Disability Rights California

California's protection and advocacy system

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PUBLIC BENEFITS FOR PEOPLE WITH DISABILITIES

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A. Social Security/SSI Benefits for People With Disabilities:

1. Two Kinds of Benefits from the Social Security Administration

This section covers two programs. Both of them use the same definition of disability (except there is a special definition for children on SSI):

a. SSI Benefits

Supplemental Security Income (SSI): These benefits are for children and adults with limited income and resources. Persons aged 65 or older are also eligible (with certain limitations for non-citizens). The 2010 SSI benefit level in California is $845 for an aged or disabled person and $1,579 for a couple. If you receive other income (such as SSDI/Title II benefits) which is less than the SSI standard, you can also get an SSI check to supplement your other income. If you receive even one dollar of SSI, you are automatically entitled to Medi-Cal at no cost.

b. SSDI/Title II Benefits

There are two types of Social Security Disability Insurance (SSDI) Benefits. The first is for disabled workers who are insured under Social Security. The second is for children of disabled workers who are insured under Social Security and who are either retired, disabled or deceased. These benefits are sometimes called Title II benefits. Title II is the section covering disability, retirement and dependent benefits in the Social Security Act.

(1) For disabled workers

Social Security Disability Insurance (SSDI) Benefits: These are benefits for people who have worked and paid into Social Security long enough to qualify for benefits when they become disabled. The spouse and children of the worker with a disability may be eligible for benefits in addition to worker's benefits. After 24 months of SSDI benefits, the recipient starts getting Medicare.

(2) For disabled children

Social Security Disabled Adult Child Benefits (DAC or CDB): This is a special Title II program for persons who are at least 18 years of age, who became severely disabled prior to age 22 and who are unmarried when they apply. These special dependent benefits draw upon the earnings record of a retired, disabled or deceased parent (or other caregiver) that paid into Social Security. The Disabled Adult Child is not eligible for these benefits until the parent begins receiving Title II benefits when retired or disabled or when the parent dies. After 24 months of benefits, the DAC/CDB recipient is eligible for Medicare.

2. The Application Process

Start the application process by calling 800-772-1213. Write down the name of the person you talk with and the date. You will be sent an application packet to fill out and return. If the packet is returned within 60 days of the first phone call, that phone call will be treated as the date the application is made. If you need help in understanding or filling out the forms and cannot find someone to help you, ask for help from Social Security itself. Under Section 504 of the Rehabilitation Act, Social Security is required to help when you need the help because of a disability.

There are local agencies which can help with initial Social Security application, such as Independent Living Centers. If you receive General Assistance, the county may also help you with the SSI application.

If your initial application is denied, it is very important to appeal. (See later section on appeals). You are more likely to win if you get an attorney to handle your appeal. Private attorneys will represent initial applicants at the administrative law judge hearing stage without advance payment. If you win, the attorney's usual fee is 25% of the award of retroactive benefits

back to your initial application date. If you lose, there is no charge. To find a local attorney who will help, contact the county bar association or the National Organization of Social Security Claimants' Representatives (NOSSCR) at 1-800-431-2804.

3. Meeting the Disability Standard

The local Social Security Office sends the forms completed by the applicant, including medical releases and information about the person's disability problems, to the California Department of Social Services, Disability Determination Services (DDS) The DDS is responsible for collecting medical evidence before making a decision. Each applicant will be assigned an analyst to develop the case. Usually the analyst will send Daily Activities Questionnaires to the applicant and to someone who knows the applicant.

a. How an Advocate can help

Help from an advocate in the disability evaluation process can make a real difference. The advocate can assist or get somebody to assist the applicant in completing the questionnaire so that the answers accurately reflect the impact of the disability problem on daily life. The advocate can touch base with the DDS analyst and help get missing medical evidence. In most cases erroneous denials are because the DDS did not have all the medical evidence it needed. If the advocate thinks that there may be an underlying organic element to the disability – as may be the case with some people with a history of drug or alcohol use – the advocate can suggest referral for special neuropsychological testing. Sometimes the analyst will send the applicant for a consultative psychiatric examination, but the exams arranged by DDS are often superficial and fail to address the applicant's disability problems. The advocate can assist the applicant by arranging for an examination through county providers.

b. Definition of Disability for Adults

An adult is disabled if unable to engage in substantial gainful activity (SGA) because of a medically determinable physical or mental impairment which is expected to last 12 months or longer or to result in death. In addition, the individual must be incapable of doing their past work, if any, or any other work which exists in significant numbers in the area where the individual lives. The test is not whether or not an applicant would be hired for an

entry level job, but whether, if hired, the applicant would be able to keep the job. Identify the disability problems which would interfere with an applicant's ability to keep a job such as a parking attendant, as a dishwasher in a restaurant, as a cashier in a fast food restaurant, as an assembler.

The definition of disability does not include persons who are disabled as a result of current alcohol or other substance abuse. However, such persons may be covered if they meet the disability standard because of other impairments even if those impairments were the result of past substance abuse.

The DDS will look first to whether or not the applicant's impairment or combination of impairments meets or equals the criteria one of the individual Listings of Medical Impairments. These are found in the Social Security regulations (20 CFR Part 400) behind 20 CFR § 404.1599. For people with psychiatric disabilities, start with Listing at 12.00, Mental Disorders. Even if a person does not squarely meet the criteria in one of the listings, the person can qualify if he or she is found to have a disability which is comparable in severity to a listed impairment. This may be because, for instance, the person has multiple disabilities and some of the criteria are met in two or more listings. Or the person's disability may have the functional impact of a listed impairment. Look at the ABD criteria under the Mental Disorder Listings.

