SSA Disability Programs: The Eligibility and Appeals Process

Part II

A Transcript of the
PATH National Teleconference Call

Presenter: Connie Ferrell
Respondent: Debbie Webster
Respondent: Carol Luna-Anderson

November 21, 2000
Moderator: Gary Shaheen

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I. Welcome and Introductory Remarks

Welcome, everyone, to another PATH national teleconference. My name is Gary Shaheen, and I'm from Advocates for Human Potential (AHP) in Delmar, NY, the technical assistance contractor for the PATH program. I will be serving again as your moderator for today's call. We are pleased that you have decided to join us in the second of two teleconference calls on the Social Security Administration's disability programs.

There is a growing interest at the federal, state, and local provider levels in today's topic. As I mentioned during our first call, we need your help to keep national momentum going on Social Security issues that are relevant to PATH providers and clients. We are asking that any PATH provider or state PATH contact who has a staff person assigned primarily to benefits management issues please provide us with that person's name, title, e-mail address, and phone number. Send this information to Marjorie Steinman at msteinman@ahpnet.com or fax it to Marjorie's attention at (518) 475-7654. We will use this information to create a list of national disability benefits management specialists as well as to help us in considering additional training in SSA disability and Medicaid eligibility issues in the future.

Before we begin, I would like to review the format for the call. I will begin by asking Dr. Michael Hutner, the PATH Government Project Officer, to say a few words of introduction. I will then introduce our featured presenter, Connie Ferrell, and our two respondents, Debbie Webster, State PATH Contact from the State of North Carolina, and Carol Luna-Anderson, Executive Director of LifeLink—a PATH provider from the State of New Mexico. Connie has graciously agreed to step in and present on behalf of Thomas Golden, who is recovering from emergency eye surgery. She will have 45 minutes to deliver her presentation.

After Connie's presentation, each of our two respondents will have 15 minutes to describe the issues they are facing in the denial and appeals process, effective strategies for advocacy, and issues related to helping consumers retain their benefits. We will use the remaining time to open the lines for questions and comments from the audience.

A. Comments from Michael Hutner

Thanks very much, Gary. I just want to mention that I am delighted about the response to this technical assistance offering. I think this is an area of such importance—important for any future technical assistance and training we might offer and essential to the possibility of CMHS joining with both state PATH contacts and local providers to see how, working together, we can begin to change the policies and the procedures to make it easier to gain eligibility for our clients. It's a crucial area, one that may not have been addressed sufficiently in the past. But certainly there's increased focus on this, and increased possibilities of making some changes.

So I hope that you will us know if you are involved in helping with the eligibility process and if you would like to be contacted again for future networking or advocacy possibilities. Again, I am totally delighted. This is the beginning chapter of a continuing effort, and I'll be listening carefully both to our presenter and to your comments. Thanks.

Gary. Thank you so much, Michael. It gives me great pleasure to introduce our speaker and our two state PATH respondents for today's teleconference on SSA disability programs.

II. Panelist Presentations

A. Introductions

Connie Ferrell is a private consultant and training specialist from Morgantown, Indiana, and prior to this she was a supportive employment consultant for the Virginia Department of Mental Health and Mental Retardation in Richmond, Virginia. Ms. Ferrell has conducted training on the Social Security Administration benefits process throughout the country and is currently on faculty with Indiana University's Institute for the Study of Developmental Disabilities. She has also worked for a number of years as a member of the Virginia Commonwealth University's Rehabilitation Research and Training Center. Ms. Ferrell has a Master's degree in clinical social work from Norfolk State University and is a licensed clinical social worker. She is a trainer on faculty at Cornell University, and also has a private counseling practice, providing services to individuals with disabilities and their families. I'm pleased to welcome my good friend and colleague, Connie Ferrell.

Debbie Webster is the State PATH Contact for North Carolina. In her state, providers are grappling with numerous barriers to help people with mental illnesses who are homeless acquire benefits. One of the greatest challenges they face is repeated denials and the need to go through the appeals process. Debbie will share some of the

effective methods that PATH programs are using to meet these challenges. Welcome, Debbie. We're glad that you could join us on today's call.

Carol Luna-Anderson is the Executive Director of LifeLink, a PATH provider located in Sante Fe, New Mexico. LifeLink has a strong supported employment program, and they also help people obtain SSI benefits. They also have established a strong disability management services component that helps their clients retain benefits as they become employed. As we all know, advocacy is essential if individuals are to avoid losing benefits while working. So, welcome, Carol and thanks for sharing your experiences with us.

At this time I'll turn the mike over to Connie Ferrell to begin. Her presentation will be about 45 minutes.

B. Connie Ferrell

Thank you very much, Gary, and welcome, everyone, to this teleconference. It's a pleasure to be joining you. By way of review, I want to remind you of a particular concept Thomas Golden put forward when he spoke to you about the eligibility process. In talking about the disability determination process, Thomas discussed something called the sequential evaluation process. This is a five-step process required of anyone applying for benefits.

The very first of those five steps—and people go through them in order—is a question that asks: Is the person working at a substantial gainful activity level, also called SGA? Only if the answer to that question is no, does the Social Security representative go into the following questions that have to do with the individual's medical determination and whether or not they're considered to have a severe disability.

