond appropriately to such claimants.
- **Expand the list of "acceptable medical sources" that can provide medical evidence of impairment to include nurse practitioners, physician assistants, licensed clinical social workers, and psychiatric clinical nurse specialists.** Many clinical services are provided by nurse practitioners, physician assistants, licensed clinical social workers, and psychiatric clinical nurse specialists rather than by physicians and psychiatrists. SSA should reduce barriers to SSI/SSDI enrollment by expanding the list of "acceptable medical sources" that can provide medical evidence of impairment to include the clinical providers that clients are more likely to see in the programs that serve them.
- **Collect data on the housing status and success rates of SSI/SSDI applicants.** Report aggregate numbers of homeless SSI/SSDI claimants, rates of approval, and average length of time between application and final determination. Not only will this appropriately identify the most vulnerable individuals seeking disability assistance, but this recommendation also reflects a larger national strategy contained in the *Federal Strategic Plan to Prevent and End Homelessness*, which seeks to incorporate housing status as a common data element in mainstream programs. Analysis of this data would better describe the needs of those using key safety net programs and hopefully help improve program results.
- **Eliminate the 2-year waiting period for Medicare.** Federal law requires individuals qualifying for SSDI to wait 2 years prior to being eligible for Medicare, leaving many uninsured during this period. A study by the Commonwealth Fund found the cumulative mortality rates by the 13th, 25th, and 37th month after entry in the SSDI program to be approximately 9 percent, 13 percent, and 15 percent, respectively. Nearly 13 percent of the individuals studied never receive Medicare benefits, even though they likely contributed to Medicare's financing for many years.<sup>15</sup> Claimants meeting the stringent eligibility criteria for SSDI are considered to have a significant disability and should have immediate access to health coverage. The 2-year waiting period for Medicare after qualifying for SSDI presents significant barriers to health care access for individuals who have already insured themselves for benefits by virtue of their contributions to the Social Security trust fund through a tax on their earnings. Indeed, the Accelerated Benefits Demonstration, which provides immediate access to Medicare for SSDI beneficiaries, has resulted in fewer reports of unmet health care needs of the project participants.<sup>16</sup>
- **Expand the list of Compassionate Allowance categories to include disabling health conditions that are disproportionately experienced by homeless applicants**—such as uncontrollable diabetes, traumatic brain injury, schizophrenia, and chronic neuropathies. Compassionate allowances (CAL) enable Social Security to provide SSI/SSDI benefits quickly to applicants whose medical conditions are so serious that their conditions obviously meet disability standards.<sup>17</sup>

## **2. Ensure SSI benefit amounts are adequate to meet the needs of homeless recipients.**

The SSI program was “designed to provide a positive assurance that the Nation’s aged, blind, and disabled people would no longer have to subsist on below poverty-level incomes.”<sup>18</sup> Yet, in 2011, the maximum monthly federal benefit for an individual is \$674. For a disabled individual living solely on SSI, the annual income is just over \$8,000, thereby ensuring that the SSI recipient remains nearly destitute. We urge Congress and the Administration to make the following changes to current policy:

- **Ensure disability benefit levels are high enough to enable program participants to meet basic needs, including housing.** Index disability payments to local costs of living (e.g. HUD Fair Market Rent calculations). Minimally, the federal SSI payment should allow beneficiaries to be able to access adequate housing using 30% of their annual median income.
- **Update income disregards and asset eligibility criteria** to reflect current living standards. The earned income disregard (\$65)<sup>19</sup> has remained unchanged since 1972. SSI asset limits (\$2,000 for an individual), have not been adjusted since 1989, failing to keep up with inflation.

The earned income disregard is the amount of earned income that is excluded from earnings when SSA determines SSI eligibility and payment. One consequence of maintaining such a low income disregard is that an individual who works steadily but earns low wages could have a combined income and SSI benefit that is only slightly larger than the SSI benefit the individual would have received if he or she had not worked at all. If the disregard were adjusted to account for inflation since 1972, the updated amount would be approximately \$342. Though the asset limit excludes an individual’s home, car and certain other assets, it allows no room for unexpected expenses. Increasing the asset limit would further reduce poverty among people with disabilities. An adjustment in asset limits could be made in one of two ways. The resource limit could be increased by a flat amount, as was done in the past. (The 1984 legislation gradually raised the asset limits from \$1,500 to \$2,000 for individuals and from \$2,250 to \$3,000 for couples.) Alternatively, the asset limit could be increased each year based on the change in the Consumer Price Index. This would be consistent with the treatment of SSI benefits, which are updated using the CPI.<sup>20</sup>