If the applicant does not meet or equal a listing, then the DDS looks to see whether or not the applicant can go back to past types of work, if any. If you cannot do past work, then the DDS looks to see whether or not there is other work reasonably available which you could do in light of your age, education, work experience, and disability limitations. For people with psychiatric disabilities and other mental or neurological impairments, there are usually "nonexertional limitations" which are considered. Social Security Rulings 85-15 and 85-16 discuss how Social Security looks at disability limitations relating to mental or neurological impairments.

c. Definition of Disability for Children

In 1996 Congress narrowed the definition of disability for children. The primary impact of the narrowed definition was on children with mental impairments. Children under the age of 18 years are disabled if they have "a medically determinable physical or mental impairment which results in marked and severe functional limitations, and which can be expected to

result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." In practice, it means that children must show that they meet the listings or that they medically or functionally equal the listings.

4. Meeting the Financial Eligibility Requirements

The amount of resources and income other than from work does not matter for purposes of the SSDI and DAC (Title II) programs. However, SSI is a needs based program and the amount of resources and income matter.

For SSI, an individual can have up to $2,000 in countable resources. A couple can have up to $3,000 in countable resources. However, certain resources are exempt: a home, household furnishings, wedding and engagement ring, a car used for transportation, a burial trust or account, resources used for self-support. Social Security also does not count the retirement accounts owned by the spouse of a person with a disability or the parent of a child with a disability.

Income is money or something you can convert to money which you receive in a month. What is left over as of the beginning of the next month counts as a resource. The income received less allowable deductions can affect the amount of SSI benefits received:

> *Example:* Dora receives $460 a month in SSDI/Title II benefits. That is considered unearned income and is reduced by the Social Security deduction of $20 which applies to any income so that the countable income for SSI purposes is $440. Dora's SSI payment will be for the difference between the SSI amount she would receive if she had no income ($845 in 2010 for a single person) and $440, for an SSI grant of $405.

For SSI, Social Security takes into consideration or "deems" the income and resources of other people in certain cases: The income and resources of a parent or stepparent living with a child with a disability is considered; the income of a spouse in the same household is considered; the income of an immigrant's sponsor is considered in certain circumstances.

5. Living with Another and "In-Kind" income

There are special rules when you receive in-kind income. In-kind income only counts if it is for food or shelter. If someone gives the SSI beneficiary a bus pass or cat food or pays someone else directly for medical treatment or other services that is not income which counts. However if the SSI beneficiary is living with other people and is not paying his or her fair share of the food and/or housing expenses, the SSI payment will be reduced under the “living-in-the-household-of-another” rule by one third of the federal part of the SSI grant (in 2010, about $224) even if that is more than the discrepancy between what is contributed and the SSI beneficiary’s “fair share.”

This rule only applies when the SSI recipients are receiving all their food *and* shelter from the household. If the rule does not apply (when receiving food or shelter), then Social Security applies the “presumed value” rule which treats as countable income the lesser of (1) the difference between the value of what is received and what you pay for it, and (2) the “presumed value” which is one third the federal part of the SSI grant plus $20:

> *Example:* Eduardo lives rent free in an apartment over the garage behind his sister’s house. Eduardo agrees that the rental value is $300 a month. Eduardo’s 2010 SSI monthly payment of $845 is reduced by $224 and $20 so that his reduced SSI is $601.

6. Effect of Immigration Status

For purposes of receiving Title II Social Security Disability and DAC benefits, the recipient only need be lawfully present in the United States. That includes persons who are present under a visa or for whom there is a stay of deportation.

For purposes of SSI, the universe is divided between those noncitizens who were either receiving SSI benefits before August 22, 1996 (the date the Welfare Reform Legislation was enacted) or lawfully residing in the United States on that date and those noncitizens who began lawfully residing in the United States on or after that date. For persons here or receiving SSI before August 22, 1996, the SSI rules are unchanged except that noncitizens who were not receiving SSI before August 22, 1996, will

not be eligible to qualify for SSI on the basis of age when they reach age 65. Seniors will be able to establish eligibility based on disability.

The rules are complicated for persons who were lawfully admitted *after August 21, 1996,* and their eligibility should be reviewed with someone knowledgeable about immigrant rights.

7. Retroactive Payments

Because resources and nonwork income are not considered for purposes of the Title II programs (SSDI and DAC benefits), receiving a retroactive payment does not affect benefits.

Under SSI, an adult has nine months in which to spend a check covering back benefits (both SSDI/DAC and SSI) before that money will be counted as a resource. Receipts should be kept to show Social Security how resources were brought down to the allowable $2000 for an individual or $3000 for a couple.

8. Continuing Reviews, Terminations and Cessations

Under the SSI program recipients will be reviewed once a year to see if they still meet the income and resource requirements of the SSI program.

Under SSI, SSDI and DAC benefits, current recipients will be reviewed to see whether they continue to be disabled. Congress has given Social Security more money so that people will be reviewed at least every three years. People being reviewed are not treated as new applicants. The review is supposed to look at whether there has been improvement which results in the ability to work. The first step of the review is an appointment at the local office. That is to get information about treatment and support services and to get releases so that health care providers may be contacted. That information is sent to the DDS, the state agency that also makes disability determinations for applicants.

The role of advocates is important in this process. Sometimes people become fearful and do not respond to the Social Security appointments or contacts from DDS In those cases the current recipient will be terminated from benefits not because he or she is no longer disabled but because of a “failure to cooperate.” The advocate can provide important assistance by identifying someone to assist the recipient through the process and by

advising DDS of the need to make reasonable accommodation to the person's disability limitations.