Thomas mentioned that, generally speaking, about $700 worth of earnings in a month is considered to be substantial gainful activity. The reason I'm reminding you of this is because as we go through today's presentation, we will talk many times about the fact that this disability review is done again at various points in a person's life, and SGA may be the reason why at a later time a person may be denied benefits.

Further, Thomas noted that a person who applies for SSDI, Social Security Disability Insurance, has to have enough credits in the system to qualify as a former worker, and a person who applies for SSI, Supplemental Security Income, has to meet a financial needs test that includes income and resources. An individual may be accepted into one or the other of these programs or both.

All of these points will be important as we discuss today's topic, which has to do with those people who apply for benefits and are denied.

Initial Denial of Benefits. There are three reasons why people would be denied benefits during the initial eligibility process. Number one would be that they didn't meet the disability determination process—in other words, their disability has not met the disability definition that the Social Security Administration uses.

The second reason would be that they have met the disability definition but they don't qualify for SSDI because they don't have enough credits—in other words, they haven't paid in enough F.I.C.A. to qualify as a former worker. The third reason a person would be denied on initial eligibility is that they don't meet the income resources test for SSI. In other words, either their income level or their resource level is too high to meet the initial eligibility criteria.

If the individual does not qualify, they will get a letter, in the mail, from the Social Security Administration, saying that the application for benefits has been denied. And that letter will give the reason why that individual is not eligible, which will be one of the three reasons I just stated. That letter is critical, and we're going to talk about why when we talk about the appeals process. There are other reasons why an individual may be denied benefits at a later point in time, which we'll discuss in a few minutes.

Continuing Disability Reviews. Let's talk about continuing disability reviews, which we'll refer to as CDRs. Every so often, any individual who receives benefits has a CDR that is aimed at determining whether or not this person still meets the definition of disability. By law, the CDR has to take place. This is the mechanism that Social Security uses to decide whether or not to continue a person's benefits.

There are two different ways that a person would have a CDR. One of those ways is something called a work-triggered CDR. An individual receiving SSDI benefits who begins to work will trigger a CDR once they have worked nine trial work months. Those who receive SSI will trigger a CDR when they begin to earn above SGA, which is about $700 a month. Now, the fact that the person had been working is not necessarily a bad thing; it simply triggers the action. It doesn't necessarily mean the individual is going to lose benefits. Social Security will do a medical review to make sure there hasn't been significant medical improvement since there is evidence of work.

For an individual receiving SSDI who goes to work, the CDR will entail two different things. One—and this is very important—the CDR will review any work activity that is currently happening or has happened since the last review, and it will scrutinize whether or not the individual is currently, at the time of the review, engaged in substantial gainful activity.

Both SSDI and SSI beneficiaries and recipients also have a medical review at every CDR. The medical review is where the Social Security Administration looks very specifically at the medical evidence that first qualified an individual to be a beneficiary

or recipient. They're trying to determine whether or not there's been medical improvement.

Specifically, they're looking at whether an individual's level of disability has changed. Is there any probability that this individual's condition has improved enough that now they're considered to be medically recovered? If so, they don't meet the disability definition anymore.

The person who hasn't gone to work is still going to have a CDR because everyone, working or not, has a CDR based on what's called their diary date. When a person is first determined to be eligible for Social Security benefits, they're assigned a date to be reviewed and told how often they will be reviewed, based on the severity of their disability. Some individuals may go six months and have a CDR based on their diary date; others may go seven years and not have a CDR because of the severity of their disability and the statistical odds that it's not going to significantly improve.

Everyone has a diary date. And, up until 1993, whenever the diary date came, Social Security asked the person to come in for an interview and a full-blown medical review. But in 1993, in order to expedite the process and save taxpayers some money, Social Security moved to a process they call the CDR mailer.

What happens now is that Social Security does a computerized, statistical analysis of all individuals whose diary dates will come due in a fiscal year. They develop a profile for each individual and put them in one of two categories: those with a high probability of medical recovery or those with a low probability of medical recovery. Individuals in the high probability category get a letter from Social Security asking then to come in for an interview and go through a full disability determination process. Those in the low probability group get something called the CDR mailer, which is a questionnaire for the individual to complete.

When the individual returns the questionnaire, that may be the end of that CDR. If it doesn't appear, by the answers to the questions, that there's any chance at all of medical recovery or significant medical improvement, the process is over. On the other hand, if the answers to those questions cause the reader at the Social Security Administration to believe that this person may have had some medical improvement, the individual will get a letter and will be asked to come in for an interview and a full-blown CDR.

The CDR mailer for the person who is in the low probability of recovery group includes such questions as: Have you received medical treatment in the last two years? If this is an individual with a significant mental illness, there's a pretty good chance that he or she has received some medical treatment. If you're counseling an individual about this, it would be important for you to help them understand that medical

treatment includes more than visits for physical illnesses; such things as mental health therapy or seeing a psychiatrist also qualify.