- **In all states, ensure SSI recipients are automatically linked to Medicaid coverage**, which is essential to persons with disabilities who are homeless. Timely Medicaid coverage should be guaranteed for all persons determined eligible or presumptively eligible for SSI benefits. Currently, 11 states do not link Medicaid eligibility with disability determination, and instead have their own eligibility rules for Medicaid. This gap creates additional process burden on individuals attempting to access the health insurance needed to managing disabling health conditions.<sup>21</sup>

## **3. Ensure that individuals with substance use disorders who meet current Social Security disability criteria receive SSI/SSDI benefits**

Welfare reforms in 1996 terminated SSI/SSDI eligibility for individuals whose substance dependence is “a contributing factor material to the determination of their disability” but it was not intended to disqualify individuals with other impairments that meet Social Security disability criteria. We urge SSA and Congress to make the following policy changes:

- **Ensure those individuals who have both substance disorders and co-occurring impairments who meet current Social Security disability criteria are able to receive SSI/SSDI benefits.** The Drug Addiction or Alcoholism (DAA) policy has been inconsistently interpreted and applied at all stages of disability determination. The intent of Congress was not to exclude people who are dealing with co-occurring impairments from receiving SSI/SSDI benefits. Congress and the Administration should restate this intent and provide sufficient oversight to ensure that SSI/SSDI eligibility is more consistently granted to persons whose disability is not materially affected by their alcohol or drug use.

- **Restore SSI/SSDI eligibility to persons whose alcohol or drug use is material to their disability.** In 2009, Health Care for the Homeless Projects cared for approximately 21,700 individuals whose primary diagnosis was an alcohol related disorder and nearly 24,000 whose primary diagnosis was another substance related disorder. This represents 2.6% and 2.9% of total HCH patients respectively and also accounts for many of the individuals who are unable to access treatment due to lack of insurance or limited availability of subsidized treatment programs. The continuing exclusion of such persons from benefits fails to recognize medical knowledge about the nature of addictions and creates a barrier to accessing medical services and treatment for patients suffering from progressive and often fatal disorders.

#### **4. Protect and strengthen state disability assistance programs**

For those awaiting federal disability determination, thirty-nine states have a cash assistance program that provides a small stipend each month to help meet basic needs. Most of these programs are loan programs, meaning that the state is reimbursed for its expenditures once benefits are awarded. These programs tend to be counter-cyclical; enrollment increases during economic hardship at the same time that states are generating less income and tax revenue. When this happens, states respond by freezing the program, changing eligibility, reducing payment amounts, or otherwise curtailing assistance. Disability assistance programs should be protected from these reactive and counter-productive decisions. Ultimately, if individuals were able to access federal benefits more quickly (e.g., through the SOAR initiative), states would realize those savings with better outcomes.

State disability assistance programs should be strengthened to provide adequate assistance for people who are waiting for federal SSI/SSDI benefits. Currently, the stipend in most states is far below that required to meet basic needs (e.g., in Maryland, the monthly stipend is \$185; in Colorado, it is \$200). Individuals experiencing homelessness who are disabled and unable to work usually have to wait much longer to receive SSI/SSDI, and therefore, are homeless longer. Likewise, disabled individuals who have homes and who are unable to work are at risk of slipping into homelessness. States should be encouraged to increase the stipend levels for their disability programs so that recipients are less likely to experience homelessness or prolonged homelessness while awaiting federal benefits.

#### **5. Strengthen employment programs for SSI/SSDI beneficiaries**

Many people who have disabilities are able to work yet have difficulty transitioning to meaningful careers. Employment programs for SSI/SSDI beneficiaries can be improved through better coordination and integration with other mainstream programs, tailoring programs to include supports specifically for people who are experiencing homelessness, and by simplifying SSA work requirements.

**Improve coordination and integration of mainstream programs.** The *Federal Strategic Plan to Prevent and End Homelessness* categorizes mainstream programs into three categories (health care, income support, and work support). The U.S. Interagency Council on Homelessness describes the process for applying for services as complex, fragmented, and often designed to screen people out rather than reaching out and expediting support for people who need it. Mainstream programs could be better coordinated through a combined application process or “one door” policy and with structures in place to prevent loss of benefits and supports as new supports are gained.

