March 5, 2012

Office of Regulations
Social Security Administration
107 Altmeyer Building
6401 Security Boulevard
Baltimore, Maryland 21235–6401.

Re: Supplemental Security Income and Homeless Individuals [Docket No. SSA–2011–0087]

Thank you for the opportunity to submit comments regarding the unique needs of SSI recipients who are experiencing homelessness. The National Health Care for the Homeless Council is a membership organization comprised of over 100 organizational members and over 1,000 individual members who work to improve the health of people experiencing homelessness. NHCHC organizational members include grantees and subcontractors of the federal Health Care for the Homeless funding stream, other health care providers, and advocacy organizations.

Our responses to SSA's questions are below. However, we believe that the focus on public and private shelters is not the best way to understand the unique needs of SSI beneficiaries who are experiencing homelessness. Following our responses to the posed questions, we offer additional insights and recommendations to help SSA better understand the unique needs of SSI beneficiaries who lack housing. We also make ourselves available to those at SSA to arrange for a shelter tour in your area so a better understanding of the realities of shelter life can be seen firsthand—we believe it would make a significant difference in the way homelessness is addressed in SSA policies.

1. What is your experience with SSI recipients in homeless shelters?

SSI recipients and non-recipients have similar experiences when using homeless shelters. While SSI recipients make up a less than 10% of people experiencing homelessness, nearly 40% of people experiencing homelessness are actually reported to have one or more disabilities. For most people who lack housing, staying in shelters is often a last resort. Many people avoid shelters due to shelter policies and procedures that diminish the dignity of those who need assistance. Individuals are often required to stand in line for long periods of time and check in during the early evening with little flexibility to leave the premises without losing one's bed. Many shelters require attendance to religious service before a bed is made available. Such requirements make presumptions about one's morality based on housing status. For this reason and others, shelter stays may be sporadic.

While most shelter guests would like to find and maintain housing, affordable housing is generally unavailable. For every 100 extremely low-income renters in 2010, there were only 56 units they could potentially live in without spending more than 30% of their income on housing and utility costs.[1] Additionally, in 2010, the fair market rent for an average apartment was $960 per month nationwide. Given that a monthly SSI benefit is only $698, SSI recipients who are experiencing homelessness are unable to

access housing at market rates and have no choice but to remain in the homeless service system. HUD and other subsidized housing programs are also often inaccessible with waiting lists often years long. For example, on February 15, 2012, the Section 8 waiting list in Orange County California opened for a 2-week period after being closed for 7 years.[2] Waiting lists in many other cities have been closed for years, with thousands of families still unable to access resources.

Shelters also lack the capacity to provide adequate supportive services to people who have disabilities. For example, a guest who has cancer may not have the support needed to manage the side effects of their treatment. Additionally, special diets and assistive devices are often unavailable to those who need them. Many shelters are not wheelchair accessible, do not have elevators, require walks up several flights of stairs, and only have bunk bed sleeping arrangements. Hence, for those with physical limitations on movement, shelters may not be possible to navigate.

Finally, violence and thievery are extremely hard to eliminate from shelters, and disabled persons are frequently the victims. Reports of predators targeting disabled persons on check day (in shelters and elsewhere in the community) are common. In our experience, current representative payee programs and other safeguards are insufficient for protecting the integrity of the SSI entitlement. This observation should NOT be misconstrued as an objection to provision of benefits to shelter residents.

2. In your experience, do both public and private homeless shelters meet the needs of the homeless in the same way? If they differ in how they meet the needs of the homeless, how do they differ?

Very few shelters operate on public funding alone. Most shelters are private and receive some public funding. Shelters vary significantly in quality and scope of services. Many shelters offer little more than a bed (or a mat or foam pad on the floor) at night while others provide a wide range of services in partnership with other entities. For example, federally qualified health centers (FQHCs) are increasingly establishing service sites at shelters. However, FQHC site selection is not based on the shelter's funding. Generally, the quality and quantity of services available at shelters are a reflection of how well the shelter leadership is engaged in partnerships and collaborations in their community. Hence, whether the shelter is publicly or privately funded is not a meaningful distinction; it is the breadth of services provided that makes a difference in quality.

3. Do individuals rely on public emergency shelters exclusively to address short-term needs, or is transitioning out of such shelters into permanent housing becoming more difficult? Is the short-term assistance provided by public emergency shelters meeting the transitional needs of SSI recipients?

People experiencing homelessness are a heterogeneous population having various degrees of resources and support available to them. Some people may move between shelters, street, motels, and friends and family while others who have fewer supports use shelters (or the street) more consistently. Others might move from city to city searching for work and may use the shelter system until a steady source of income becomes available. Even those who are considered to be chronically homeless may move between shelters and outdoor dwellings (e.g., abandoned buildings, encampments, under bridges, etc.).