The next question is: As compared to two years ago, do you feel the same, or better, or worse? This is a tricky one for people with mental illnesses. We know that with many of the mental illnesses, people have cycles in which they're doing quite well and cycles in which their symptoms are much worse. So an individual who happens to be doing quite well might answer, “I'm doing so much better than I was two years ago.” And yet, when Social Security looks at that, there's a chance they're going to see it as evidence of improvement, rather than the fact that the individual is feeling well at the time.

The next question has to do with whether the individual has talked with their doctor about working and whether the doctor has cleared them to work. The final question has to do with whether or not in the past couple of years the individual has finished an educational program or performed work in the last two years.

Those are the mailer questions. Case managers and social workers need to help people understand that CDRs happen, regardless of whether or not they go to work. Individuals need to know when they get a CDR notice with this “funny” list of questions, it's extremely important to answer those questions and return the form. It may be important to have someone help the individual answer the questions, especially if they're not certain what's being asked and why.

If an individual gets that CDR mailer and throws it in the trash, the Social Security Administration will send a second. A lot of the letters that come from Social Security sound so threatening, but you need to know that the law does not allow the agency to terminate a person's benefits because a person didn't fill out a mailer on a first request. However, as we’ll discuss in a few minutes, continued failure to answer questions that the Social Security Administration is asking may be a reason for termination.

To sum up what we’ve discussed so far, everyone will have a CDR on their diary date. Some people will have a full-blown CDR, and others will get the mailer. People who go to work will have a CDR at certain points in their working history, based on what’s called a work-triggered CDR.

The process for a CDR is the same sequential evaluation process that Social Security uses to determine initial eligibility. So, for instance, if this was the initial eligibility process and the individual was working above about $700 a month, he or she would just flat out be denied.

However, if a CDR occurs and the person is now engaged in the SGA, consistently earning above about $700 a month, it may or may not result in the individual being terminated from the rolls. Social Security is generally harder on people around that SGA test during initial eligibility than they are in follow-up CDRs. On the other hand, there's no insurance that being consistently engaged in SGA is going to be discounted. It certainly is part of the sequential evaluation process, even in the CDRs.

Subsequent Denial of Benefits. There are other reasons why a person may be denied benefits after they've already been receiving benefits for a period of time. For instance, I just mentioned one that I think is particularly important for people who may be somewhat transient or may be homeless for periods of time. If the Social Security Administration repeatedly tries to contact the individual given the contact information they have (the address, the phone number, etc.)—by sending out three or four notices or calling them or running a computer search—and still cannot locate the individual, by law they can terminate a person from the rolls.

So that's an important point to remember, and it's critical to remind the consumers that we're working with that if they're moving from one spot to another and their address is changing, it's very important to let the Social Security Administration know how to reach them.

There's another thing that can be helpful, and it's certainly not something we want to do unless an individual would like us to. An individual who's receiving either SSDI or SSI can have the Social Security Administration send a copy of every letter that they send to the beneficiary or recipient to a designated person, as well. There's a form that can be filled out requesting that duplicate notices be sent to a specific individual and indicating how long the request should be in effect.

If someone has difficulty getting their mail either because their mailbox is not secure or because they are moving around, it's not a bad idea to at least think about whether there's someone they trust who could be copied on all notices from the Social Security Administration. This way there is less chance the individual will be terminated because the Social Security Administration is unable to contact them.

Another reason why people would be denied benefits after they've been receiving them for a period of time is if an individual who receives SSI goes over the income threshold. I know Thomas talked to you last time about 1619(a) and (b), and if you remember, 1619(b) is a status that protects Medicaid even if earnings are fairly high. However, there's an annual income threshold at which point the individual exceeds the 1619(b) protection. The annual income threshold varies from state to state. In the State of New York, for example, it's close to $32,000 a year. But whatever the annual income threshold is, if a person's earnings were in excess of that, they would not be protected by 1619(b) and would eventually be terminated from the rolls.

Another reason why an SSI recipient could be denied benefits after they've been on the rolls for a period of time is because of what we call excess resources. Even though the rules are set up to allow individuals to earn some pretty significant money, in some states, the problem would be if they put it in the bank. In New York, for example, individuals can earn up to $32,000 a year before they would lose eligibility, but they can't have more than $2,000 in the bank or they are considered to have excess resources. People really have to monitor that resource standard if they receive SSI, or they could have their benefits terminated because of excess resources.

The Appeals Process. Whether it's during initial eligibility or whether it's after the fact, a person may receive a letter that says, "You are not going to be getting benefits from the Social Security Administration, and, if we had a case file open for you, we're closing it." The letter will tell the individual why this action is being taken and will indicate that they have the right to appeal.

So let's look at how the appeal process works. First of all, a person has the right to appeal under any of five conditions. One is that the Social Security Administration has made an initial determination with which the applicant doesn't agree. Maybe a person was denied benefits, or was awarded an amount they feel is too low. They can appeal that.

At any point an individual in the system, receiving either SSI or SSDI, gets a letter that says their benefits will be reduced or terminated, they can also appeal those decisions. Finally, the last reason for appeal is receipt of a letter that says an individual has been underpaid or overpaid. You generally don't see people appealing when they're told they've been underpaid and the Social Security Administration wants to send them more money, but they could if they wanted to.

