



Expediting Access to SSA Disability Benefits: Promising Practices for People Who Are Homeless

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Helping people with disabilities who are homeless gain access to the Social Security Administration's (SSA) benefit programs for people with physical and/or mental disabilities—Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI)—is a financially sound investment in people, in programs, and in communities. For individuals, the immediate gains of SSI and SSDI are clear: a steady income and health coverage. In addition, having SSI and/or SSDI brings homeless adults a step closer to accessing stable housing, treatment, and support services. Using SSA's work incentive programs, individuals can return to or begin employment, which may be an integral part of their recovery from serious mental illness.

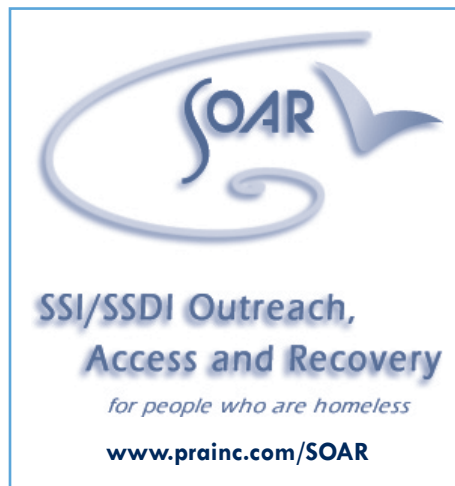
For community providers, SSI/SSDI eligibility for individual clients, and Medicaid eligibility that results from SSI eligibility in most States, help agencies expand their capacity to serve people with the most complex needs. State and local governments may recoup money spent on general assistance to applicants, and health care providers may receive Medicaid reimbursement for services they provide. These are not small incentives. In San Francisco, the County Department of Public Health realizes a 7:1 return on investment for assisting SSI applicants. State and local agencies that recoup such monies then have funds to provide services and support to other people who are homeless.

Despite the benefits to individuals and communities, many homeless adults, particularly those who are chronically homeless and have mental illnesses or other disabilities, do not receive SSA disability benefits. Estimates are that two-thirds of people who are chronically homeless have one or more serious health or behavioral health problems. Many likely would be eligible for SSA benefits. Overall,

only 11 percent of the homeless population is estimated to receive SSI.¹ There are many reasons why eligible people who are homeless do not receive benefits; chief among these are:

- They are unaware of SSA programs.
- They have difficulty completing the application and are unable to get help in applying.
- Factors related to homelessness—such as lack of an address, not keeping in contact with SSA, and not keeping essential records, including records of treatment—can complicate the application process.
- Factors related to mental illness—such as denial of mental illness because of the associated stigma and the effect of symptoms on the ability to work—may inhibit individuals or the agencies that serve them from filing a complete application.

The process of applying for SSA disability benefits is difficult for anyone to navigate, regardless of whether they are homeless or housed. Nationally, the success rate on initial application for *all* applicants is 37 percent.² However, successful programs cited in this report, serving people who are homeless, have achieved approval rates on initial determinations, of between 65 and 95 percent.



What Works? Key Qualities for Success

As communities become increasingly aware of the costs of homelessness, they are helping people who are homeless and who have disabilities access SSA disability benefits. Staff that work in mental health and homeless assistance programs become knowledgeable about the application process and work closely with the SSA and the State-level Disability Determination Services

(DDS).³ The strategies that successful programs use to enhance access to SSA disability benefits can be replicated by other communities as part of their efforts to end chronic homelessness.

What does it take to make a difference? While the specifics of their programs vary, successful SSI initiatives have several qualities that contribute to their success. In particular, they:

- Use promising practices (see text box)
- Ensure adequate staffing
- Provide staff training
- Collaborate with other key stakeholders
- Collect and report on outcomes

These approaches are examined in the following pages in an effort to help others identify strategies they may wish to adopt or adapt for use in their own agencies or communities.

Use Promising Practices

Organizations and communities have identified the following practices as key to their success:

Promising Practices

1. Focus on initial applications
2. Become an applicant's representative
3. Avoid the need for CEs or collaborate with DDS to make CEs more effective
4. Work closely with health care providers
5. Reach out to medical records departments
6. Establish ongoing communication with SSA and DDS
7. Create a summary report

■ Focus on initial applications

On average, only 37 percent of initial determinations for all applicants are favorable.⁴ With appeals, this figure rises to 52 percent. The appeals process, however, is lengthy and can take years. By focusing on improving documentation for the initial application submission, organizations assisting people who are homeless are able to offer more effective and timely service to their clients. The national average turnaround time for initial determinations for all

Success on Initial Applications in Baltimore

Starting in 1993 with a 1-year SSA demonstration grant, the Baltimore SSI Outreach Project was created in response to the obstacles that homeless adults with mental illnesses face when applying for SSI:

- Mental illness makes navigating the complicated application process more difficult.
- Stigma surrounding mental illness affects people's willingness to acknowledge it.
- People who lack a fixed address face extra challenges keeping and organizing paper records.

