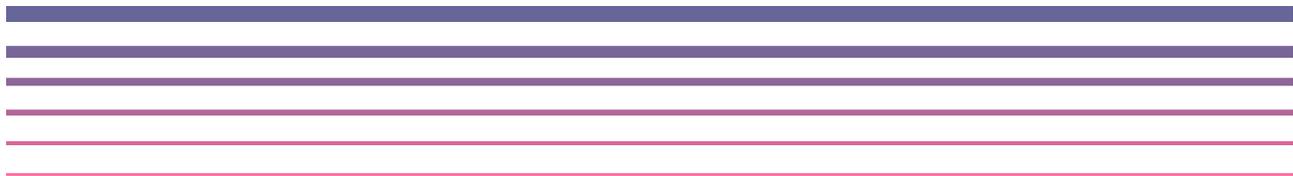


Replicable Best Practices for Accessing Mainstream Resources: A Guide for Continuums of Care



The Technical Assistance
Collaborative Inc.

Policy Research
Associates, Inc.

The Corporation for
Supportive Housing

Fall 2006

A series of two horizontal lines, one purple and one pink, stacked vertically, serving as a decorative element at the bottom right of the page.

Table of Contents

INTRODUCTION	3
What Is the Purpose of This Guide?	3
What Is in This Guide?.....	3
Who Should Read This Guide?.....	3
MEDICAID	4
Need for Medicaid	4
Access to Medicaid	4
Challenges	4
Recommended Best Practices for CoCs	6
First Steps for Action.....	10
TEMPORARY ASSISTANCE TO NEEDY FAMILIES	11
Need for TANF	11
Access to TANF	11
Challenges	12
Recommended Best Practices for CoCs	14
First Steps for Action.....	18
SOCIAL SECURITY DISABILITY PROGRAMS	19
Need for SSA Disability Benefits	19
Access to SSA Disability Benefits.....	19
Challenges	20
Recommended Best Practices for CoCs	21
First Steps for Action.....	27
FOOD STAMPS	28
Need for Food Stamps	28
Access to Food Stamps	28
Challenges	28
Recommended Best Practices for CoCs	30
First Steps for Action.....	32
APPENDICES	34

INTRODUCTION

What Is the Purpose of This Guide?

This guide is a tool for helping Continuums of Care (CoCs) discover new practices for improving access to four mainstream resources for people who are homeless: Medicaid, Temporary Aid to Needy Families (TANF), Social Security disability programs and Food Stamps. Featured in this guide are replicable best practices from around the United States. The intent is to share strategies that CoCs can consider implementing to increase access to mainstream resources.

What Is in This Guide?

For each mainstream resource profiled, this guide describes:

1. Challenges

Various challenges interfere with the ability of people who are homeless to access each of the four profiled mainstream resources and to maintain their enrollment. Recognizing these challenges is an essential first step to take before considering any of the practices presented in this guide.

2. Best Practices

There are two kinds of best practices that CoCs can adopt or promote in an effort to improve access to mainstream resources.

- Systems Level Best Practices are innovations that a CoC and its grantees can recommend to state or local government agencies responsible for administering the mainstream resource. The CoC can sensitize representatives of the mainstream resources to the needs of homeless applicants and strategize with them about ways to address these needs.
- Program Level Best Practices are innovations that can be implemented by CoCs through education, planning, and encouraging adoption by CoC grantees.

Who Should Read This Guide?

This guide is written with the needs of CoCs and their grantees in mind. While other reports have been written about the homeless population's lack of access to mainstream resources, this guide focuses on steps that CoCs can take to address this. All best practices in this guide are presented in terms that are easily understood by readers who are not experts in public policy related to mainstream resources. Recommended readers of this guide include:

- CoC coordinators;
- CoC grantees;
- Other homeless service network providers;
- Supportive housing providers serving formerly homeless people; and
- Local government representatives engaged with CoCs.

MEDICAID

Need for Medicaid

Medicaid is a means-tested, federal-state entitlement program that covers basic health and long-term care for certain categories of low-income Americans. Medicaid is available to individuals and families who can demonstrate need as established through income and asset standards. Recipients must be children, parents of dependent children (or pregnant), blind, disabled, or age 65 or older. The online resource First Step provides detailed information on how to assist people who are homeless to access Medicaid.¹

For homeless people served by local CoCs, Medicaid is a vital resource that can transform lives by paying for and providing services that treat underlying causes of homelessness. It also improves access to the kinds of secondary care that people experiencing homelessness need. By helping people manage disabling conditions that often prolong their time in shelters and on the street, Medicaid is can be key to ending homelessness for families and individuals with disabilities. Moreover, in some states Medicaid can be used to finance some of the support services needed to maintain people in housing. In these states, Medicaid is a key resource for financing “housing first” and other permanent supportive housing models.