The advocate can provide help in insuring that the DDS gets medical evidence from treating sources so that the recipient is not sent to one of Social Security's consultative examiners. If the recipient is being seen by a clinic, we recommend that the clinic person most familiar with the person draft a report including a comparison between the status before and now to be signed by the treatment team. Social Security only recognizes reports signed by a physician or a clinical psychologist.

If the client receives a notice that Social Security benefits will be terminated, **appeal immediately.** In many cases, benefits will continue if an appeal is requested within 10 days of the notice. *See* "Appeals" later in this section.

9. Representative Payees

If Social Security determines that the recipient needs help in managing his/her money, Social Security may appoint a relative, agency, or friend to be the representative payee. People whose disability includes problems with drugs or alcohol are required to have a payee. Only in rare occasions will Social Security approve a board & care operator as the representative payee. While the payments are made directly to the representative payee, the money belongs to the recipient. Under certain circumstances, Social Security authorizes the representative payee to deduct $35 a month ($68 a month for persons who require a representative payee because of drug or alcohol abuse) as fee.

The recipient may challenge the determination that a representative payee is needed and the naming of a particular person as the payee. Social Security is obligated to investigate complaints of financial abuse by a payee. Reports should be made in writing to Social Security. Where there is a serious question, Social is obligated to investigate and suspend payments to the representative payee.

10. Disability Benefits and Work

Social Security treats work differently depending on whether you are receiving SSI or Title II disability benefits. If you are receiving both, both sets of rules apply to you at the same time.

a. SSI and Impairment Related Work Expenses

You can work and still get SSI unless your income gets so high that you are no longer financially eligible. SSI has generous income counting rules, $20.00 of any unearned income, the first $65.00 of earned income and one half of your earned income is excluded in figuring the amount of your SSI.

You can also reduce your countable income and thus increase the amount of your SSI through Impairment Related Work Expense (IRWE) deductions. These are the charges the recipient pays out of pocket for assistance and treatment related to the disability and for the extra expenses someone has because of working and having a disability. Blind Work Expenses (BWEs) also allow blind individuals to deduct expenses related to work. BWEs are more liberal because the expense does not have to be related to the beneficiary's blindness, and because the expenses are deducted later in the process. For example Federal, state, and local income taxes and Social Security taxes are considered BWEs.

Comparison of Monthly SSI Payment with BWE versus IRWE:

With $40 BWE	With $40 IRWE
$361 Earned Income -20 General Income Exclusion $341 -65 Earned Income Exclusion $276 ÷ 2 =138 ½ Remaining Earnings $138 -40 Blind Work Expenses =$ 98 $98 Countable Income $845 2010 SSI Benefit Rate for a blind individual -98 Countable Income $747 SSI Payment	$361 Earned Income -20 General Income Exclusion $341 -65 Earned Income Exclusion $276 -40 Impairment Related Wk Exp $236 ÷ 2 = 118 ½ Remaining Earnings $118 Countable Income $845 2010 SSI Benefit Rate for a disabled individual -118 Countable Income $727 SSI Payment

Practice Tip: If you live in a board and care which provides care and supervision in addition to room and board, the value of these services can be deducted from any earned income as an Impairment Related Work Expense.

b. SSI and PASS Plans

With a “Plan for Achieving Self Support” or PASS, income or an excess resource can be sheltered and not counted in determining eligibility for SSI. The income or resources sheltered can be used to pay for tuition, equipment needed to work, etc. Persons interested in seeing whether a PASS would assist them, and particularly persons not now eligible for SSI, should be referred to someone with expertise in writing and implementing Plans for Achieving Self Support. SSA has specially trained employees called Pass Cadres that work with the PASS program. The following internet site provides a map that you can use to locate the PASS Cadre for your area: www.socialsecurity.gov/passcadre. Beneficiaries can also be referred to their local benefits planner (see WIPA information below).

c. SSDI/Title II, Trial Work Period, Extended Period of Eligibility and SGA

For SSDI/Title II benefits, work can result in a termination of benefits even for persons who are still disabled. You will have a "trial work period" (TWP) month if (1) you earn more than $720 (in 2010) or (2) if self-employed, you work more than more than 40 hours per month. The amount earned in any trial work period month does not affect the amount of benefits until the ninth month of trial work. After the month trial work period, there is a consecutive thirty-six month extended period of eligibility (EPE). When a beneficiary’s gross earnings are more than $1,000 (in 2010) during the thirty-six month period Social Security presumes the recipient is performing “substantial gainful activity” or SGA and benefits for that month cease. During these thirty-six months, the recipient is entitled to benefits if his/her work activity is below SGA However, if the recipient continues to earn above the SGA level after the thirty-six month period, Social Security benefits stop.

Even if gross earnings are more than $1,000 a month, sometimes other factors such as extra help in doing the work or participation in a supported work program (“subsidy”), medical care you pay for yourself or the part of

the payment you make to a Board & Care which counts as care and supervision (IRWE) indicate that work is not SGA. Disability and work issues are particularly complicated for persons receiving Title II Disability benefits. If possible, persons who want to try working should consult with an advocate first.

WIPA (Work Incentives Planning and Assistance) projects are community-based organizations that receive grants from SSA to provide all Social Security and SSI disability beneficiaries (including transition-to-work aged youth) with free access to work incentives planning and assistance. Each WIPA project has counselors called Community Work Incentives Coordinators (CWIC) who can provide work incentives planning and assistance to beneficiaries with disabilities. If you want to locate the WIPA organization nearest you call 1-866-968-7842 or 1-866-833-2967 (TTY/TDD) for the hearing impaired.