The Baltimore SSI outreach team includes two case managers (a Master's-level clinician director and an administrative assistant) and has an annual operating budget of \$190,000. Because applying at SSA field offices was so difficult for many homeless adults, the team was trained by SSA to complete the application on an outreach basis, notes Yvonne M. Perret, LCSW-C, former Project Director.

The SSI Outreach Project focuses on getting approvals at the initial stage of disability determination. The project obtains relevant information about the applicant from a large network of collaborating partners, including psychiatrists, medical records departments, and other homeless services, mental health, and housing providers. To help DDS make an accurate determination, the team then creates a medical summary report that is signed by a community psychiatrist or other physician who has met with the individual. (Occasionally, the reports have been signed by a psychologist instead of a physician.)

In addition, the project recommends presumptive disability payments, where appropriate, based on the project clinician's evaluation, along with a physician's signature on a form that addresses the disability criteria. Since the project began, 95 percent of individuals recommended for presumptive disability have been approved on initial application.

During the process of helping people apply for benefits, case management staff also provide direct assistance to facilitate access to needed services and housing. "The project helps people get what they need to recover," Perret says.

The Baltimore SSI Outreach Project was named a Best Practice by the National Alliance to End Homelessness in 2001 and an Exemplary Program by the Federal Substance Abuse and Mental Health Services Administration in 2005.

applicants is about 3½ months. The projects featured here report that decisions often are made much more quickly. The sooner a person receives benefits, the sooner he or she receives income, accesses health insurance, and obtains housing. When people who are homeless receive SSI and/or SSDI, State or local governments may be able to recover costs for general assistance, interim health insurance provided, or previously uncompensated health care costs.

■ **Become an applicant’s representative** One common reason that applicants who are homeless are denied disability benefits is that SSA and DDS cannot reach the applicant to request more information, such as additional medical records, or to schedule a consultative examination. To avoid these types of denials, a case manager can become an applicant’s representative.⁵ This is an approach used by many SSI initiatives, such as the Baltimore SSI Outreach Project and those of Clackamas County Social Services in Oregon, and Jewish Family Services of Atlantic and Cape May Counties in New Jersey.

Becoming an applicant’s representative is a simple process that opens the channel of communication between the case manager and SSA and DDS. The case manager can then “stand in” for the applicant and reply to requests for information from SSA and DDS. The case manager receives a copy of every written communication that SSA and DDS send to the applicant and, if the application is denied, the case manager has access to the applicant’s file. In addition, SSA and DDS are much freer to discuss the progress of an application.

To become an applicant’s representative, a case manager must submit an SSA-1696 Appointment of Representative form to the local SSA office where the application is on file. This form can be downloaded from the SSA website at www.socialsecurity.gov. An applicant may change representatives at any time (e.g., if a case manager serving as an applicant’s representative leaves the agency before the case is decided).

■ **Avoid the need for consultative examinations (CEs) or collaborate with DDS to make CEs more effective**

The term “consultative examination” (CE) is a technical term for a specific type of evaluation that DDS may request when the information submitted to them doesn’t address the disability criteria and they

Documenting Cognitive Impairments in Contra Costa County, California

Virginia Luchetti, Ed.D., Clinical Director of Homeless Services for Phoenix Programs, Inc., of Contra Costa County, California, supervises a multidisciplinary outreach team called HOPE (Homeless Outreach Project to Encampments). Despite her clients’ lack of success in being approved for SSI, she was certain that many clients would qualify. Eighty percent of the people served by the HOPE team have been homeless for more than 1 year and 40 to 50 percent self-report mental illness. To help provide objective documentation of her clients’ difficulties, Luchetti began conducting cognitive assessments and was surprised at what she found.

“I couldn’t believe the low level of functioning in people who appeared to be doing fairly well,” Luchetti says. Her testing revealed that, among other shortfalls, “many people who are chronically homeless have an inability to learn new information.” In addition, she found that regardless of whether or not they have a diagnosable mental illness, they have deficits in what is termed “executive processing,” which includes the ability to pay attention, sequence, make decisions, and plan and coordinate their activities. This means they have a difficult time managing simple tasks, such as using public transportation, that are critical to the ability to work. Average or above average verbal abilities may mask these deficits.

Luchetti uses the Woodcock Johnson III Test of Cognitive Abilities available from Riverside Publishing (see www.riverpub.com/products/clinical/wj3/cognitive.html). By sending the results of the objective tests, along with a report that details how these impairments relate to the person’s ability to work, directly to the DDS examiner, “we often can avoid the need for a consultative examination,” Luchetti notes.

need an additional exam to make their determination. CEs are conducted by a physician or psychologist under contract with DDS. Typically, the consultant is not familiar with the applicant and may lack information about his or her treatment history. This can be a problem, particularly for an applicant who is homeless and who has a mental illness. He or she may not be symptomatic during the CE, may deny his or her illness, or may make a special effort to present well. If the consulting physician or psychologist does not observe evidence of a disability, the person is more likely to be denied.