Access to Medicaid

Despite its importance, CoCs nationwide report limited access to Medicaid by people who are homeless. Of the people who are homeless and presumed eligible for Medicaid, an estimated 50 percent are not receiving it.² Thus, CoCs that want to improve access to Medicaid are encouraged to considering implementing some of the best practices in this section.

Challenges

To choose among the recommended best practices for improving Medicaid access, CoCs must first understand the challenges that people who are homeless typically encounter. Given the variation in Medicaid programs from state to state, challenges for homeless people fall into two general categories: those common to all states and those common to states with 1115 Medicaid Waivers.³

¹ First Step is online at <http://www.cms.hhs.gov/apps/firststep/index.html>

² Post, P. (2001) *Casualties of Complexity: Why Eligible Homeless People Are Not Enrolled in Medicaid*. Nashville, TN: National Health Care for the Homeless, p. 22.

³ 1115 Waivers are modifications made to eligibility and benefits for an individual state that are requested by that state and approved by the federal government. In some states, 1115 Waivers have the effect of increasing the likelihood that some people who are homeless qualify for Medicaid.

In All States:

1. The Medicaid eligibility process is typically prolonged and multi-step. It is linked in most states with applying for Supplemental Security Income (SSI), a process with which many people who are homeless experience difficulty.
2. The Medicaid application process for people who are homeless is often disrupted when symptoms of mental illness and substance abuse create chaos and upheaval in their lives.
3. A homeless person's lack of permanent address and phone number leads to disruptions in communications about pending Medicaid applications as well as inadvertent disenrollment from Medicaid when homeless people fail to respond to documents related to redeterminations.
4. Changes in Medicaid eligibility requirements, application procedures, and benefits confuse people who are homeless and the service providers attempting to help them access this resource.
5. People who are homeless with untreated or symptomatic mental illness are, at times, intimidated by Medicaid's requirements that they share extensive personal information and history as part of the application process. Without accommodation, such fear can disrupt applications.
6. Homeless families are vulnerable to derailment of the Medicaid eligibility process when seeking TANF and Medicaid together. TANF agencies at times divert heads-of-household towards satisfying that program's work requirements. As a consequence, linked Medicaid applications go uncompleted.
7. Homeless people on Medicaid who are incarcerated commonly face obstacles to re-enrollment upon reentry to the community. Such individuals often arrive back in homeless service systems without this essential resource.
8. Federal Medicaid rules limit categorical eligibility for people who have substance use disorders or nonsymptomatic HIV. While these conditions are common among homeless populations, they do not qualify as disabilities under Medicaid.
9. There is a misconception among homeless service providers that categorical eligibility for Medicaid is more difficult to obtain for persons without easily recognizable disabilities. Consequently, many people who are homeless and who have co-occurring mental and substance use disorders are not referred to Medicaid. However, mental illness that prevents a person from performing substantial gainful activity may, in fact, qualify as a disability under Medicaid.
10. There is a general deficit among homeless service providers in the technical knowledge and clinical skill needed to recognize subtle and underlying conditions that would qualify homeless persons for Medicaid.

*In 1115 Waiver States:*⁴

1. States with 1115 Waivers typically have more inclusive state-tailored Medicaid eligibility definitions than non-Waiver states that follow federal definitions. However, at least one Waiver state has moved to curtail Waiver program eligibility and benefits. Where such changes have occurred, much of the benefit the Waiver once provided to homeless people is lost.
2. CoCs and grantees are not always well informed about their state's Medicaid Waiver program, its rules, and how to go about linking homeless people with this resource.

Recommended Best Practices for CoCs

Presented here are two kinds of best practices that CoCs may adopt for improving access to Medicaid for individuals and families experiencing homelessness: Systems Level Best Practices and Program Level Best Practices.