11. Overpayments

a. Appeal whether an overpayment exists

When the recipient gets the overpayment notice the first question is whether there really was an overpayment. If the amount of, period of, or any factual information in the notice of overpayment is not correct, request an appeal within 10 days. In some cases, benefits will continue during the appeal. *See, "Appeals."* If the recipient cannot tell from the notice, then a reconsideration by "informal conference" should be requested so that the recipient can find out the reason for the overpayment.

b. Waiver of the Overpayment

Even if the recipient agrees the overpayment is correct but does not believe he or she was at fault, then the recipient should request that SSA waive the overpayment.

Waiver Standard

In order for a waiver to be granted, two things have to be true: (1) that the recipient was without fault in causing the overpayment *AND (2)* that the recovery of the overpayment would defeat the purpose of the Social Security Act by depriving the recipient of income and resources needed for

"ordinary and necessary living expenses" *or* that the overpayment would be "against equity and good conscience." 42. USC 404 (b); 20 CFR 404.509.

In determining "fault," SSA will evaluate whether the recipient:

- Failed to furnish information which he or she knew or should have known was material; or
- Made an incorrect statement which he or she knew or should have known was incorrect; or
- Did not return a payment which he or she knew or could have been expected to know was incorrect. 20 C.F.R. §404.507

If the overpayment is because of income or changed living situation, Social Security looks primarily at whether or not the recipient told Social Security about the income or changed living situation. Social Security is required to take into consideration disability limitations when determining whether or not someone was at fault for purposes of a waiver.

To determine whether recovery of the overpayment "defeats the purpose of the Social Security Act":

SSA will look at the financial information the recipient provides as part of their waiver application to make this determination. The recipient must demonstrate that they need all or most of their income to meet their ordinary and necessary living expenses.

Even if Social Security finds that the recipient was not at fault, the request for a waiver will be denied if there is not convincing evidence of hardship from repayment

To determine whether the overpayment would be "against equity and good conscience":

There is a court decision that states that in determining equity and good conscience the decision must take into account "all of the facts and circumstances of the case and be based on a broad concept of fairness." *Quinlivan v. Sullivan*, 916 F.2d 524.

PRACTICE TIP: When there is an overpayment and the person is receiving SSI or both SSI and a Title II disability benefit, the amount of recovery is limited to 10% unless there is fraud. Although this protection does not apply to persons who receive only Title II disability benefits, as a practical matter, Social Security will often arrange a monthly payment schedule. The recipient often needs assistance in filling out the waiver form and/or in explaining how the disability limitations interfered with the recipient's ability to understand or act with respect to reporting requirements. When the recipient did not report, or did not keep records of reporting, the advocate can provide or secure help for the recipient to put reporting and record keeping systems in place. Every SSI recipient should have a notebook and three-hole punch so that everything received and a copy of everything sent is put in the notebook and so that every contact and communication is written down.

c. Representative Payees and Overpayments

When there is an overpayment and a representative payee, in most cases the recipient should be found not at fault for the overpayment. The recipient has a right to ask for a waiver separate from any right that the representative payee may have.

12. Lost Checks, Immediate Payment Procedure and Emergency Advance Payments

SSI or Title II benefits applicants who appear eligible for these benefits and who are having a financial emergency can get an emergency advance payment of up to a month's benefits. SSA POMS SI 02004.005, DI 11055.245. The applicant must be presumptively eligible based on age or disability (Social Security has a list of presumptively eligible disabilities such as AIDS, total blindness, etc.); or SSI eligibility must be proven but Social Security has not finished the paperwork for benefits to start. The financial emergency must pose an immediate threat to health or safety, such as lack of food, clothing, shelter or medical care. The Social Security office can issue a check on the spot, with no computer or mail delays.

For clients whose SSI or Title II have already been approved and who face a financial emergency, Social Security can request expedited check issuance, where the Treasury Department mails the check to the client. If

the emergency is such that the client cannot wait for a check in the mail, the Social Security office can issue an SSI Immediate Payment of up to $999 on the spot. POMS SI 02004.100 and POMS RS 02801.010.

If a Social Security check is late or lost, the client may immediately report the check missing. Social Security then has up to 10 days to issue a replacement check to be issued. POMS SI 02004.100B.4.

13. Appeals

a. Steps in the Appeal Process

The steps in the Social Security appeal process are: (1) reconsideration, (2) appeal to an administrative law judge (ALJ) hearing, (3) appeal to the Appeals Council (4) appeal to federal court.

Reconsideration

The time period for filing an appeal (request for reconsideration or request for hearing) is 60 days from receipt date of the decision. Social Security presumes the notice was received by the fifth day after the date on the notice. How you can present your case depends upon the issue involved and whether you are asking SSA to reconsider a determination on an application or a determination on a suspension, reduction or termination of benefits.

New Application

If you have been receiving SSI or SSDI benefits because you are blind or disabled and you request reconsideration of an initial or revised determination that, based on medical factors, you are not now blind or disabled, SSA will give you an opportunity for a disability hearing. Your disability hearing will be conducted by a disability hearing officer who was not involved in making the determination you are appealing. The disability hearing will enable you to introduce evidence and present your views to a disability hearing officer

Suspension, Reduction, Termination of Benefits

Due to Non-Medical Reason

Recipients who are getting SSI can request reconsideration by case review (someone else in the office will review the papers in the file and anything you submit), informal conference (allows you the opportunity to present witnesses), or formal conference (like an informal conference but with the ability to have a subpoena issued to compel the presence of a person or papers that may be needed for a fair decision). If you leave the form blank as to which kind of reconsideration you want, Social Security will only give you case review.