Conduct comprehensive evaluations to avoid the need for a CE when possible—There are, however, strategies for dealing with this dilemma. The first is to avoid the DDS CE process altogether. Although treating physicians who care for homeless adults may be trained by DDS to conduct CEs under contract, it is preferable to avoid the delays inherent in waiting for DDS to order a CE. Community clinicians can conduct comprehensive assessments and collaborate with a physician who is willing to develop an accurate diagnosis. This saves time and helps reduce the risk of denial.

When a DDS adjudicator indicates a need for more information concerning a client of the Freestore Foodbank’s SSI outreach programs in Cincinnati, Ohio, staff arrange a comprehensive evaluation with one of several SSA-contracted providers with whom program staff have developed good working relationships. Clients receive a comprehensive medical or psychological examination focused specifically on evaluating disability. “We can schedule a comprehensive evaluation within a week, and we pick up our clients and take them to the appointment,” says Robert VieBrooks, Homeless Outreach Projects Coordinator. “The report is sent to us, and we send it to DDS. This cuts weeks off the process and may avoid the need for a consultative exam.” Agency staff also transport clients to and from any consultative exams that DDS may order. Eighty-one percent of the program’s clients are approved for disability benefits on initial application in an average of 60 days.

Staff of the Washington State SSI Facilitation Program conduct and pay for comprehensive evaluations to avoid the need for a CE, whenever possible. “We work with a cadre of practitioners that have an awareness of what DDS needs,” says Mark Dalton, an administrator with Washington Department of Social and Health Services’ Belltown Community Services Office (CSO). “Most doctors are good at diagnosing illnesses, which is very different than documenting how a person’s illness affects his or her employability,” Dalton notes.

Work with DDS to make CEs more effective—At the Colorado Coalition for the Homeless in Denver, the Benefits Acquisition and Retention Team (BART) advisory committee recognized that people who are homeless often are “no shows” at DDS-ordered CEs. In response, DDS—represented on the committee—arranged for its medical providers to travel to the Stout Street Clinic, site of the Coalition’s Health Care for the

Homeless Program, to conduct CEs on site. “Homeless individuals are more likely to participate in a CE at the Stout Street Clinic because they are familiar with the clinic and its staff,” notes Don Ketcham, Executive Officer of the SSA regional office in Denver.

■ Work closely with hospitals and other health care providers

Hospitals and other health care providers, such as physicians and community health centers, are important allies and collaborators in any effort to increase access to SSA disability benefits for people who are homeless. Community providers that do not directly provide medical services can establish relationships within the medical community to help develop evidence of an applicant’s disability and incorporate the SSI/SSDI application process in discharge planning from hospitals and other health care facilities.

Hospitals and other health care providers also benefit from such collaborations since SSI beneficiaries generally receive Medicaid support that pays for health care services otherwise not reimbursed. In addition, once a beneficiary receives Medicaid, providers can recoup expenses for medical care given while a person is awaiting an SSI determination and for up to 3 calendar months prior to the month of application.⁶ For hospitals, receiving retroactive Medicaid may result in their ability to recoup thousands of dollars in uncompensated care.

Health Care for the Homeless (HCH) providers are particularly important partners and often offer both health care and case management services. These agencies have a distinct advantage because they have an in-house capacity to develop the medical evidence necessary to document an applicant’s disability. Community mental health centers (CMHCs) may also be important collaborators. Many CMHCs receive Federal PATH (Projects for Assistance in Transition from Homelessness) funding from their State mental health agency to provide outreach and case management services to people who are homeless and have mental illnesses and/or co-occurring substance use disorders. Health and behavioral health care providers can help in several ways:

Develop medical evidence—Developing medical evidence for a disability determination involves more than making a diagnosis or recording symptoms and

treatment history. The connection between the person's impairment and his or her inability to work must be explicit. However, some medical providers may not be aware of that expectation or may not feel competent to describe their patients' functional impairments. Providers that routinely document functional impairments in clinic notes may be more prepared to do this.⁷ When a case manager or agency works with the same practitioners over time, both parties learn what the other needs to provide complete medical evidence to DDS.

Conduct comprehensive examinations focused on documenting disability—As discussed above, when a physician or psychologist knows what the DDS disability examiner seeks in the medical evidence, he or she can conduct an examination to assess relevant health questions. A physician or psychologist who can present a longitudinal picture of the applicant and respond to these relevant DDS requirements is a tremendous asset. Mark Dalton of Washington State's Belltown CSO credits that agency's access to practitioners that understand and address DDS disability determination criteria as one of the keys to the program's success.

■ Reach out to medical records departments

The medical records department of local health care facilities can provide necessary information about an applicant. However, to obtain the most useful and comprehensive information, an agency assisting an applicant may need to be very specific about the types of records it requires, or agency staff may need to review, at the medical records office, the information that is gathered to select only those records that are relevant for a disability application.

If agencies serving people who are homeless develop collaborative relationships with the medical records staff of area health care facilities, obtaining this information can be much easier. It may be helpful to point out to a medical records administrator that SSI eligibility will not only benefit the individual applicant but will likely also reduce the health care facility's amount of uncompensated care. The Baltimore SSI Outreach Project offers to copy the records (with the proper releases of information in hand) to reduce the burden on short-staffed medical records departments. Once established, this arrangement is often welcomed by medical records departments.