Systems Level Best Practices

Systems Level Best Practices are innovations that can be recommended and strongly encouraged by CoCs but are ultimately at the discretion of the state and local government agency that administers the Medicaid program. Included in the Programmatic Best Practices are suggestions for how CoCs can establish working relationships with agency representatives and educate them about the need for the Systems Level Best Practices described here.

1. Adapt Procedures for Homeless People

State Medicaid offices can implement relatively simple procedures for applicants who are identified as homeless with far reaching improvements in access. For one, the application can include a designation of "homeless." This designation may then be used to gather data on the program's success with homeless people with respect to completed applications and services rendered. Second, Medicaid agencies can adapt procedures to accommodate applicants with the homeless designation. This may include the use of third-party representatives such as case managers from a homeless shelter to facilitate enrollment and access to services. The state of Connecticut and the cities of Boston and New York are examples of localities that flag the applications of people who are homeless, which allows the Medicaid agency to track its success with this population.

2. Adopt State Waivers

Among the most ambitious and challenging innovations to a Medicaid program is the adoption of an 1115 state Waiver. State Medicaid offices can initiate a Waiver, with the approval of the federal government, to modify aspects of eligibility and benefits associated with the Medicaid program in their individual states. States may use a Waiver to broaden eligibility and include those who are not considered disabled under the federal Medicaid program. This can significantly increase access for the large proportion of homeless people who may otherwise not qualify for Medicaid. Tennessee was among the first states to adopt a

⁴ States with 1115 Waivers include: Arkansas, Delaware, Hawaii, Iowa, Maryland, Massachusetts, Mississippi, Minnesota, Missouri, Montana, New Jersey, New York, Oregon, Rhode Island, Tennessee, Utah, Vermont, Washington D.C., and Wisconsin (Source: State Coverage Initiative, Robert Wood Johnson Foundation, www.statecoverage.net)

Waiver program. Known as TennCare, the program served homeless people well and was recognized as a national model for improving access for many disenfranchised groups including homeless people. Recently, however, the program was curtailed.

3. Allow for Presumptive Eligibility

In states where Supplemental Security Income (SSI) and Medicaid are applied for together, the state can develop a provision whereby an applicant to both programs can receive Medicaid relatively quickly, on a provisional basis, while the SSI application is pending. As the SSI approval process can be prolonged, this provision extends care to needy individuals in a much more timely way and, therefore, averts health crises. People who are homeless benefit from this provision on multiple levels. Not only is their health stabilized but they are immediately eligible for some forms of supportive housing where the services are reimbursed by Medicaid. Michigan and Washington State are examples of localities that use this policy to the advantage of people who are homeless. In Washington, the Medicaid benefit that accompanies presumptive SSI eligibility is used to finance home-based support services for formerly homeless tenants of permanent supportive housing.

4. Suspend Rather than Terminate When Incarcerated

The federal law prohibiting participation of incarcerated individuals in Medicaid disrupts care and medication regimens for released inmates with disabilities many of whom are homeless. While there is no federal mandate to terminate benefits upon incarceration, most localities terminate Medicaid because they have no mechanism to suspend benefits. To receive Medicaid after release, individuals often must go through a reapplication process which can delay access for months. However, some localities are beginning to implement strategies to temporarily suspend but not terminate Medicaid during incarceration. Other states and localities are working to ensure that people, who are new to Medicaid or who have been terminated, have coverage upon release. Lane County, Oregon developed an initiative that allows individuals, upon release, to resume Medicaid coverage as if the incarceration had not occurred.⁵ Texas, Minnesota, and Pennsylvania also have programs to improve Medicaid access for released inmates.

5. Initiate Cross-System Efforts

CoCs can initiate cross-system efforts between Medicaid, housing, homeless service providers, and other stakeholder agencies to cultivate a culture of cooperation among these groups with the goal of increasing access to Medicaid for people who are homeless. Such efforts can take many forms, including meetings, designation of liaisons, task forces, and policy mandates. Among the results is that local Medicaid agents and representatives of other mainstream resources assume greater responsibility for making their agency accessible to people who are homeless. Michigan stands out as having considerable cross-system exchange of ideas and common goals related to the needs of people who are homeless. While much of this exchange is led by state officials in Michigan, CoCs can play leadership roles as initiators of such activity.