As described in the previous response, transition to permanent housing is dependent on many variables including supply of affordable housing, quality of housing placement services, income, and any support services that may be needed to maintain housing. During the current economic climate which is characterized by significant unemployment and home foreclosures, transition to permanent housing has become particularly difficult. Affordable rental units are in high demand and are claimed quickly. Further, landlords are in a position to be selective of their tenants and may choose renters who are more self-sufficient (e.g., not working with a case manager or using vouchers). In many states, it is legal to discriminate against renters based on their source of income (e.g., no Section 8 vouchers allowed). Also, nearly all public housing units and many private landlords ban tenants who have any criminal record, no matter how small. Since homelessness

exposes one to the public eye 24 hours a day, citations and charges for small infractions (public urination, loitering, panhandling) are not uncommon. Any or all of these reasons can create barriers to leaving shelters and obtaining permanent housing.

4. What specific needs do public emergency shelters meet?

In general terms, the only specific need met by shelters is a place to sleep at night out of the elements. As shelters vary in terms of services available to them, we cannot say that public shelters consistently serve any other specific need. Even the provision of food, bathing facilities, and laundering services vary across sites.

5. Do public emergency shelters usually address the health care needs of individuals in the shelter? To what extent do individuals in public emergency shelters rely on Medicaid to meet their health care needs?

Data is unavailable regarding the number of shelters that provide health care services. A number of shelters are service sites for federally funded Health Care for the Homeless (HCH) projects. These projects may establish a clinic onsite at the shelter or may conduct health screenings (such as TB screenings that some shelters require) or outreach at shelters. The provision of these services may vary with some operating under contracts or memoranda of understanding (MOUs) and others collaborating more informally. With only 223 HCH grantees in the United States, we presume that more shelters are operating without such health care services than with them.

According to 2010 HRSA UDS data, about 35% of HCH patients were insured; most of these were insured under Medicaid. An unknown but presumably significant portion of these Medicaid recipients qualify for Medicaid on the basis of being enrolled in SSI. Those who have Medicaid coverage are usually able to access a broader range of health care services. For example, people who have Medicaid are able to access specialty care, home and community-based services, rehabilitation services, and other services that promote wellness and health stability. It is important to note that many health care providers do not accept Medicaid patients; hence, simply having Medicaid coverage does not guarantee access to services. Those who are not Medicaid beneficiaries must depend on the availability of indigent care programs which are not consistently or widely available.

6. Do residents of public emergency shelters usually lose their Medicaid coverage if they stay longer than 6 consecutive months and their SSI is suspended?

As noted earlier, we do not believe that most people stay in shelters uninterruptedly for long durations of time. Many people may choose to stay outdoors during nicer weather, in a motel when resources allow, or with friends and family. Additionally, individuals may move back and forth between various local shelters depending on shelter capacity and other factors.

Though not the norm, it is possible for a SSI recipient to stay in a shelter for 6-consecutive months. Suspending SSI benefits for this population would be reckless and would prolong homelessness for individuals who need more time to gain life stability, particularly in a time when affordable housing opportunities are bleak.

Though a significant number of Medicaid beneficiaries are SSI recipients, some may have access to Medicaid because their state has elected to expand Medicaid coverage. As such, these individuals would not be subject to SSA policies.

7. Do current SSI eligibility rules present obstacles to homeless individuals who are in need of emergency shelter?
AND
8. Do current SSI eligibility rules present obstacles to individuals who are trying to transition from a public emergency shelter to a permanent living arrangement?

Current SSI eligibility rules related to shelter stays would present significant obstacles if they were consistently enforced. Identifying SSI beneficiaries who have stayed in a public homeless shelter for six consecutive months would be onerous, require intensive reporting protocols, and do nothing to advance housing stability for those with disabilities. Additionally, such rules are contrary to widely accepted approaches to preventing and ending homelessness. People experiencing homelessness may need more than six months of shelter and services to gain life stability. With six months of resources invested in one person, an agency may be reluctant to submit a report that would remove a client from SSI and Medicaid rolls, particularly for those who have shown marked improvement or who are simply waiting for subsidized housing to become available. In fact, to do so fails to demonstrate any understanding of the challenges to overcoming long-term homelessness and the barriers to obtaining (and maintaining) permanent housing.

9. After residing in a public emergency shelter for 6 months, do SSI recipients tend to remain there until they can transition to a permanent living arrangement or do they consider other options?

No one wants to stay in a shelter. In many cases, they are dangerous, scary and unsafe places, especially for those with physical or mental disabilities. Individuals who are experiencing homelessness would consider other options if they were available. However, until permanent living arrangements are available, emergency shelters are frequently the only option in order to prevent individuals from sleeping on the street or in dwellings not fit for human habitation.

Additional comments on the unique needs SSI beneficiaries who are experiencing homelessness.