■ Establish ongoing communication with SSA and DDS

Many mental health or homeless service agencies develop relationships with local SSA and DDS staff to try new ideas for working with applicants who are homeless and who have mental illnesses. As Dan Reardon, Benefits Acquisition Retention Team (BART) coordinator for the Colorado Coalition for the Homeless, states, "One of the most important steps we took was to reach out to our regional and local SSA and DDS offices. SSA buy-in has made everything possible." Programs in a number of states, including Colorado, Massachusetts, Rhode Island, and Maryland, have collaborated with SSA and DDS to expedite the application process in several ways. Some examples are highlighted below:

Dedicated staff—Local SSA and DDS offices can dedicate specific staff to work with applicants who are homeless. The DDS office in Boston has a specific unit that works on determinations for applicants who are homeless. This helps DDS staff expedite applications

DDS Takes a Lead Role in Boston

In response to barriers identified for people who are homeless, a special unit was started in the Boston area's DDS office in 1985 to handle all disability determinations for applicants who are homeless. When an application is filed at the local SSA office for a person who is homeless, the application is flagged and assigned directly to the DDS homeless unit. The flagged file is dealt with promptly by disability examiners and doctors in the unit who are well versed on issues related to homelessness.

The Boston unit uses presumptive disability whenever appropriate, which allows applicants to begin receiving benefits based on the presumption that they will be found disabled once the usual process is complete. In addition, the unit expedites consultative examinations when they are necessary.

The Massachusetts DDS also actively encourages relationships with agencies throughout the State. The DDS statewide homeless liaison provides trainings to shelter staff regarding SSA disability programs and the application process. In 2004, a DDS employee began visiting two area shelters once a week to assist with applications. Staff also work closely with an advisory board made up of DDS employees, advocates, and consumers, and they actively participate on the board's subcommittee on homelessness.

Cause for HOPE in Denver, Colorado

When Dan Reardon began working as a volunteer at the Colorado Coalition for the Homeless (CCH), he was the benefits acquisition team. In 2004, when CCH received an SSA HOPE (Homeless Outreach Projects and Evaluation) grant,⁸ the Benefits Acquisition and Retention Team (BART) program became a full-fledged department. Reardon was appointed project director, and the unit is staffed with medical providers, case managers, an occupational therapist, and a data specialist. The program has an advisory committee that includes representatives from SSA, DDS, the Office of Hearings and Appeals (OHA), and consumers.

BART team members help clients with the application, which they complete together and submit to the local SSA office. They also compile a complete medical evidence package, which is sent with the application. The application is flagged and expedited by SSA and DDS. OHA also expedites hearings when an appeal is necessary. Due to relationships BART has developed, the staff has open communication with SSA and DDS, who will contact them when further information is needed to make a determination. This open and expedited communication process has shown great success. In Denver, only 10 percent of homeless applicants were approved on initial application (compared to the national average of 37 percent for all applicants). When DDS dedicated a staff person to focus on applications from homeless adults, the approval rate rose to 20 percent. Since the BART team began assisting applicants, 75 percent of initial applications are approved, and the average processing time is only 40 days.

for people who are homeless because the staff become expert in the complexities of such determinations.

Flagged applications—Some local SSA and DDS staff “flag” applications of people who are homeless. Flagged applications can be identified easily for speedier determinations. In addition, flagging applications from people who are homeless makes it possible for SSA and DDS to report on approval rates and processing time for this group of applicants. These data can be used to spot important trends and make improvements in how cases from claimants who are homeless are handled.

■ Create a summary report

In applications for SSI/SSDI, the most critical challenge often is to understand and provide the medical information that DDS needs to make a disability determination. Physicians and psychologists are trained to produce a patient’s diagnosis. However, DDS is looking not only for the diagnosis, but also for how the diagnosed impairment has affected and does affect the person’s ability to work.

Many case managers and benefits specialists, including those at the Baltimore SSI Outreach Project and Jewish Family Services (JFS) of Atlantic and Cape May Counties in New Jersey, write a medical summary report about each applicant. Laura Rodgers of JFS credits the use of the medical summary report with a marked “decrease in turnaround time. We’ve also gotten many more initial approvals.”

In a summary report, the case manager or other clinician outlines the applicant’s personal, medical, and employment histories in a single document, relating the diagnosis and resulting impairment to the person’s ability to work. He or she also is able to reference the applicant’s medical records, as well as provide third-party evidence such as testimony of family and friends and the case manager’s and other clinicians’ own observations. Whenever possible, this summary report is co-signed by a physician or psychologist who has seen the person. This report then is submitted to DDS along with the rest of the application information. Although the summary report is important regardless of whether a physician signs it or not, *without a physician’s or psychologist’s signature, it does not constitute medical evidence, a fact that can be crucial to the DDS determination.* Sample medical summary reports can be found at www.prainc.com/SOAR.

