



NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

WRITTEN TESTIMONY
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to the
SUBCOMMITTEE ON SOCIAL SECURITY OF THE COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

April 2, 2012

Chairman Johnson, Ranking Member Becerra, and Members of the Subcommittee:

Thank you for the opportunity to submit written testimony for the Hearing before the House Ways and Means Committee Subcommittee on Social Security on How Disability Insurance Eligibility Decisions Are Made. 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. In 2010, our members served nearly one million homeless patients, many of whom have disabilities. The SSI Task Force of the National Health Care for the Homeless Council (NHCHC) attempts to eliminate systemic barriers to accessing benefits for people who have a disability and are concurrently experiencing homelessness.

The Link Between Homelessness and Disability

Disability causes and prolongs homelessness. About 15% of the non-institutionalized U.S. population is disabled, yet people with disabilities constitute 37% of people who are homeless in America.^{1,2} Diminishing affordable housing, depressed wages, higher unemployment, and decreased access to health insurance coverage over the past two decades has placed an increasing number of individuals and families with disabilities at risk of homelessness, and makes leaving homelessness more difficult as well.

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

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 Medical records and other historical documents needed to demonstrate functionality and the duration of disabling conditions are often dispersed among many emergency rooms and hospitals where those without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

Homeless SSI/SSDI claimants often are denied benefits for failure to meet the requirements of an arduous application process, rather than for lack of serious medical impairments that meet SSA disability criteria. Systemic barriers include poor access to health care, insufficient documentation of diagnosis and functional impairments by an approved medical source, remote application offices, complex application processes, disability evaluators unfamiliar with the realities of homelessness, and inconsistent implementation of SSA disability determination policy across jurisdictions. Barriers can be exacerbated by an applicant’s mental illness or by the lack of stability necessary to maintain contact, keep paperwork organized, and meet deadlines throughout the application review.³ In short, homeless claimants do not often get the right decision as early as possible. There is more work to be done to make that promise into a reality.

RECOMMENDATIONS

Include questions in the SSI 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. The Social Security Administration, 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.⁴ 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 district 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.⁵ 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.

Revise the SSA Homelessness Plan to incorporate lessons learned from HOPE,⁶ the SSI/SSDI Outreach, Access & Recovery (SOAR) Project,⁷ and the Baltimore SSI Outreach Project and increase support for these initiatives.⁸ Demonstration projects have confirmed policies and procedures that can improve allowance rates at initial consideration, and expedite access to SSI/SSDI for applicants who are homeless. Successful strategies include: (1) educating SSA and DDS staff about issues related to homelessness; (2) designating SSA and DDS staff to assist homeless claimants; (3) ensuring that all such applications are flagged for expedited processing; (4) tracking outcomes of applications from homeless applicants separately from those of other applicants; and (5) developing processes to ensure that eligibility determinations are made as soon as possible. Such strategies should be incorporated into a revised SSA Homelessness Plan that includes timelines for implementation. By implementing these strategies, SSA could improve approval rates while reducing waiting periods for homeless claimants. Indeed, the SOAR program has resulted in a 71% approval rate at initial application with an average processing time of 101 days.⁹

Repeal the Drug Abuse and Alcoholism (DAA) policy: The 1996 termination of SSI and SSDI eligibility for individuals whose drug addiction or alcoholism is material to their disability was not intended to disqualify persons disabled by co-occurring impairments that include substance use disorders. Such denials have nevertheless been widely reported to occur at the initial stage of disability determination, many of which are reversed to allowances at the appeals level. Inconsistent interpretation and application of the DAA policy

combined with the complexities of determining whether DAA is material to disability have prevented many people with severe disabilities from accessing assistance. One study found that over half of the people who lost their benefits due to the DAA policy had severe physical health disabilities that required hospitalization the year before termination. Another 15% of the population had been hospitalized for schizophrenia and psychosis unrelated to substance abuse.¹⁰

Extend Compassionate Allowances for people who are diagnosed with schizophrenia. Whereas the national incidence of homelessness is less than one percent, twenty percent of people with schizophrenia are homeless.¹¹ Homelessness is an indicator of the extent of functional impairment among people with schizophrenia. Commissioner Astrue held a Compassionate Allowances Outreach Hearing in San Francisco, California on November 18, 2009. As SSA has noted, “[s]ome of the nation’s leading experts on schizophrenia provided testimony about possible methods of identifying and implementing Compassionate Allowances for young adults with schizophrenia. Many of the experts including clinicians and advocated provided information on the effects of homelessness on individuals with schizophrenia.”¹² While SSA and its state and local partners are to be commended for implementing a demonstration project in San Francisco and Santa Cruz CA Counties offering Presumptive Disability to individuals experiencing homelessness with schizophrenia¹³, we look forward to the day when this population will be offered something more than a demonstration project. Expedited receipt of SSI will reduce homelessness among people with schizophrenia.

Thank you again for the opportunity to submit these comments.

Respectfully Submitted,

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Chair, on behalf of the SSI Task Force
National Health Care for the Homeless Council

Notes

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

² HUD. 2010 Annual Homeless Assessment Report.

<http://www.hudhre.info/documents/2010HomelessAssessmentReport.pdf>

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

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

⁴ See, e.g., POMS DI 81020.085[Certified Electronic Folder Flags]

⁵ <http://bhpr.hrsa.gov/shortage/>

⁶ The Homeless Outreach Projects and Evaluation (HOPE) program, established by the Social Security Administration, provided grant funding to 41 agencies in 2004 to assist chronically homeless individuals in applying for SSI and SSDI benefits. <http://www.ssa.gov/homelessness/outreach.htm>

⁷ Policy Research Associates. (2012). 2011 SOAR outcomes. Retrieved from <http://www.prainc.com/cms-assets/documents/51178-875138.2011-outcomes-summary-021612.pdf>. For more information about SOAR see: www.prainc.com/soar

⁸ The University of Maryland Medical System Baltimore SSI Outreach Project began in 1993 as SSA funded outreach demonstration project, designed to assist homeless adults with severe and persistent mental illness in obtaining SSI benefits. Over 10 years, the project achieved a 96% success rate on application for those whom project staff believed to be eligible for benefits.

⁹ Ibid 5.

¹⁰ Hanrahan, P., Luchins, D., Swartz, J., et al. (Jan 2004). Medicaid eligibility of former Supplemental Security Income recipients with drug abuse or alcoholism disability. *Am J. Public Health*, 94(1): 46-47.

¹¹ Folsom, D.P, Hawthorne, W., et. al. "Prevalence and Risk Factors for Homelessness and Utilization of Mental Health Services Among 10,340 Patients with Serious Mental Illness in a Large Public Mental Health System." *Am J. Psychiatry*. 2005.

¹² USICH Agency Annual Reports:2011, pp.72-73; available at:

http://www.usich.gov/resources/uploads/asset_library/Annual%20Update%202011%20Appendix_Jan12.pdf

¹³ Id.