When an individual gets a letter from the Social Security Administration under any of these circumstances, it should say that they have 60 days, from the date of receipt of this notification in order to exercise their right of appeal. The Social Security Administration starts counting the 60 days five days from when the letter leaves their office. Here again, if an individual is moving around or has times when they're temporarily absent from their permanent residence, they may not end up opening that letter until the 60-day window for appeal has closed.

That's another reason why people need to be diligent about letting the Social Security Administration know where they are. Another thing that happens many times with people who have mental illnesses is they may get the letter at a time when their symptoms are worse, and they may not be able to act on the appeal at that point or even to comprehend what the letter says.

The Social Security Administration can extend that 60-day window. You have to ask for it, and there has to be really good reason to get the extension. For example, Social Security will almost always extend the 60-day window if the individual can show that they were in the hospital or there was a death in the immediate family

Individuals who are already receiving benefits who appeal within 10 days of receipt of the letter will continue receiving benefits until the appeal process is over. This should also be indicated on the letter they receive. If they lose, they will have to pay back the benefits they receive during this time. But for some people who think they'll win the appeal, or who can't do without the money and are willing to deal with the possible consequences, knowing that there's a 10-day window in which the Social Security Administration can't stop their benefits may be very helpful.

Once an individual fills out the application for appeal, which is just a simple form, the first step is a reconsideration. A reconsideration is a complete review of the claim by someone who didn't participate in the original decision. For example, if the reason the individual was denied benefits or is being terminated is because the disability determination office did not find that their disability qualifies for Social Security or that the person has medically recovered, someone else in the disability determination office looks at that file, reviews it, and makes a decision. Many times, that may be an office supervisor, but it doesn't have to be.

If the reason the person is being denied or terminated has to do with financial eligibility, the reconsideration is done in the local Social Security office. At that point, the decision may be reversed, and the individual will be declared eligible to receive, or to continue receiving, benefits. If that's the case, this could be a relatively simply process.

However, I very much encourage people who intend to appeal, and who plan on getting some letters or documents to substantiate why they think they should be eligible for benefits, to get those together and get them into their Social Security office along with the intent to appeal form. This could help the reconsideration process move more quickly. Often it doesn't go quickly, but it could be turned around in a week or less, depending on whose desk it lands on.

If an individual misses the opportunity to have new information considered—such as a letter from their therapist—or if the reconsideration doesn't go in their favor, they can take their appeal to the next level. The next level, which is one that many of us have heard of, is called the Administrative Law Judge hearing—we call it the ALJ hearing for short. An individual requests this hearing by completing Social Security Administration form 501.

At the ALJ hearing, there is literally a law judge who hears the case. This is the first time that the individual whose potential benefits are in question has an opportunity to actually speak with the person who is making the decision. This is a hearing process, and the individual can be there and can bring a legal advocate with them. Generally, the judge will ask the individual and their advocate some questions. The law judge then decides to agree with the initial decision or to overturn it by reversing the decision.

Statistically speaking, this is the point at which an individual has the best odds of winning an appeal. Part of that is because this is the first time the law requires that an individual has the opportunity to review their entire file, which they may do before the hearing. What's happened many times with individuals I've worked with is when we go in together and look at that file, we discover that some of the documents that we thought were probably being considered aren't even there. Before the ALJ hearing, we have the opportunity to gather other substantiating evidence that supports the case.

The court clerk records the hearing proceedings, and when the hearing is over, the individual can request copies of that tape if they choose to. If the individual doesn't win the ALJ hearing and decides to proceed to the next level, it would be helpful to have copies of that tape. So it would be a good idea to request them before moving to the third level of appeal, which is called the appeals counsel review.

The appeals counsel review is largely a paper review process. There is a counsel of individuals who review the file, with everything in it up to that point, including the tapes from the ALJ hearing and all of the information associated with that hearing. When the appeals counsel receives a review, it can take one of three actions. 1) The appeals counsel can uphold the ALJ decision without further review. 2) The appeals counsel can examine the case and then uphold the ALJ decision or overturn it with a different decision. 3) The appeals counsel can send the case back to the ALJ level, to be heard by a different administrative law judge.

At the end of the appeals counsel review, the individual has either won the case or lost the case, and if they've lost the case, they have to decide whether or not they want to proceed to the next level, which is Federal Court review. The Federal Court review is exactly that. And, as with any other case that might go before the Federal District Court, the court may decide that it's worth reviewing or that it isn't.

From an initial denial letter to an ALJ hearing may take six months to a year. To pursue a case all the way through Federal Court may take years.

Proposed Rule Changes. We'll be hearing more about the appeals process from our next speakers. But I want to finish by telling you about a few of the new

proposed rulemaking changes that are forthcoming, some of which are directly pertinent to what we've been speaking about, and some that are just for your information.

You know that the Ticket to Work and Work Incentives Improvement Act was passed in December 1999, and it's being implemented over a course of four years. There are some pieces that just became effective October 1, 2000. There are several pieces that will become effective January 1, 2001, and other pieces that will take effect in 2002 and 2003.