For SSDI beneficiaries, only the case review procedure is available for appeals regarding non-medical issues.

b. Continuation Benefits during an Appeal

When appealing a notice saying you no longer disabled so that the termination is on medical grounds, full benefits will continue through the ALJ hearing if you appeal within 10 days of receiving the initial or reconsideration notice and you ask that benefits continue. Ask to fill out the Benefit Continuation Election Statement. If you later lose but you were appealing in good faith, any overpayment can be waived. For other issues, continuation of benefits is only available to persons who receive SSI or SSI and Title II benefits and only to the first reconsideration step in the appeal process. The request for reconsideration with the request that benefits continue needs to be made within ten days of receiving the notice.

People who receive only Social Security Title II benefits are not entitled to continuation of benefits when they ask for a reconsideration involving a nonmedical issue.

14. Complaints about Administrative Problems with Social Security Offices

Sometimes there are problems with how the local Social Security field office handles a client’s case, apart from questions which can be handled on appeal such as whether the client is disabled or whether there is an overpayment. Some examples are if the client is treated rudely; the client files an appeal but never gets an answer or a hearing and benefits are cut anyway; the Social Security worker refuses to accept an application or an appeal request; the client is refused an accommodation for her disability; a check is missing or lost and Social Security refuses to help; or Social

Security refuses to respond when the client reports problems with a representative payee.

When a client has problems with how Social Security administers benefits, write a letter of complaint to the “Field Office Manager” of the local Social Security office, explaining the problem and asking for an investigation. You should also send a copy of your complaint to the Public Affairs Unit, Social Security Administration, San Francisco Regional Office, P.O. Box 4201, Richmond CA 94904. Phone: (510) 970-0000; Fax: (510) 970-8216.

This same office also houses the "Critical Congressional Unit," which handles inquiries from Congressional staff regarding constituent complaints. In an urgent situation, such as a client being cut off benefits with no notice, they will respond to requests from an advocate (but not from a client).

Contacting Your Congressional Representative

If you have been unsuccessful with getting your issue resolved with SSA, you can contact your congressional representative. Representatives are able to help constituents with problems they are having with federal agencies. Most representatives will have you complete a “case work authorization form” which is usually located on the representative’s website. This form serves two purposes. First, it is a written consent that allows SSA to disclose information to your representative. Second, it serves to explain to your representative the assistance you seek from them. You can locate your local representative at: http://www.house.gov/zip/ZIP2Rep.html

Section 504 Complaints

Federal agencies including Social Security are subject to section 504 of the Rehabilitation Act, 29 U.S.C. § 794. Section 504 says that the Social Security Administration cannot discriminate against people because of their disabilities. Section 504 requires the Social Security Administration to make reasonable accommodations to the disability needs of people applying for benefits and people receiving benefits. If you believe you have been treated unfairly by SSA because of your disability, you have a right to file a Section 504 Civil Rights complaint. Unfair treatment may include a failure to give you the extra help you need because of your disability.

Mail your Section 504 complaint to Social Security Administration, Civil Rights Complaint Adjudication Office, P.O. Box 17788, Baltimore, MD

21235-7788. Keep a copy of your Complaint and write on your copy the date you put it in the mail. You should follow up if you do not get something in the mail from Social Security within four to six weeks. The telephone number for the office handling the Section 504 complaint is (866) 574-0374. Explain that you filed a Section 504 civil rights complaint against Social Security so you are directed to the right person.

B. MEDI-CAL

1. Eligibility is Linked to SSI

The Medicaid program, known in California as Medi-Cal, pays for medical care for low income people. People who are on SSI are automatically eligible for Medi-Cal without a separate Medi-Cal application.

When a beneficiary's circumstances change in a way that affects Medi-Cal eligibility, like losing SSI, Medi-Cal does not automatically terminate. Medi-Cal continues while the county looks for ***any possible way*** that a beneficiary could continue to get Medi-Cal. This should make it very difficult to lose Medi-Cal. The new process was designed to prevent unnecessary terminations (and re-applications). If your county is doing it right, this "seamless" process allows people to move freely from program to program without unnecessary breaks in coverage.

> **PRACTICE TIP:** It is easier and faster to get Medi-Cal based on disability than to get SSI. Apply first for Medi-Cal and then, once the Medi-Cal is in place, apply for SSI at the Social Security office. If the applicant is denied SSI, Medi-Cal will continue as long as one keeps appealing. If SSI is denied first, this denial will also control the Medi-Cal application, which will be denied.

2. Medi-Cal with a Monthly Share of Cost

People who do not get SSI can still get Medi-Cal. To get Medi-Cal alone, apply at the county welfare office. Medi-Cal must approve or deny the application within 45 days. When a disability determination must be made the county has a longer period of time, 90 days.

Even if an individual's income is too high to get SSI, you can still get Medi-Cal if:

- You meet the Medi-Cal resource limits ($2000 for an individual, $3000 for a two person family, higher amounts for larger family sizes);
- You are over age 65, blind *or* have a disability that meets the SSA standards; *and*
- You are a resident of California and either a U.S. citizen or a "qualified" immigrant, such as a legal permanent resident.