Ensure Adequate Staffing

Any effort to prioritize SSI outreach most likely will involve an increase in staff or reallocation of existing resources to accommodate the increased work demands. However, staff can be organized in any number of ways to be effective. Dedicated benefits specialists, case managers, consumers, or attorneys may staff an SSI outreach effort. For example, since helping people with SSI applications is only one part of its overall work, Jewish Family Services of Atlantic and Cape May Counties in New Jersey has a dedicated benefits specialist who helps people with the application process and acts as the agency’s liaison with the local SSA office. Focusing on SSA disability benefits allows

the specialist to develop an expertise and foster a relationship with claims representatives (the staff who process applications) at the local SSA office.

Other organizations have taken a different approach. Heartland Alliance in Chicago and the Baltimore SSI Outreach Project use a team model, where every member of the team is trained and has a role in assisting a person not only with SSI but with other service needs. “Since we do a lot of outreach, it doesn’t make sense for us to have a single person with all the SSI knowledge,” Heidi Nelson of Heartland Alliance points out. “Instead, every person on our team is involved in all aspects of a client’s service provision.”

Positive Resource Center in San Francisco has a Benefits Counseling Program that employs a staff of five attorneys, two legal assistants, and one benefits specialist who work in concert to advocate for and assist applicants. Staff assist clients from initial application through the hearing and appeals process, if that becomes necessary. They help more than 700 clients a year; in 2004, they had an 85 percent

approval rate over the three levels (initial application, reconsideration, and hearing), according to Jane Gelfand, Program Director.

Although SSI outreach efforts may be staffed or organized differently, there is little evidence yet available that supports one model over another. Most programs choose an approach that works within their existing management and financial structure. Regardless of how they are organized, all programs that conduct SSI outreach recognize the importance of having sufficient time from physicians, particularly psychiatrists, to conduct physical and psychiatric examinations and to help document resulting impairments.

Provide Staff Training

Heidi Nelson and Ed Stellan of Heartland Alliance in Chicago credit two things for the success of their program: training and collaboration. Ongoing training is crucial to the success of any effort to increase access to SSA disability benefits. As Mark Dalton of Belltown CSO in Washington State remarks, “You need experienced, knowledgeable staff. Helping people apply for SSI benefits is not easy. The individuals’ situations can be challenging and the documentation process takes time and good detective work.” Ideally, a supervisor or someone in the agency who is experienced with the SSI/SSDI application process should review the work of case managers or benefit specialists to provide quality control for the agency’s SSI outreach efforts and ensure, prior to submission, that applications are complete.

Many training resources are available to community mental health centers and homeless service agencies—within experienced agencies, within the community at large, and within SSA and DDS. The Federal Substance Abuse and Mental Health Services Administration (SAMHSA) has recently completed one such resource, a case manager training curriculum, an accompanying train-the-trainer curriculum, and a reference manual as part of its *Stepping Stones to Recovery* series designed to enhance access to SSI and SSDI for people who are homeless.⁹

An agency may have a benefits specialist or clinician who can share his or her knowledge and experience with others. Programs such as the Colorado Coalition for the Homeless conduct regular in-service trainings to keep their staff up to date. Several local and State

Helping Peers Access Benefits in Los Angeles

When it began in Los Angeles in 1986, BACUP (Benefit Assistance Clients Urban Projects) was one of the first such agencies of its kind—created and staffed by current and former mental health consumers to help their peers apply for SSI and SSDI. “Clients choose to work with BACUP because staff members have a personal understanding of the application process for benefits,” says Director Andrew Posner. Consumer case workers represent 90 percent of the agency’s staff.

Several of the strategies that make the program successful—BACUP has a 75 percent approval rate for initial applications and reconsiderations—are shared by programs with non-consumer staff, including having a good working relationship with the local SSA field office and with DDS. But it’s the use of consumers and former consumers, some of whom have experienced homelessness, that sets BACUP apart from similar SSI outreach efforts. Though the agency does not require that consumer staff self-disclose, when they do, “often a real connection is made,” Posner says. In addition, consumer staff who receive benefits while working part-time serve as role models for clients who want to work. To be certain that all case workers are qualified and prepared to help applicants, staff receive training from the agency, through their SSA HOPE grant, and from local advocacy organizations.

governments, such as the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, have developed trainings or have hired trainers to present information on SSA disability benefits and the application process for local providers.

As the people involved in making disability determinations, SSA and DDS staff offer a wealth of information. They can provide training on the many intricacies of the disability application process, including how to fill out and file the various application forms, document income and resources, and navigate the appeals process. Most important, they can provide information on exactly what they need when making determinations. The Community Partnership for Southern Arizona (CPSA) invited two professional relations officers from the Arizona DDS to provide trainings throughout the State. Barbara Montrose, the CPSA Housing and Homelessness Specialist, credits them with “demystifying and simplifying the process. They answered questions, dispelled some of the common myths about determinations, and even gave out their contact information so that people could ask questions later.” The assistance, she says, has been invaluable.

Collaborating to Train Providers in Virginia

Led by Michael Shank and Sarah Paige Fuller of the PATH program in the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), the State is working to improve access to SSA disability benefits for people who are homeless and who have mental illnesses. Beginning in 2003, the Department provided statewide training for mental health and homeless service providers. Yvonne Perret, former Director of the Baltimore SSI Outreach Project and developer of SAMHSA’s *Stepping Stones to Recovery* training curriculum, conducted four regional trainings on the application process and strategies for creating more effective applications.