One thing that's really important and very relevant to what we've been speaking about are two new CDR protections. First, the Social Security Administration is going to begin sending out tickets, which are like vouchers, to Social Security recipients and beneficiaries who can use the voucher with an approved employment provider to help them get a job.

If a person who gets one of these vouchers or tickets decides to use it and engages the services of an employment provider, during the period of time that they're using that ticket, which could be up to five years, they will not have a medical review. So whether they were scheduled to have a diary date medical review, or whether it was a work-triggered CDR that was going to include a medical review, the individual simply will not have a medical review during the period of time that they're actively using their ticket.

When this provision takes effect depends on when your state becomes eligible for having tickets. There will be some states that will start up January 1, 2001; some that will come on board on January 1, 2002; and the rest of the states will come on board in 2003. The CDR protection will become available to people across the country as the ticket program is phased in.

There's a second provision in the Ticket to Work and Work Incentives Improvement Act that will eliminate work-triggered CDRs beginning January 1, 2002. Remember that individuals who receive SSDI are subject to a work-triggered review at the end of the trial work period, and those who receive SSI are reviewed when they begin to engage in SGA. When this provision takes effect, individuals will only be subject to review on their diary date.

Those are the provisions in the Act that are most relevant to what we're discussing today, but there are some other important pieces, as well. These include extensions of Medicare that add an extra four and a half years of coverage for a person who goes to work above SGA. There are also options for states to extend Medicaid to employed people with disabilities at much higher income levels. The Act also establishes a national advisory panel to help the Social Security Administration put the

new regulations in place, and Thomas Golden is on the national advisory panel, so you know at least one member of that group.

Further, I'd like to tell you about some rules that we're 99 percent positive are going to take effect January 1, 2001. One of these is a planned adjustment in the SGA level each year in January, based on the National Average Wage Index. Currently, the SGA level is at $700. In the past, it would stay at the same amount, year after year, until the Social Security Administration decided to change it.

What's going to happen as soon as this new rule is in place is that the SGA level will be adjusted to keep pace with inflation. It will never go down, but it may go up. The new rule will also remove a kind of "danger zone" for people who made more than $300 but less than $700. This is the point at which the Social Security Administration potentially could say that an individual was engaged in SGA. That gray area will be eliminated. We fought for that for years, and it's finally going to happen.
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We also believe that on January 1, 2001, there will be an increase in the amount an individual can earn in a trial work period month. I know Thomas told you last time that a person receiving SSDI who earns more than $200 in a month has used up one of their trial work months. When this new provision takes effect, an individual would have to earn $530 in a month before that month would count as a trial work month. And that also will be adjusted each year with inflation, so that's excellent news.

Finally, there's one very specific work incentive for students under age 22 who receive SSI. It's called the Student Earned Income Exclusion, where an extra $400 a month is excluded from earnings for students who are working. That $400 per month exclusion will go up to $1,620, with an annual cap of $5,200. And that also will be indexed to inflation.

All of these rules have been through the proposed rulemaking process, and we're just waiting for Social Security to finalize the date of implementation. The unofficial word from the agency is they will all be in place January 1, 2001. Gary?

Gary: Thanks so much, Connie, for a wonderful presentation. That was great. I'd like to turn the mike over now to Debbie Webster. Debbie will have 15 minutes to talk about what's going on in her state concerning denials and the appeals process.

C. Debbie Webster

Thanks, Gary. Hello, everybody. I'm going to talk first of all about what happens to our clients when they're denied benefits. First of all, they can become very discouraged. It feels like a failure to them, and they may refuse to go through the appeals process. Worse than that, they may become lost to us again and end up back

on the streets, and when we reconnect with them we have to start the whole process over. This makes more work for case managers and keeps our clients from being able to move forward.

Another problem is housing. I'm not sure about other states, but in North Carolina, housing options for our clients are very limited. And when you add to that the fact that people with serious mental illnesses have no income, it further diminishes what could be available for them. So our clients without benefits remain in shelters or end up back on the streets because they can't afford housing.

They also have no way to pay for services and may be denied needed help. They may be put on a waiting list for services until they become Medicaid approved, which would happen once they receive SSI. Without services, individuals may remain in a state of psychosis and have trouble restoring some sense of normalcy to their lives.

In North Carolina, our PATH sites find it difficult to transition folks to mainstream services if they are not Medicaid approved. I stress with our staff to go ahead and begin that process as soon as possible because, if a program does not have the revenue to be able to serve people who are indigent, they're going to put these individuals on a waiting list. Often, clients end up staying on caseloads for long periods of time, which makes it difficult to provide services or open a PATH case to folks who are waiting.

The other thing I want to talk about is what you can do to help an individual avoid a denial or have a successful appeal. First, when you complete the initial application, you need to include as much documentation as possible. I have the opportunity to work in partnership with our disability determination section, and our goal is to train program staff to help a person get through the application process. This partnership is very important, because it forms a liaison between the area programs and the disability determination section. We're going to be doing joint training throughout the state. I'm also developing a checklist for case managers to help them make sure that they're gathering all the appropriate information that's needed to help get an application approved.