6. Outstation Eligibility Activities at Health Centers

Federal law requires that states allow poverty-level pregnant women and children to apply for Medicaid at locations other than the state's TANF agency. Acceptable locations include

⁵ Griffin, P. et al (2002) Maintaining Medicaid Benefits for Jail Detainees with Co-Occurring Mental Health and Substance Abuse Disorders. Delmar, NY: The GAINS Center, Policy Research Associates, p.2.

federal qualified health centers (FQHCs), community-based clinics that provide primary health care to underserved, underinsured and uninsured people. These settings offer a convenient opportunity for people who are homeless to have a first interface with the Medicaid program. However, out stationing of Medicaid enrollment is not universally carried out. Providing state-level support to FQHCs can be an important factor in whether or not health centers engage in these activities. FQHCs in the western states such as California, Oregon, and Washington are active in Medicaid enrollment activities.⁶

7. Set Performance Standards for Managed Care Organizations

Many states operate their Medicaid program and provide services through a collection of contracted managed care organizations. Such organizations provide the actual outreach and care to Medicaid recipients. In contracts with these organizations, states can specify expectations for excellence in outreach and delivery of services to homeless enrollees in particular. Such contracts can explicitly set performance measures that the managed care organizations must attain. Maryland is an example of a state implementing such a policy. It requires certain standards for outreach to homeless people along with other Medicaid subpopulations.

8. Expedite Enrollment for Homeless People

An effective policy showing significant results is one of expediting Medicaid enrollment specifically for homeless people with disabilities. This “fast tracking” has been dovetailed with wider efforts to address the needs of persons with mental illness returning to the community from jail, and increasing access to SSI for people who are homeless. Washington State is among the leaders in such initiatives to prioritize homeless people for mainstream resources given the numerous obstacles impeding them.

9. Simplify Application Procedures

Several best practices can be implemented to simplify the Medicaid application process. These include allowing people who are homeless to practice self-declaration of residency in the absence of support documentation. Allowances for substituting income verification documents with audits of state records and/or state record data matching can also be useful, as can the elimination of requirements for in-person interviews and the use of remote applications. Also constructive is requiring verification of eligibility on an annual, rather than semi-annual, basis. This minimizes the possibility of accidental disenrollment of people who are homeless.

Programmatic Best Practices

This section outlines best practices that CoCs and their grantees themselves can initiate independent of leadership from state Medicaid agencies. These strategies do not rely on change at the policy level but on the resourcefulness and persistence of the CoC.

⁶ Maloy K. and Rosenbaum S. (2006). Medicaid Out Stationing Activities at Federally Qualified Health Centers: A Progress Report, Center for Health Policy Research. Washington, DC: The George Washington University, p. 1.

1. Plan Medicaid/ SSI Access Initiatives

In 33 states, the Social Security Administration (SSA) makes disability determinations, and Medicaid is automatically authorized when a person is approved for SSI. These states are known as 1634 states. For CoCs in these states, the SSA section of this guide suggests multiple replicable programmatic best practices that are not only relevant to SSI access but to Medicaid as well. The strategies suggested in that section should be reviewed by any CoC operating in one of the 1634 states wishing to improve Medicaid access. Appendix A provides a list of these states.

2. Offer Medicaid Access Skills Forum

In states where Medicaid is applied for separately from SSI, CoCs can still do much to increase the technical skill level of case managers and social workers employed by their grantees about Medicaid eligibility and application procedures. One method is for the CoC to sponsor a forum led by experts in the state’s Medicaid program as well as local Medicaid representatives. If the state has a managed care model for its benefits, representatives of these health provider groups also can attend to explain how their services can meet the needs of people who are homeless. Such forums can be offered at regular intervals to all grantees within the CoC. In these sessions, limited understanding of the Medicaid program is assumed. Complementary forums might include education on disabilities and Medicaid eligibility to help grantees improve their skill at making appropriate referrals. A CoC in the region of Macomb County, Michigan sponsors such forums and reports improved skill on the part of CoC grantees.

3. Develop Medicaid Linked Program Models

Recent years have brought advances in linking Medicaid with permanent supportive housing models targeted to formerly homeless people. In some jurisdictions, Medicaid is “braided” with multiple other funding sources to provide “housing first” and rapid re-housing programs. It pays for home-based forms of care needed by persons with disabilities to retain their housing. When CoCs have such programs, the application process for people who are homeless and without Medicaid is expedited. Typically, the housing provider supports the homeless person through the Medicaid application process. Paying for services during the time it takes new residents to receive Medicaid benefits, however, remains a challenge. King County of Washington State is a leader in developing such models and now has several in operation. Private foundation money is used to bridge the gap that precedes qualification for Medicaid. Such projects serve an array of disabled, chronically homeless, and other high need homeless people.