Following these trainings, DMHMRSAS worked with the Virginia Department of Rehabilitative Services to produce a series of four additional trainings, which brought together experts from the State, including representatives from SSA and DDS. Since the trainings, attendees have reported an increased level of involvement with SSI, more comfort working with clients on applications, and a greater knowledge of the intricacies of the application process.

Training also can be extended beyond agency staff to include other key stakeholders. For example, programs that have relationships with health care providers can train those providers to document impairments more effectively. Correctional facility employees who work with pre-release programs also can benefit, as can local and State agency administrators.

Collaborate with Other Key Stakeholders

Collaboration is critical to any successful effort to increase access to SSA disability benefits. The process of applying for, receiving, and maintaining SSI benefits is one that involves many different organizations and people within a community. It makes sense that the process can be improved by facilitating communication and cooperation among those key stakeholders. Regardless of a program’s role in the process—service provider, hospital, correctional facility, State mental health office, etc.—a collaborative perspective is needed to create a strong, community-wide outreach initiative. Collaborative efforts with health care providers and with SSA and DDS were cited earlier. Additional avenues for collaboration include the following:

The Criminal Justice System

Departments of Corrections and criminal justice agencies are important collaborative partners. Connecting people who have been incarcerated to services, including SSA disability benefits, can reduce recidivism and prevent homelessness. This, in turn, can help prisons or jails reduce costs. Collaborations with the criminal justice system often focus on providing pre-release services.

Pre-release programs—While people who are incarcerated typically wait to apply for benefits until they are released from prison or jail, they can file an application for SSI benefits 30 days prior to release. Documenting the applicant’s disability can start much earlier so that a complete application can be filed as soon as possible. Programs such as Oregon’s Joint Access to Benefits (JAB) and Legal Action in Wisconsin have developed successful programs with several correctional facilities to prepare applications for individuals prior to their release. Such arrangements are often sanctioned and welcomed by SSA, which has a process for setting up pre-release agreements with such programs. These agreements are crucial because, as Liv Jenssen, Program Manager for the Transition Services Unit in the Multnomah County (OR)

Pre-Release Outreach in Multnomah County, Oregon

Joint Access to Benefits (JAB) was started to initiate the SSA disability application process for individuals who are being released from incarceration in Multnomah County, Oregon, or who have been released and are homeless. JAB is a collaborative project among the Multnomah County Department of Community Justice's Transition Services Unit, the State of Oregon Departments of Corrections and Human Services, the Multnomah County Sheriff's Office, the Multnomah County Department of Human Services, and the SSA district office.

Much of JAB's work is done inside correctional facilities. To ensure a complete application, the application development process is begun 4 months prior to release (though the application itself can be submitted no more than 30 days before the individual is expected to be released). The JAB staff works with corrections counselors inside the correctional facilities to complete the application by phone. The application is then flagged as a JAB file and expedited through the process so that the applicant can begin receiving benefits as soon as he or she is released. To facilitate this process, JAB has developed relationships with the county, SSA, and DDS staff.

Department of Community Justice, states, "If clients are unable to receive benefits within a reasonable time frame, they are left with few options and many return to jail or prison, or their chronic homelessness and disabling condition worsens."

Agencies can help reduce the chances that a person will become homeless on release by working with staff, benefits specialists, physicians and psychologists, and social workers within the correctional facility to screen for people who are eligible to receive SSA benefits and to help them with the application process. For those individuals who have been receiving SSI prior to their incarceration, SSA policy specifies that SSA field offices should suspend, but not terminate, eligibility status for SSI recipients incarcerated for less than 12 consecutive months.¹⁰

Local and State Governments

Government, whether local or State, can play a role in creating a successful SSI outreach initiative. Many effective programs either originate within a government agency or are able to attract the support of government officials. Governments can help develop the infrastructure, intervene to reduce complexity wherever possible, and foster the support to begin and sustain efforts to increase access to SSA disability benefits. This can involve several strategies:

Create partnership opportunities—Many successful SSI initiatives have been developed through partnerships between government and community agencies, including those in Washington State; Savannah and Atlanta, Georgia; Franklin County, Ohio; and Broward County, Florida. For example, the Belltown Community Services Office (CSO) of the Department of Social and Health Services (DSHS)

in Washington has managed a highly successful SSI outreach effort for more than 15 years. The DSHS has been able to facilitate the development of a complex network of social workers, clinics, outreach teams, physicians, lawyers, SSA claims representatives, DDS disability examiners, and other key people. All these groups work together with the Belltown CSO to increase access to SSA disability benefits for individuals who are eligible to receive them.

Create an internal program—While some programs have been developed through external partnerships, others have found success working from within. Clackamas County, just south of Portland, Oregon, for example, was awarded one of 41 SSA HOPE grants in 2004 to help people access SSI benefits more effectively. The County Social Services agency has designed its own SSI HOPE Project unit that works directly with people on their SSI applications, guiding them through the process.