Another thing that's very important, and I think you're going to hear this continuously, is you have to have the right type of documentation. Specifically, the documentation needs to show that the person has an impairment, how severe it is, and that it is long-lasting—it has to be something that's going to last for 12 months or more. You need to have information on their daily activities, their symptoms, and the effect that these symptoms have on the person's level of functioning.

One of the most important things you need is the documentation from the doctor. In particular, the doctor has to report that this person has an inability to function or an

inability to secure gainful employment because of his or her disability. If the doctor reports this and there is documentation to support it, that's going to help your client be approved for benefits.

Many of the folks we serve are indigent and have not been in services. So what do you do with a person for whom you don't have a "paper trail?" You have to create that paper trail. You may want to go ahead and do an initial application, knowing that it's going to be denied, and immediately get ready for your appeal.

To begin the paper trail, your case manager notes should indicate that you observe your client's inability to perform different tasks of daily living due to their disability. More importantly, get that person connected to the doctor for an assessment. That is going to be the crucial piece but is sometimes difficult when your client is reluctant to go for services. And again, be certain the doctor reports the individual's inability to function or to obtain gainful employment due to the disability.

I think Connie talked about the form you can fill out to make sure that you receive information from the Social Security Administration at the same time your client receives it. That's crucial. If you receive this correspondence and are aware of what's going on, you won't lose the window of opportunity to appeal if the application is denied. The disability determination section tells me that a significant reason why people have to redo an application is because they did not respond to an appeal in a timely manner.

Another thing that's important is to be certain all medical records are included with the application. If your client is attending a psychiatric rehabilitation program or a clubhouse or a day treatment program, notes from these providers need to be included. The Social Security Administration has a brand new book called *Disability Evaluation under Social Security* that came out in July of 1999. It's free, and it lists every type of disability that Social Security recognizes and exactly what type of documentation would support lack of functioning or inability to work. This is available from the Social Security Administration, and it's going to be your bible.

I want to just speak briefly about disability benefits for people who are HIV-positive. Some of the folks in my state had the impression that if a person who is HIV-positive has a T-cell count under 200, they're going to be approved automatically. But that's not really true. You have to send in the supporting documentation, including the actual lab report that shows they've been diagnosed as HIV-positive and that their T-count is under 200. Further, you have to show that the individual has one of the opportunistic infections or indicative diseases, and, because of that, they are unable to function effectively or to become gainfully employed.

In summary, I think the most important point to remember is that, right at the outset, you have to have the documentation from the doctor showing that the individual

is not able to be gainfully employed and has difficulties in functioning. Help your client make appointments and be certain they keep them, especially if the disability determination section sets up a doctor's appointment for them. Make sure that you attend any appointments with your client to help provide accurate information about them. Be certain you begin addressing the issue of benefits as soon as you start engaging the person into services.

You may want to consider having a benefits advocate on staff. If you have somebody in your shop who really understands this whole process, they can look over an application and the documentation you've pulled together to tell you what you might be missing.

I'm not certain how this is working, but two of my sites have reported that they've been able to tap the services of an attorney to help with the appeals process for an individual who has been denied. One of these sites indicated that all of the appeals the attorney has handled have been successful. If you can advocate within your community for attorneys who are willing to do some work pro bono to help your clients with an appeal, that might make the appeal proceed more quickly and be more likely to succeed.

Gary, that's about all I have.

Gary: That's great, thank you so much, Debbie. I'm going to turn the discussion over now to Carol Luna-Anderson for a 15-minute response.

D. Carol Luna-Anderson

Thank you, Gary. Thanks, everyone, for being here. I'd like to begin by noting that, especially when working with individuals who are homeless, the relationship between the individual and the case manager is key, because the case manager is going to be the client's advocate throughout this whole process and is going to help educate others with whom they come in contact.

In our state, because of outlying Social Security programs, often we find that it's our staff that has most of the information that is needed. And they can then educate those who need to complete the documentation, as well as the client.

Our goal for helping individuals obtain benefits is something we call "the getting" and "the keeping." The process begins by making sure all the documentation is in place. With individuals who have had repeated episodes of homelessness, we find that timeliness is not one of their strong suits, so it's important that the advocate stresses that appointments must be kept.

Another problem that we often encounter is that when individuals are feeling good, they don't want to go to the appointments or continue the process, so they need some real encouragement from their case workers.

Sometimes if feels as if almost everyone is denied initially, and that's discouraging for clients and staff. The real trick is becoming as knowledgeable about the eligibility process as anyone, so that at each step you have the answers yourself before you move on to the next one.

Individuals who are homeless tend to move around a lot, so we have found in some of our programs that it helps to have the person's mail received at a central site. I think that's an excellent suggestion that was made earlier that a staff person receive copies of Social Security Administration correspondence that is sent to their client.

For individuals who have been receiving their benefits, we want to promote self-sufficiency, so we encourage employment. This means we have to understand what the nine-month trial work period is and what will trigger a review. And we have to help our clients not be afraid of receiving a letter from the Social Security Administration, because they may feel like they're being punished when they're starting to do better.