**Tailor mainstream employment programs to meet the needs of homeless populations.** Currently, most mainstream employment programs, including those available through SSA and the Workforce Investment Act, do not have structures in place to target people who are experiencing homelessness. Processes should be put in place to reach out and expedite support for people who are experiencing homelessness. The Workforce Investment Act, designed to help all Americans prepare for employment and re-enter the workforce, could be expanded to include funding for counselors who could specifically work with homeless claimants to access employment opportunities.

**Reduce the complexity of SSI and SSDI work rules and ensure that people have the opportunity to maintain health coverage and build financial independence.** The BOND<sup>22</sup> (Beneficiaries Offset National Demonstration) Project (also known as the “\$1 for \$2 Benefit Offset”) tests the effects of allowing SSDI beneficiaries to work without total loss of benefits. The demonstration project attempts to simplify work rules for SSDI beneficiaries but could create confusion (participation in the demonstration is voluntary and beneficiaries are placed in one of three experimental groups with different program regulations.) Further, the present earned income thresholds are not sufficient to provide economic security and financial independence. Currently, SSI beneficiaries who are no longer eligible for the SSI program due to their income are only able to maintain their Medicaid coverage until their income reaches a certain income threshold established by their state. Health coverage for people who have disabilities is extremely costly, and the income threshold may not reflect the true cost of health care for people who have a disability even within the high-risk pools created for people with pre-existing conditions. Health costs contribute to bankruptcy and homelessness in the United States; income threshold requirements that do not take into account the true health care costs could jeopardize the financial stability of people attempting to return to work.

**Improve notices to recipients about overpayments and improve timeliness of overpayment decisions.** Overpayments occur when a change in income or assets is not reported on time, resulting in an unadjusted SSI/SSDI payment. Most SSI/SSDI beneficiaries will face an overpayment at some point while receiving benefits.<sup>23</sup> For a SSI or SSDI beneficiary who depends on multiple benefit programs to meet their basic needs, changes in benefits are common and frequent. SSA should make sure that beneficiaries know what and when to report, send annual statements that are easy to understand, and ensure that any claimant reports are rectified in a timely manner. This will help ensure that beneficiaries make timely reports, and avoid large overpayments. Repayment for an overpayment of benefits can place extreme stress on a beneficiary and even hamper efforts to return to work.

**Simplify and improve reporting procedures.** The 2010 Red Book published by SSA explains that SSA will provide a receipt when a beneficiary fulfills their obligation to report changes in their work activity. SSA also states that a beneficiary can ask for a receipt if one is not offered, which can be confusing. SSA should implement policies that require SSA staff to give receipts to everyone reporting work income (including parents who are reporting income that affects children’s SSI benefits). Receipts should be made to both representative payees and the beneficiaries. SSA should have a unified set of procedures for staff to follow, and should improve accountability by putting in place procedures for evaluating timeliness and accuracy of processing reports by district office employees.

---

## Notes

<sup>1</sup> The federal HUD definition of chronically homeless is an unaccompanied disabled individual who has been continuously homeless for over one year. <http://www.hud.gov/offices/cpd/homeless/chronic.cfm>.

<sup>2</sup> HUD. 2009 Annual Homeless Assessment Report. [http://www.huduser.org/Publications/pdf/2009\\_homeless\\_508.pdf](http://www.huduser.org/Publications/pdf/2009_homeless_508.pdf)

<sup>3</sup> O’Connell et al. (2007). *Documenting Disability: Simple Strategies for Medical Providers*. Health Care for the Homeless Clinicians’ Network, National Health Care for the Homeless Council, Inc.

<http://www.nhchc.org/DocumentingDisability2007.pdf>

<sup>4</sup> 2010 National SOAR Outcome. Available online at:

<http://www.prainc.com/SOAR/soar101/pdfs/SOAROutcomes2010.pdf>.

<sup>5</sup> National Coalition for the Homeless. (August 2009). Homeless Employment Report: Findings and Recommendations. See <http://www.nationalhomeless.org/publications/homelessemploymentreport/index.html>

<sup>6</sup> Baltimore Health Care for the Homeless (December 2010). In publication.