The county should assess whether an applicant meets the criteria for any free or no share of cost Medi-Cal program first. There are several Medi-Cal programs that do not require the beneficiary to pay a monthly share of cost or premium. A helpful website that describes the different Medi-Cal programs can be found on the Health Consumer Alliance website: http://healthconsumer.org/Medi-CalOverview2008Ch7.pdf

If a person's income is above the Medi-Cal standard ($600 for one person, $750 for two, $934 for three people or a couple, higher levels for larger families), he/she can get Medi-Cal with a monthly "share of cost." The share of cost is the difference between the person's countable income and the applicable Medi-Cal Maintenance Need Level. Once the Medi-Cal recipient gets medical bills equal to the amount of his/her monthly share of cost, Medi-Cal will pay the rest of his/her medical bills for the month. A Medi-Cal recipient can also meet his/her share of cost for months into the future with old, unpaid medical bills.

3. Medicare and Medi-Cal

People who get Medicare benefits because they get Title II benefits but not SSI can also apply for Medi-Cal. Medi-Cal covers some services which Medicare does not cover.

4. Medi-Cal Covered Services

Medi-Cal pays for a wide range of medically necessary services. Mental health services are covered through the county Medi-Cal Mental Health managed care plan. Other covered services include doctor's visits, hospitalization, prescription drugs, x-ray and laboratory services, durable

medical equipment, and home health care including nursing care. After a provider submits a Treatment Authorization Request to cover needed services, Medi-Cal has 30 days to approve, deny or send the request back for more information. If Medi-Cal does not act within 30 days, the request is deemed to be approved automatically.

5. Medi-Cal Appeals

If Medi-Cal denies an eligibility application or a request for services, the county or the Medi-Cal agency must provide a written notice of action to the recipient explaining the reason for the denial. The notice must also explain how to appeal by requesting a Medi-Cal fair hearing. Even if there was no notice of action, for example when there is a delay in getting needed services, a client can appeal by calling or writing the Medi-Cal fair hearing office.

> **PRACTICE TIP:** Medi-Cal appeals are heard by Administrative Law Judges from the State Hearings Division, California Department of Social Services, 744 P Street, Sacramento CA 95814.

Toll-free Appeal Line: (800) 743-8525
Fax: (916) 229-4110
Office of Chief ALJ: (916) 657-3550

Los Angeles Regional Office:
(213) 833-2200
Toll Free: (866) 708-0792
Fax: (213) 833-2231

Northern Coastal Office:
(510) 622-4000
Toll Free: (866) 525-2211
Fax: (510) 622-4004

San Diego Regional Office:
(760) 510-4999
Toll Free: (866) 388-4427
Fax: (760) 510-4998

Northern Valley Office :
(916) 229-4187
Toll Free: (866) 538-2431
Fax: (916)229-4158

C. MEDI-CAL FOR CHILDREN AND THE EPSDT PROGRAM

1. Broader Medi-Cal Eligibility for Children

Children with disabilities whose parent's income is high may still qualify for Medi-Cal with a share of cost. Even if the share of cost is several thousand dollars per month, Medi-Cal can help by covering the rest of any hospital charges, etc. for the month.

Some other special Medi-Cal eligibility rules:

(a) In calculating share of cost, the income of a step-parent is not counted; only the child's income and the income of a parent with whom the child is living is counted.
(b) Children placed out of home through the Dependency court are automatically Medi-Cal eligible.
(c) Children with Adoption Assistance funding are Medi-Cal eligible.

In addition, children can qualify for Medi-Cal with *no* share of cost and without regard to their parents' assets and resources through the "Percent of Poverty" programs. This is important because family savings sometimes appear to make the child ineligible for Medi-Cal. These special programs are: *100% of Poverty:* Children age 6 but less 19 years of age are eligible if family income is less than 100% of the federal poverty guidelines ($1838) per month for a family of four in 2010); *133% of Poverty*: Children from age 1 to 6 are eligible if family income is 133% of poverty ($2444) for a family of four in 2010); *200% of Poverty*: Pregnant women and infants up to age one are eligible with family income up to 200% of poverty ($3675 per month for four in 2010). Income is counted after the $90 deduction for earned income and child care costs. Children may also qualify for the Healthy Families program (see next section).

2. Healthy Families

Healthy Families is an insurance program for children who are ineligible for Medi-Cal or eligible only for Medi-Cal with a share of cost. The child must have no health insurance and may not be covered by any other employer based insurance plan. Family income (after allowable deductions when there is earned income) may not be more than 250% of the federal poverty level. Call 800-880-5305 about where to apply. Children in Healthy Families will then be covered by a participating managed care plan (not Medi-Cal).

Mental health services under a Healthy Families plan are identical to those in the CalPERS program. This includes up to 30 days inpatient services or, as a substitute for each day of hospitalization two days of residential treatment, three days of day care treatment, or four outpatient visits. In addition, short-term mental health intervention is covered up to 20 visits a year.

There is also a SED benefit under Healthy Families. DMH Information Notice No. 98-14, September 1, 1998. Children determined to be seriously emotionally disturbed (SED) or to have a serious mental disorder as defined in Welfare & Institutions Code § 5600.3 are eligible for the mental health services available from the county Mental Health Plan (MHP). The services available are the full range of Medi-Cal Rehabilitation Option and Targeted case management services; to the extent resources are available. The county MHP is responsible for the costs of inpatient hospitalization after the annual 30 day benefit through the health plan is exhausted, and for all medically necessary services, medication and laboratory services provided on an outpatient basis for the SED condition. Any provider enrolled to provide services through the county MHP will be enrolled for the SED benefit under Healthy Families.