Physical and cognitive impairments are among the factors that increase the likelihood of becoming (and remaining) homeless if services to meet basic needs are not available.[3, 4] People who have disabling physical and cognitive impairments are at risk of becoming homeless from unemployment, loss of family support, severity of symptoms, and inadequate supports after institutional discharge. Indeed, people with disabilities represent nearly 40% of the homeless population and constitute the entire "chronically homeless" population in America, as defined by HUD.[5, 6]

Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) constitute a critical safety net for persons with disabilities, providing cash assistance and, usually, eligibility for public health insurance (Medicaid/Medicare). For many people living in poverty, the income from SSI entitlements prevents homelessness and assists in meeting basic needs. For people who are already homeless, SSI benefits can improve opportunities for finding and maintaining housing, including supportive housing. By increasing access to housing and health care, people who are disabled and homeless have a greater chance at achieving stability and resuming productivity.

While public and private shelters play an important role in meeting a basic need for people who lack housing, these shelters are not a panacea for ending homelessness. Shelters cannot be expected to meet the health care needs of people experiencing homelessness particularly in a time when funding for such services (e.g., HUD's Supportive Services Only funding stream) are reduced. Additionally, shelters cannot improve access to permanent housing when affordable housing is unavailable.

Authority over housing and services is outside the scope of SSA. However, SSA plays an important role in eliminating the need for these services by implementing stronger policies that prevent people who have disabilities from becoming homeless in the first place and by expediting access to SSI benefits for people

who have become homeless due to their disability. We believe that the following recommendations will improve access to SSI for people at risk of and currently experiencing homelessness.

Include questions in application package to ensure personnel correctly identify homeless claims: Many offices that expedite processing of homeless claims have difficulty identifying claims from homeless people. Being able to provide an address does not guarantee that the claimant is not homeless. We recommend adding questions to the Disability Report that would reflect a claimant's possible homeless status, including questions about the person's living arrangements, about the length of time at the current address, and past episodes of homelessness. Such questions on the Disability Report would not only indicate a claimant's homeless status, but could add information regarding a claimant's functional limitations.

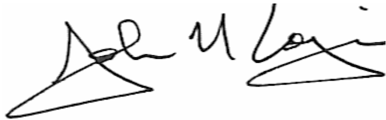
Flag and expedite homeless claims: Claims filed by homeless persons should be flagged at all levels of consideration to trigger expedited disability determination due to urgency of need. This same process worked well when applied to the disability claims filed by Katrina survivors and demonstrates that the proposed process is both feasible and effective in connecting disabled individuals with life-saving benefits. Social Security, in special circumstances, has had policies in place for some time that allow for flagging cases. In some offices, the e-file recognizes "homelessness" and in others, DDS offices use paper flags to identify homeless claimants and direct their claims to certain units or workers. The problem with this ad hoc process is that there is no uniform system that could identify the claims. A directive from headquarters that mandates such flagging and more complete inquiries about homelessness at field offices would be extremely useful and can be accomplished administratively. Although SSA did issue an administrative message encouraging offices to do this, we believe such flagging needs to be required and this policy set at the HQ level. A new system should include mechanisms for electronically notifying SSA and DDS personnel of an expedited claim.

Ensure that all DDSs and District Offices have personnel who are trained to handle homeless claims: This can be accomplished through a dedicated Homelessness Unit (as in the Boston DDS and other urban DDS offices that have large homeless populations). In other areas, it might be more feasible to have designated DDS staff to work on applications from people who are homeless. In both instances, designated staff would develop expertise on homelessness and would understand how such a living situation affects people's lives. This would also be consistent with flagging homeless claims so that such applications would go to designated staff. The National HCH Council and our community partners who serve people who are homeless would be more than happy to offer training to DDS (and SSA) staff on issues related to homelessness as well as on mental illness, should that be of interest.

Expand the list of Acceptable Medical Sources: We appreciate the Social Security Administration's recognition of evidence from non-physician professional sources such as therapists and social workers. However, we believe that these non-physician professional sources should be considered "acceptable medical sources." Although most medical doctors and psychiatrists have the training necessary to determine disability, they are not often found in high concentration in the programs that serve extremely low-income and homeless populations. HRSA consequently recognizes Health Professional Shortage Areas and Medically Underserved Populations in awarding Health Center grants. Low-income and homeless patients receive much of their care from Nurse Practitioners, Psychiatric Clinical Nurse Specialists, Physician Assistants, and Licensed Clinical Social Workers. These professions follow national standards of care and have the skills necessary to determine the source of functional impairment in their patients. We urge SSA to expand the list of acceptable medical sources to include Nurse Practitioners, Psychiatric Clinical Nurse Specialists, Physician Assistants, and Licensed Clinical Social Workers in order to expedite and improve access to SSI/SSDI entitlements.

Thank you for the opportunity to present our ideas. We hope these very specific recommendations help build a better system that can meet the needs of those who are disabled and experiencing homelessness as well as your organization's need to ensure quality services to those who qualify. We also re-iterate our offer to facilitate a shelter tour for any SSA staff who would like to see first-hand how a shelter works (or visit several shelters to understand the breadth of services we describe above). We have community partners throughout the United States and can make arrangements to partner with an outreach worker or other knowledgeable service provider. Should you or someone on your staff be interested in discussing these in further detail, please contact Sabrina Edgington, MSSW, Program and Policy Specialist, at 615-226-2292 or at sedgington@nhchc.org.

Sincerely,



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