4. Ensure Medicaid Agency Representation at CoC Meetings

Many CoCs in recent years forged working relationships with representatives of local Medicaid agencies and other mainstream resources, by inviting representatives from these agencies to participate in regular CoC quarterly or monthly roundtable meetings. CoC grantees use the opportunity for face-to-face contact to ask direct questions related to the application process and troubleshoot problems encountered in their jurisdiction. Many CoCs, including in Michigan and Maryland, report the benefits of using this method.

5. Develop Cross-System Planning Bodies with Medicaid

CoCs can develop a formal task force or other planning body made up of CoC leaders and representatives from the state Medicaid office, as well as other mainstream resource

agencies. By analyzing the CoC's success rates in accessing Medicaid and other resources and the specific obstacles faced, they can devise innovations to better serve people who are homeless. When threats to progress occur, collective action can be taken by drawing upon each representative's constituency. Kalamazoo, Michigan, created such a Cross-System Group in the form of a subcommittee of their 10 Year Plan to End Homelessness. It has become an effective instrument of change in their community.

6. Sponsor Shelter-based Medicaid Open House

An Open House is an all-day session scheduled at a large shelter, soup kitchen, or other setting where people who are homeless frequent. The CoC invites homeless people in its jurisdiction and representatives of the Medicaid agency, and other mainstream resource organizations if desired, to the Open House. On the day of the event, homeless people visit informal "stations" where they can submit applications and troubleshoot problems that may arise in the eligibility determination process. Some small CoCs in Maryland report that this is effective and can be repeated on a semi-annual basis. It reduces barriers by bringing applicants and agents face to face with one another without the formality of offices, appointments, and other bureaucratic requirements.

First Steps for Action

Given the low participation rate of people who are homeless in Medicaid, CoCs are encouraged to consider implementing some of the new best practices related to Medicaid presented in this guide. Given that Medicaid is automatically awarded to persons eligible for SSI in 33 states, the practices suggested in the SSA disability programs section should be reviewed in conjunction with those described in this section. CoCs with experience in implementing best practices for Medicaid recommend that CoCs new to the process develop a cross-system planning body as a first step in undertaking best practices related to Medicaid. Also recommended as initial steps for CoCs, are ensuring Medicaid representation at CoC meetings, initiating Medicaid Open House sessions for people who are homeless, and recommending to local Medicaid representatives that simplified application procedures and out stationed eligibility workers be considered to accommodate the needs of people who are homeless.

Temporary Assistance to Needy Families

Need for TANF

Temporary Assistance for Needy Families, known as TANF, provides time-limited cash assistance and work opportunities to low-income families with dependent children. The program is designed to be temporary and to help move recipients into work. Basic eligibility varies from state to state, but in general a person who is homeless with little or no monthly income (approximately \$400 or less), no other appreciable assets, and one or more dependent children will be eligible for TANF. For homeless families, TANF is an essential resource for helping to address homelessness. For families that have recently exited homelessness, TANF assists in maintaining stability and preventing future periods of homelessness. TANF is a reliable, if time-limited, source of income typically used to pay for basic necessities such as food, diapers, baby formula, transportation, clothes, and savings towards rent. While insufficient to cover all costs of living, TANF is a “leg up” for homeless families that plays an essential role in helping them achieve and sustain stability.⁷ The online resource First Step provides details on how to assist homeless people to access TANF.⁸

Access to TANF

Helping homeless families access TANF is not, in itself, widely problematic. Many, if not most, homeless families are eligible for TANF and, not surprisingly, they make up a significant portion of most states’ TANF enrollees. Homeless families are, in fact, filling a growing proportion of TANF caseloads nationwide.⁹ When homeless families enter shelters, their enrollment in TANF increases from about 33 percent to between 50 and 75 percent.¹⁰ This rate is relatively high compared with SSI enrollment, but somewhat lower than enrollment in Food Stamps.¹¹ TANF, therefore, seems to be a success story for homeless families, and most local CoCs are effective at linking homeless families with this mainstream resource.