<sup>7</sup> Government Accountability Office. (July 2010). Highlights of a Forum: Actions That Could Decrease Work Participating for adults with disabilities. Available online at: <http://www.gao.gov/products/GAO-10-812SP>

<sup>8</sup> Ibid.

<sup>9</sup> U.S. Interagency Council on Homelessness. (2010). Opening Doors: The Federal Strategic Plan to Prevent and End Homelessness. See [http://www.usich.gov/PDF/OpeningDoors\\_2010\\_FSPPreventEndHomeless.pdf](http://www.usich.gov/PDF/OpeningDoors_2010_FSPPreventEndHomeless.pdf)

<sup>10</sup> The Homeless Outreach Projects and Evaluation (HOPE) program, established by the Social Security Administration, provided grant funding to 41 agencies in 2004 to assist chronically homeless individuals in applying for SSI and SSDI benefits. <http://www.ssa.gov/homelessness/outreach.htm>

<sup>11</sup> Launched in 2005 with SAMHSA and HUD support, SOAR helps states and communities develop strategies and provide training to case workers who assist individuals in preparing accurate and complete SSI or SSDI applications. Outcomes for 37 states reporting to date indicate that SSI/SSDI allowances for homeless applicants averaged 73% on initial application with decisions received in an average of 91 day. SOAR efforts have helped state and local economies realize \$53,041,104. See <http://www.prainc.com/SOAR/soar101/pdfs/SOAROutcomes2010.pdf>. For more information about SOAR see: [www.prainc.com/soar](http://www.prainc.com/soar)

<sup>12</sup> The University of Maryland Medical System Baltimore SSI Outreach Project began in 1993 as SSA funded outreach demonstration project, designed to assist homeless adults with severe and persistent mental illness in obtaining SSI benefits. Over 10 years, the project achieved a 96% success rate on application for those whom project staff believed to be eligible for benefits.

<sup>13</sup> See reference 11

<sup>14</sup> Folsom, D.P., Hawthorne, W., et. al. "Prevalence and Risk Factors for Homelessness and Utilization of Mental Health Services Among 10,340 Patients with Serious Mental Illness in a Large Public Mental Health System." *Am J. Psychiatry*. 2005.

<sup>15</sup> Livermore, G., Stapleton, D., and Claypool, H. (May 2009). Health Insurance and Health Care Access Before and After SSDI Entry. Available online at: <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/May/Health-Insurance-and-Health-Care-Access-Before-and-After.aspx>

<sup>16</sup> Mathematica Policy Research, Inc. (April 2010). Providing Health Benefits and Work-Related Services to Social Security Disability Insurance Beneficiaries: Six-Month Results from the Accelerated Benefits Demonstration. See: [http://www.mathematica-mpr.com/publications/pdfs/disability/Accelerated\\_Benefits\\_Brief.pdf](http://www.mathematica-mpr.com/publications/pdfs/disability/Accelerated_Benefits_Brief.pdf)

<sup>17</sup> Compassionate allowances (CAL) enable Social Security to provide SSI/SSDI benefits quickly to applicants whose medical conditions are so serious that their conditions obviously meet disability standards. <http://www.ssa.gov/compassionateallowances/>

<sup>18</sup> "Social Security Amendments of 1972, S. Rpt. 92-1230." *U.S. Senate Committee on Finance*.

<sup>19</sup> Not all income is counted in determining SSI eligibility and payment amount. First, there is a general income disregard. Twenty dollars per month of unearned or earned income is excluded. Second, a separate and additional \$65 of earned income plus 50 percent of any remaining earnings are also excluded. This is called the earned income disregard. <http://www.socialsecurity.gov/redbook/eng/ssi-only-employment-supports.htm#1>

<sup>20</sup> Center on Budget and Policy Priorities. (2000) Options for Reducing Poverty Among Elderly Women by Improving Supplemental Security Income. Available online at: <http://www.cbpp.org/cms/index.cfm?fa=view&id=1522>

<sup>21</sup> Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, Virginia. See <http://www.gao.gov/products/GAO-10-812SP>.

<sup>22</sup> BOND Project website: <http://www.bondssa.org/>

<sup>23</sup> Sheldon, J.R. & Cebulla, R.A. (2009). Overpayments and the Return to Work: A Practical Guide for Benefits Planners and Advocates. Employment and Disability Institute at Cornell University. Available at: <http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1281&context=edicollect>