3. Continued Medi-Cal for Children With Disabilities.

Children who were terminated from SSI under the new stricter disability standards are entitled to Medi-Cal if they would be eligible for SSI but for the change in definition; they also are entitled to continue Medi-Cal while appealing. This is true even if their SSI benefits are not continuing through the appeal. The Medi-Cal continues not just to the Social Security ALJ hearing but also through the request for review by the Appeals Council. If children lose the ALJ hearing, it is important that they appeal to the Appeals Council if they believe they are still disabled and need Medi-Cal.

4. EPSDT Mental Health Services

Children under the age of 21 who are eligible for Medi-Cal are entitled to extra services, including intensive home and community-based mental health services, through a special program known as EPSDT, which stands for “Early and Periodic Screening, Diagnosis, and Treatment.” 42 U.S.C. § 1396a (a)(10)((A); 42 U.S.C. § 1396d(a)(4)(B). Under the EPSDT program, the state must provide diagnostic and treatment services "to correct or ameliorate defects and physical and mental illnesses and

conditions covered by the screening service, whether or not such services are covered under the State plan." 42 U.S.C. § 1396d(r)(5). This is an easier standard of medical necessity than regular Medi-Cal: children can get services to maintain functioning, even if their condition will not necessarily improve.

Children are entitled to receive the EPSDT services they need even if the services would not be available to them if they were adults. These are known as "supplemental" EPSDT services. The EPSDT program can cover individual or family therapy more frequently that Medi-Cal would otherwise authorize. EPSDT can also cover extensive behavior management and crisis intervention services in the home, in group homes or in residential placements for children with mental disabilities. These services may include one-on-one or even two-on-one behavior aides and other in-home behavior management programs, family counseling, in-home therapy, therapeutic staff support and behavioral intervention or life skill training. The cost of EPSDT services in the home or community must be no more than the cost of institutional placement.

The provider should request authorization to provide EPSDT supplemental mental health services from the county managed care Mental Health Plan. Authorization for other non-mental health supplemental EPSDT services should be requested from the state Department of Health Services, or if the child is enrolled in Medi-Cal managed care plan for physical health services, from the managed care plan. If the request for authorization is denied, the family can appeal through the regular Medi-cal appeal process. (See Section B.5 above.)

5. EPSDT Case management

Under EPSDT, children can qualify for intensive case management similar to Targeted Case Management for adults. Children and their families can request case management to assist with a request for supplemental EPSDT mental health services identify a provider, develop a treatment plan, etc. A provider or family can also request EPSDT mental health services directly from the county.

6. EPSDT Behavior Intervention Aides

Therapeutic Behavioral Services (TBS) are one-to-one behavioral intervention services for children with intensive mental health needs. TBS

has been provided as a supplemental specialty mental health service under EPSDT since 1998 as a result of a federal lawsuit, Emily Q. V. Belshe, No. 98-4181 WDK(AIJX), (U.S.D.C, C.D. Cal.). The lawsuit was brought against the State Department of Health Care Services (DHCS) on behalf of a class of children who were in or at risk of high level residential placement as a result of behaviors related to their mental health needs.

TBS is an outpatient treatment intervention for EPSDT beneficiaries under age 21 with serious emotional disturbance who need individualized behavioral intervention services on a short-term basis to accomplish behavioral outcomes written into a treatment plan. A significant component of TBS is having a TBS aide or coach on-site, wherever the child is, for specific periods of time to redirect the child or to provide other interventions as individually determined in the treatment plan.

Children/youth meet the class definition for TBS eligibility established under the Emily Q lawsuit if the child/youth is placed in a high level group home (RCL 12-14) providing mental health treatment or a locked mental health treatment facility, or if placement in a group home providing intensive mental health treatment or a locked mental health treatment facility is being considered as one possible option for the child/youth; or if he or she has had at least one psychiatric hospitalization within the past 24 months. Such children/youth are eligible for TBS if a mental health provider finds in his or her clinical judgment that is highly likely that, without the additional short-term support of TBS, the child/youth would either need placement in a group home providing intensive mental health treatment services or a locked facility for the treatment of mental health needs, or will need acute psychiatric hospital inpatient services, psychiatric health facility services, or crisis residential treatment services; or (2) the child/youth needs the additional support of TBS to enable him or her to transition from any of those levels to a lower level of residential case.

The child/youth must be receiving at least one other mental health service to be eligible for TBS, but they do not have to receiving “wraparound” services to receive TBS.TBS services, however, are generally most effective when provided as part of an intensive, coordinated “wrap-around” plan for children who would otherwise be placed in high level group homes (RCL 12 to 14) or in an acute psychiatric unit or state hospital.

Through EPSDT, the state and the county must cover TBS, and other mental health services for children when they are medically necessary,

including case management to help families find providers and submit requests, and intensive, coordinated case planning. The state and county must provide EPSDT services to all children who need them promptly and without waiting lists.

D. IN-HOME SUPPORTIVE SERVICES/PERSONAL CARE SERVICES

1. The Three IHSS Programs

There are now *three* IHSS programs: (1) The original residual program (IHSS-R) (very few people remaining under this program); (2) The Self-Directed Personal Assistance Program (IHSS Plus); and (3) Medi-Cal Personal Care Services Program (PCSP). When people say "IHSS" they usually are referring to all three programs. Most people's services are covered by the Medi-Cal PCSP where the federal government pays for about half the cost of services under regular Medicaid program rules– just as the federal government pays for about half the cost of other Medi-Cal services. If the services are being provided by the spouse or the parent of a minor, or if there is advance pay or a restaurant meal allowance, *and* the recipient is an unrestricted Medi-Cal beneficiary, then the services are covered under the IHSS Plus program because of federal Medicaid rules. Persons not eligible for unrestricted Medi-Cal must receive their IHSS services under the IHSS-R Program.