Collect and Report on Outcomes

One barrier to starting an SSI outreach effort is convincing key stakeholders within an agency, as well as in the larger community, that such an effort is worth the resources necessary to make it happen. As noted earlier, when people who are homeless receive SSI and/or SSDI, State or local governments may be able to recover costs for general assistance or interim health insurance provided. Health care providers also benefit since SSI beneficiaries generally receive Medicaid support that pays for health care services otherwise not reimbursed. Also, individuals with a regular source of income are able to contribute toward their housing costs. Seen in this light, even benefits that accrue to the

individual, such as having regular income and health insurance, benefit the community as a whole.

Providing data of past successes and cost savings to stakeholders is one way to convince them of a program's potential value. As defined by researchers and health economists, a true cost-benefit analysis, which is often conducted from the perspective of society at large, can be complex, costly, and time-consuming. However, showing a return on investment for SSI outreach from the point of view of the stakeholder that funds these efforts (often a government entity) can be far simpler. In particular, recovery of past benefit payments and future cost savings may be fairly straightforward to calculate. And the question they answer is clear-cut as well: Are SSI outreach activities worth supporting?

For example, in San Francisco, the Department of Public Health compiled data on recovery of past benefit payments realized through SSI outreach activities. Staff were able to show a nearly 7:1 return on investment for the first year of an SSI pilot (i.e., approximately \$7 was reclaimed for every \$1 spent; see the related case study for further details). They arrived at this figure by determining how much they recovered in retroactive SSI-linked Medicaid billing and general assistance for individuals approved for SSI and dividing this figure by the cost of providing SSI outreach services. Although future income projections are useful to know, these figures represent "cold, hard cash," notes Maria X. Martinez, Deputy Director of Community Programs at the San Francisco

Department of Public Health, whose calculations have led to increased funding for her programs.

Future cost savings are more speculative and involve determining how much would be spent on individuals who are eligible for other assistance if they do not receive SSI. Los Angeles County estimates cost savings conservatively by using a proxy measure—the annual cost to the county of maintaining a person who is not receiving SSI on general relief. Staff determine this cost for 1 year by multiplying the maximum general relief benefit of \$221 by 12 months by the number of people approved for SSI. For State fiscal year 2004-2005, this figure amounted to \$17 million for 6,500 people. However, according to Judith Lillard, Program Director of General Relief and the Cash Assistance Program for Immigrants (CAPI) in the Los Angeles County Department of Public Social Services, the single-year figure may be just a drop in the bucket. "If an individual gets SSI, we may have prevented 10 to 20 years of general relief. This is a tremendous benefit to the county and to the individual."

The case can also be made that a community avoids other public costs after an individual becomes eligible for SSI. For example, a person who receives SSI and achieves a measure of residential and psychiatric stability may spend less time in hospitals or jails or have less uncompensated hospital or mental health care. To reflect changes in service use related to receipt of SSI, programs would have to track changed *use* of public services for people who receive SSI, changed *costs* resulting from the changed use, and *savings*

Using Data to Make the Case in San Francisco

Maria X. Martinez, Deputy Director of Community Programs at the San Francisco Department of Public Health, compiled impressive figures on how much the City and County of San Francisco could save in the future for every individual who was approved for SSI and Medi-Cal (California's Medicaid program). Her prospective analysis revealed that the county would be able to recoup \$5,700 for each individual who was approved for Medi-Cal or approximately \$20 million a year for 3,500 uninsured mental health clients who are severely disabled. Individuals who have applied for but not yet received SSI are eligible for another \$7 million in cash assistance, bringing the total anticipated savings to the City and County of San Francisco to \$27 million a year.

But even Martinez was surprised when she conducted a retroactive analysis to calculate how much SSI-linked Medi-Cal and general assistance revenue the county recovered. Her calculations revealed that the county Department of Public Health recovered nearly \$1.4 million in SSI-linked Medi-Cal billing alone for 63 clients whose health care had been paid for by the county during the months, and sometimes years, since the SSI and Medi-Cal award effective dates. The county paid \$200,000 to a contractor, Positive Resource Center, to help individuals apply for SSI benefits. Therefore, the department's return on investment was nearly 7 to 1. Adding in general assistance recovered (and subtracting that portion of the recovered fees paid to the contractor) yields a still impressive return of 6.7 to 1 for the City and County of San Francisco. "This is cold, hard cash," Martinez notes, adding that these have been powerful figures when trying to convince key stakeholders of the need for SSI outreach.

Recouping State Funds to Pay for SSI Outreach in Washington

The Washington State SSI Facilitation Program began in 1989 as a pilot project to help the State recoup general assistance (GA) funds. GA recipients apply for SSI benefits with the help of a social worker from the Department of Social and Health Services' (DSHS) Belltown Community Services Office (CSO). Through an agreement between the State and Federal government, the State recoups from SSA the cost of GA payments to the applicant from the date of SSI application to the date of eligibility. SSA deducts this amount from the retroactive payment to the recipient. These GA recipients also become eligible for expedited Medicaid benefits. The social worker accompanies applicants through the process, including appeals when necessary.