We have found that people are very skeptical about believing that they can continue to receive their health benefit as part of their Social Security, especially when the dollar amount that they receive goes down and is replaced by the work dollar. So we use charts that will show them what the trial work period is and how much they can earn. I have seen situations where a person who receives a letter about possible loss of benefits becomes very discouraged and experiences an increase in symptoms, so it's important to continue to engage the individual throughout this process.

Finally, be aware that when positive things start happening for individuals who have been homeless for a good period of time, they may begin to sabotage themselves by missing appointments or becoming difficult to locate. They're experiencing both emotional and physical changes in their lives. So again, it's very important to maintain a connected relationship with individuals at this time.

I think that's about it, Gary.

Gary: Thank you, Carol, that was great. We'll now begin the question and answer period.

III. Question and Answer Session

Q: Can an individual appeal the results of a CDR?

A: *Connie*: Yes. As I said before, everyone has a CDR every few years, regardless of whether or not they go to work. But if a person begins working and continues to work above the substantial gainful activity level, it will trigger an extra CDR. Remember that a CDR for either reason may not result in a change. However, if the individual goes through a CDR and the Social Security Administration determines the person has medically improved and no longer meets the agency's disability definition, they will be notified of this in writing. Once the individual has that letter, they have the opportunity to appeal that decision, if they choose to.

Q: How will we know, every year, if the SGA is going up, and how can we locate that type of information?

A: *Connie*: There are a couple of different ways that you can find out about any changes. One is that you can periodically go to Social Security's Web site and look under updates. Their website is www.ssa.gov. It's a good idea to go onto that Web site around the middle of November to December every year to check for any changes. The site includes information about changes in the federal benefit rate for SSI, and it will list the cost of living increase for people who receive SSDI checks. When the new changes take effect, the update section will include information about how much the SGA and the trial work month amount are increasing. That's one way you can get it.

The second way is to contact your local Social Security office in December or January each year and ask for those new adjusted amounts.

Q: Would you define secondary SGA?

A: *Connie*: The way the rules on substantial gainful activity have always read in the past, SGA is about $700 worth of earnings, adjusted by work incentives. The rules also said, however, that earnings above $300 but below $700 could result in an SGA determination, if the nature of the work being performed is the same as it would be for a person without disabilities. So there's always been this gray area between $300 and $700 in which the Social Security Administration could potentially, by law, determine that an individual making more than $300 was capable of engaging in SGA.

That's being changed, and we believe the new provision will take effect on January 1, 2001. At that point, if the individual makes less than $700 or whatever the SGA is at that point, the Social Security Administration will not examine the situation further by looking at the conditions of employment.

Q: Connie, would this be a good example of that? Let's say you have someone who is a skilled carpenter, and the going rate in the community is $20 an hour. But this individual is only able to work 15 hours a week, so that's going to push him into that gray area even though he's not working full-time. Technically, this individual is being paid at the commensurate wage and is doing the same work as the non-disabled worker, but is earning substantially less than $700.

A: *Connie*: That's a great example. The Social Security Administration has not often determined that wages between $300 and $700 constitute SGA, but they could have if they chose to, and now they won't be able to do that.

Q: Debbie, could you please give us more information about the booklet you mentioned?

A: *Debbie*: Yes. It's called *Disability Evaluation under Social Security*. The Social Security Administration puts it out, and I think it should be available from your disability determination section or your local Social Security Office. Eventually, it may also be available on the Social Security Web site, but I'm not certain it's there yet.

Q: I have a consumer who was denied benefits initially and on two subsequent appeals before the same administrative law judge. Even though we presented new information at the last hearing, the decision was based on 15-year-old information. Should we take this to the appeals counsel or file a new application?

A: *Connie*: It's hard to say which would be better, because you're talking about a long process, and it really may be better to go with a new application. The one thing to remember is that any time you go with a new application, if you win on that one, the day of award is the date of the new application. In other words, you wouldn't be able to go back and help him get benefits for this period of time so far. On the other hand, it may be better to start with a clean slate. I'd be interested to hear the opinion of the other respondents on that.

Carol: That has happened to us a number of times, and what we've done is gathered all of the documentation and examined it to see if the physician's information is current. That has actually made quite a difference here because, in the process, we've been educating physicians. We've found that, often, their opinion carries the greatest weight.

Questioner: Would you pull in new physicians or psychiatrists to evaluate the client?

Carol: We've done that. It can be difficult when you have one appointment and that happens to be a good day for the client. If we can't change the appointment, we have requested that there be another evaluation by a physician.

Debbie: I've had it reported to me that once the individual has an attorney assisting them in the appeals process, they're getting approved, though I know that might not be possible where you are.

Questioner: We had an attorney on both appeals, but I was excluded from the hearings.

Q: How can we locate the annual income threshold for each state?

A: *Connie:* There is a table in the appendices of the manual Thomas Golden prepared for you that lists each state's annual income threshold, which is the top amount an individual can earn without losing Medicaid eligibility under 1619(b). Please note the figures in the manual are year 2000 figures. The new ones don't come out until June. You can get the updated figures on the Social Security Web site I mentioned earlier.