2. What Services Can an IHSS Worker Provide?

The IHSS program authorizes services needed to assist persons to remain safely in their own homes. "Own home" includes a residential hotel but not a Board & Care facility. IHSS provides payment for a home care worker to come in to help with chores and personal care. The services covered include domestic services (cleaning, taking out trash, etc.), related services (meal preparation, meal planning and cleanup, laundry including ironing and putting away items, and shopping and other errands), personal care services (assistance with dressing, grooming, bathing, toileting, getting in and out of bed), accompaniment to the doctor or alternative sources of services such as a day program, and paramedical services (i.e., insulin injections). Recipients are authorized for the number of hours per week or per month that are needed to complete the tasks that they require to live safely at home.

3. Who Can Be Your IHSS Worker?

In most counties services are delivered through Individual Providers which means the recipient decides who to hire. The county IHSS worker can provide the telephone numbers of agencies that maintain lists of interested workers or the recipient can call the nearest independent living center. In some counties the workers are provided through agencies.

4. Applying for IHSS

The application process is started by calling the county welfare department. The welfare department will send someone out to evaluate the applicant to determine the services and number of hours to be authorized. You have a right to be assessed *before* you move into your own home so that there will be no gap in services. DSS regulation 30-755.12. That means you can be assessed in an IMD, a skilled nursing facility or Board & Care and do not have to wait until you are actually in your own home when you apply.

Most of the county IHSS worker's experience is with seniors and persons with physical disabilities. Often, county IHSS staff are not used to applications from people with psychiatric disabilities. An advocate can help in securing the medical or treatment justification for IHSS/PCS services to help the county worker understand why services are needed. The in-home visit by the county worker can be frightening to some people. The advocate could also help by getting someone to be with the applicant at the time of the home visit to help explain why services are needed.

5. Prompts

In determining the number of IHSS hours it will authorize, the county adds together the time it takes to do each task for which help is needed. Remember that the IHSS program covers assistance needed in the form of prompt reminders. For instance, an applicant with a psychiatric disability and medication side effects may need someone to come into the home in the morning to get the applicant up and to prompt the person through the sequence of tasks related to bathing, grooming, and dressing. IHSS can cover that assistance.

6. Protective Supervision

In addition to covering specific tasks, the IHSS program also covers "protective supervision" for persons who need that service to monitor behavior related to a mental impairment including mental illness and to intervene to prevent injury to the IHSS recipient. While other services are approved on a task basis, protective supervision approved for a block of time to cover the time in between specific tasks.

In most cases the maximum hours that can be authorized for specific tasks and protective supervision together is 195 hours a month. In some cases where the time for meal preparation, personal care and paramedical services equal 20 or more hours per week, the maximum time can be 283 hours a month. Counties do not like approving protective supervision so that when this service is needed, extra time should be spent documenting why protective supervision is needed — i.e., how the person injured himself in the absence of someone monitoring behaviors, how the person would have injured himself in the absence of someone intervening.

7. Financial Eligibility for IHSS

You meet the financial eligibility requirements for IHSS if you are on Medi-Cal.

8. IHSS Appeals

The applicant or recipient has appeal rights like those under Medi-Cal. See page 15, "Medi-Cal Appeals". If there is a notice reducing or terminating benefits, there are timelines for appealing in order for benefit to continue until the fair hearing decision. **You must appeal your IHSS notice of action prior to the date the change is supposed to take effect to get Aid Paid Pending.** [MPP § 22-072.5] **Aid Paid Pending means that your services will continue at least until a hearing.**

E. GENERAL ASSISTANCE AND FOOD STAMPS

Some clients with disabilities do not get Social Security benefits, even though they have little or no income, because (a) they are waiting as much as a year or more for their application to be approved, or (b) SSA does not consider them to be disabled. These clients should apply for General Assistance (also known as general relief) and Food Stamps, since these do not require a finding of disability. (In 2008, the federal government changed the name of the food stamp program to State Nutritional Assistance

Program or SNAP. California currently refers to their program as “Cal-Fresh”.) Clients may apply at their county welfare office. The Food Stamp application can be found on line at on the California webpage: www.dss.cahwnet.gov/foodstamps; applications are generally processed within 45 days. General Assistance benefits vary from county to county but are consistently low, averaging from $200 to $250 per month for a single person. State law permits counties to limit general assistance to three months per year. Food Stamp benefits may average from $150 to $250 per year, depending on other income and family size.

F. CalWORKs

Adults and children who do not get Social Security benefits may qualify for CalWORKs benefits if there is a child in the family who is “deprived of parental support” because one parent is absent, disabled or unemployed. Again, benefit levels are far lower than SSI, with a maximum grant of only $668for a family of four. Parents are also subject to rigorous work requirements, although there are exemptions for people with disabilities and caregivers of children with disabilities. A parent can satisfy the work requirements by becoming an IHSS provider for his or her child with a disability.

Families can combine SSI and CalWORKs. For example, a parent who receives SSI for herself can get a CalWORKs benefits for the support of her child; her SSI income will not be counted in calculating the CalWORKs grant. Similarly, the single parent of a child on SSI can get CalWORKs benefits for herself as a needy caretaker without regard to the SSI income.