DSHS has developed relationships with physicians and psychologists to conduct medical or psychiatric evaluations and with lawyers who have specialized knowledge of the appeals process and who are willing to represent applicants at the hearing level. More than 15 years later, the program is going strong. As Mark Dalton of the Belltown CSO describes it, "This is big business in Washington State. Our SSI Facilitation program collects over \$20 million a year in reimbursements statewide, which, in turn, helps support our program."

(whether individuals who receive SSI cost the same or less than their pre-SSI use of services).¹¹

This is the most complex analysis, and there are a number of challenges to conducting it successfully. However, as part of preparing 10-year plans to end homelessness, many communities around the country are using simpler but equally illustrative calculations to show what it costs to serve people who are homeless in expensive systems of care; it is reasonable to assume that if these individuals had benefits, they would have greater access to more appropriate and less expensive services.

Some communities compare the costs of homelessness to the costs of providing services, such as supportive housing. For example, planners in Raleigh, North Carolina, estimated that it costs \$5,875 a month to serve a single homeless man with untreated mental illness who uses the local shelter, emergency room, and psychiatric hospital. This compares to \$33.43 per day, or just over \$1,000 a month, for supportive housing. San Diego's Serial Inebriate Program, which provides treatment in lieu of custody for individuals who are repeatedly intoxicated in public, calculated a cost of \$997 for maintaining one individual in housing plus outpatient substance abuse treatment for 1 month. This compares to \$1,470 for the cost of one police contact with an ambulance visit to the emergency room followed by a day in jail.

These types of data can help make an already good argument that much stronger for supporting programs that assist homeless people. Even simple outcome measures—such as an increase in the number of SSI/SSDI applications for people who are homeless, an increase in approvals on initial submission, and

a reduction in time from application to receipt of benefits—can reveal how successful SSI outreach efforts can be.

Conclusion

SSA disability benefits are powerful tools in the struggle to end chronic homelessness for people with disabilities. Organizations around the country are recognizing this and creating opportunities to help people access these benefits. Although SSI outreach efforts may use different strategies to accomplish the same goals, a common denominator among them is the ability to see beyond the current methods and try new ideas. These range from completing applications on outreach, to providing comprehensive evaluations, to using peers to help homeless people apply for benefits. By sharing what they have learned and encouraging others to use their promising practices, these programs help increase access to SSA disability benefits, reduce chronic homelessness, and realize cost savings for State and local governments.

Contact Us

If you have an SSI outreach program or promising practice that you would like to share with others, please contact Deborah Dennis at Policy Research Associates, Inc., ddennis@prainc.com.

To be added to the SOAR Listserv to receive information about innovative approaches to SSI outreach for people who are homeless, send an e-mail to SOAR@prainc.com.

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Endnotes

1. Rosen, J., Hoey, R., & Steed, T. (2001). Food stamp and SSI benefits: Removing access barriers for homeless people. *Journal of Poverty Law and Policy*, March-April 2001, 679-696.
2. Given the unique barriers that homeless claimants encounter, it is not surprising that their approval rates are lower than this figure, according to comparative studies conducted by the Disability Determination Services (DDS) in some jurisdictions (e.g., Boston). Unless SSA or DDS flag applications from people who are homeless, SSA does not differentiate between those who are homeless and those who are housed.
3. The Disability Determination Services (DDS) is a State office that contracts with SSA to make the medical determination on disability. The office or unit is typically an organizational component of a larger State agency. For more information about DDS, see the section on *Establish Communication with SSA and DDS*.
4. U.S. General Accounting Office. (July 2004). *Social Security Administration: More Effort Needed to Assess Consistency of Disability Decisions*. GAO-04-656. Washington, DC: Author.
5. A *representative* is not the same as a *representative payee*. A representative assists an applicant in applying for benefits but has no role in managing the applicant's financial matters. A representative payee manages the SSI/SSDI income of a person who has become eligible for such benefits. For more information, see www.ssa.gov/representation.
6. This is true unless this provision of the Medicaid statute has been set aside by a waiver requested by and granted to the State in which the applicant resides. 42 USC § 1396a(a)(34).
7. O'Connell, J.J., Quick, P.D., Zevin, B.D., & Post, P.A. (Ed.). (2004). *Documenting disability: Simple strategies for medical providers*. Nashville, TN: HCH Clinicians' Network, National Health Care for the Homeless Council. www.nhchc.org/DocumentingDisability.pdf
8. See www.socialsecurity.gov/homelessness/outreach
9. See www.prainc.com/SOAR/tools/manual.asp to download a copy of the reference manual. For information about bringing a *Stepping Stones to Recovery* training program to your area, contact Deborah Dennis at Policy Research Associates, Inc., ddennis@prainc.com
10. The Bazelon Center for Mental Health Law. (2001). *Finding the Key to Successful Transition from Jail to Community*. www.bazelon.org/issues/criminalization/findingthekey.html
11. For a discussion of preparing a cost avoidance study, see Burt, M. (2004). *The do-it-yourself cost-study guide*. New York: Corporation for Supportive Housing. A copy can be downloaded from www.csh.org