Gary: If anyone didn't receive this manual or any of the other training materials we sent, please send an e-mail to Marjorie Steinman at msteinman@ahpnet.com, and we'll be happy to send you the information via return e-mail.

Q: Is the time frame for an appeal 60 working days or 60 days on the calendar?

A: *Connie*: It's 60 calendar days. But remember that the Social Security Administration starts counting five days after they send the letter. So you actually have 65 calendar days from the date on the letter.

Q: If an individual has a disability based on a mental illness, is it more appropriate to have documentation from a medical doctor, a psychiatrist, or a psychologist?

A: *Carol*. It would be the psychiatrist. The one time it would be helpful to also get input from the medical doctor is if the individual has a co-occurring medical condition that may impact on his or her ability to be declared eligible for benefits.

Questioner: What if a mental health center psychiatrist frowns on completing that type of documentation?

Carol: Because in New Mexico we are so critically short of psychiatrists, we have found that it helps to make things as easy for them as possible. We've

even had some of the staff pull together samples of things that others have done. It doesn't really have to be difficult. What the Social Security Administration is looking for is the appropriate documentation for the diagnosis and the behaviors associated with that diagnosis that deem the person eligible to receive benefits.

You can't actually prepare the documentation because it does have to come from the psychiatrist, but you can use the correct terminology when you're speaking to him and explain what you need. Sometimes the doctor doesn't know what's needed and can end up writing reams of paper that really don't help make the determination.

Q: How does Social Security view the SGA when it's related to job coaching and supported employment?

A: *Connie*: When an individual is earning money at or above the SGA and is receiving extra services—such as job coaching or employment-specific case management services or extra support from an employer that's not typical—the cost of those extra services are discounted from earnings when determining whether the individual is above or below SGA. So, for instance, if I have a job coach on my job, or I'm receiving employment related services off the job, for half of the time I'm working, then half of my earnings don't count toward determination of SGA.

Questioner: Does Social Security have some kind of a form or worksheet to figure that out?

Connie: They don't, but they do specify in their manual that the value of services provided free of cost to an individual is based on the consumer's hourly wage. So if the person earns $10 an hour, for every hour of extra help they receive, $10 worth of earnings are discounted. If they have to pay for something that allows them to work, like a door-to-door transportation service, the amount they pay for it is discounted.

A great example is psychotropic medications for the person on Medicare. Because Medicare doesn't pay for prescriptions, if an individual pays $400 a month, out-of-pocket, for medication, that money is discounted from earnings when Social Security determines whether the individual is above or below SGA.

Questioner: What do we do when Social Security doesn't discount job-related services even when we tell them the individual has them?

Connie: You need to talk to the claims representative up front. If it's a job coach or something the person's not paying for, tell them the individual has a subsidy. Explain what it is, and they will tell you if they need any kind of documentation. If the person is paying for the service, it's called an impairment-related work expense. Again, you want to tell the claims representative what the service is and how much it's projected to cost. They will tell you if they need any particular documentation, including whether you need to keep receipts and how often to send those in.

Now, some claims representatives are going to work harder than others and will ask you questions about subsidies and impairment-related work expenses. Always proceed from the assumption that they're not going to bring it up unless you do first. Where we make our mistake is we presume that they're going to give us credit for that, and we wait until the individual is working, but if they don't agree with us at that point, we have a mess. We want to try and get it taken care of before it actually happens.

The Social Security Administration does have something called a work activity report that they send to an employer, to find out if the employer thinks that he or she is providing special conditions or extra supervision. But there's no form to request a subsidy early. You have to either write a letter or speak directly to the claims representative.

Gary: The Social Security Administration also has what it calls the Red Book, which includes examples of the type of exclusions that Connie just mentioned. It also includes information about provisions for keeping one's medical benefits, at least temporarily, after returning to work. The book is available at any Social Security office.

Carol: I think this goes back to the comment I made about why it's so important for the staff to really understand both the eligibility and the appeals process, because if you have the knowledge that we just talked about, you'll bring it up and truly be on top of the situation for your client.

Q: I have a client who's been denied disability benefits because he's capable of SGA when he takes his medication. But without benefits, he has to pay for his medication, which reduces his earnings. If he stopped taking the medication, he would be back in the hospital again. How can we help him get approved for disability?

A: *Connie*: When the Social Security Administration decide who is and isn't eligible for benefits, they're going to say that the person earning more than $700 is not eligible if they don't have the information about him paying $400 a month

for medication. Therefore, it's important to let Social Security know when you make the application that this person is paying for medication that he needs because of his disability, and you're asking them to consider it as an impairment-related work expense.

If this doesn't happen and the person is denied, you can appeal this decision within the 60-day window and get them the information about any medications or other impairment-related work expenses for which the individual pays.

IV. Closing Remarks

Gary: Well, it looks like we're out of time, so we'll conclude today's program. Our thanks to Connie, Debbie, and Carol for a great job, and to Dr. Hutner for his leadership on this important topic. Thanks also to everyone in the PATH network across the United States for joining us today. We hope you'll join us again.