Maintaining homeless families on TANF, however, is a significant challenge for CoCs. The chaotic conditions of homeless families’ lives make them susceptible to sanctions (grant reductions) and disenrollment from TANF. Furthermore, new rules contained in the 2006 reauthorization of TANF heighten this challenge. It is imperative that CoCs understand the circumstances that lead to sanctions and the extent to which their state and region can take steps to mitigate sanctions for homeless families. In addition, state and national policy shifts toward ending homelessness (as opposed to managing it) are encouraging CoCs to move away from traditional service-intense family shelters. Amidst this change, CoCs must protect against eliminating aspects of their service models that can help families maintain access to TANF.

⁷ Reeg, B. Grisham, and Shepard. (no date). *Families on the Edge: Homeless Parents and Their Welfare Experiences*. Washington, DC: Center for Law and Social Policy, p.1.

⁸ First Step is online at <http://www.cms.hhs.gov/apps/firststep/index.html>

⁹ National Alliance to End Homelessness: *Tools to End Homelessness Among Families*.

¹⁰ *Ibid*, p.3.

¹¹ *Ibid*, p.3.

Challenges

In choosing among best practices for this mainstream resource, CoCs need to understand the challenges that homeless families encounter related to TANF. These challenges fall into two general categories: those that impede the ability of some homeless families to engage with a TANF agency or complete the application process and those that affect the ability of homeless families or families that recently exited homelessness to retain TANF until no longer needed or until the state's time limit has been reached.

Access Challenges

1. The presence of mental illness and/ or other disabilities and a lack of needed support impedes some heads-of-household from fulfilling their obligations as TANF recipients. This is evident in national data indicating that families headed by people with disabilities are overrepresented among those who have been sanctioned or disenrolled from TANF.¹²
2. Many communities lack adequate outreach and public education directed to young minor homeless parents who often do not know they might be eligible to receive TANF.¹³
3. Homeless families are often without the support documentation required to complete TANF applications. Birth certificates, in particular, are a commonly missing but essential element.¹⁴
4. Some states use state funds to extend TANF to immigrants who would not be eligible under federal categorical eligibility rules for the program. However, in these states, there is often insufficient community education directed to homeless immigrant populations and in languages they understand to assuage their fears that applying for TANF may have other negative impacts on their lives.
5. Unmarried, custodial, minor parents who receive TANF must live with their own parent or in approved settings according to federal rules. Although this rule may be exempted for good cause, there are limited numbers of CoCs and grantees making this evident to homeless minor parents. As a result, minor parents who are homeless at times forego applying to TANF if they believe it means they must return to violent or unwelcoming homes. A lack of support for such families makes the TANF living arrangement rule a barrier to TANF for this group.

Retention Challenges

1. Despite the availability of subsidized childcare for TANF families, there are often insufficient community-based childcare resources available to allow single TANF-enrolled parents to work. In addition, the complicated logistics of piecing together a plan of coordinated transportation, childcare, and work can be an insurmountable obstacle for homeless heads-of-household. This challenge impedes homeless families' ability to fulfill

¹² National Alliance to End Homelessness. (2006). TANF Reauthorization Proposal: Concern for Homeless Advocates, Washington, DC: NAEH, p. 1.

¹³ Reeg, B. et al. (no date). Families on the Edge: Homeless Young Parents and Their Welfare Experiences. Washington, DC: Center for Law and Social Policy, p.3.

¹⁴ Washington State Department of Social and Health Services, p.4.

TANF's work requirements making them vulnerable to sanctions and, ultimately, disenrollment.

2. There is insufficient availability of community-based English as a Second Language classes offered on a year round basis in convenient locations in which homeless heads-of-household can enroll to fulfill expectations for training and education associated with receiving TANF.
3. Living in a family homeless shelter brings expectations for a head-of-household's time that compete with TANF's work requirements. Typical shelters suggest that heads-of-household perform housing search and service planning for themselves and their families among other activities. When a head-of-household fails to synchronize her time to accommodate work as well, there is a danger of losing part or all of a TANF grant through sanctioning.¹⁵ TANF families that manage to stay enrolled while in shelter often experience sanctions and disenrollment only a few months after achieving housing stability and, as a direct result, cycle back into homelessness.
4. The 2006 federal rules pertaining to TANF's work requirements present new challenges for homeless families. These rules include more limited flexibility about what constitutes TANF-accountable work activity, more formal tracking of work hours, fewer hours deemed acceptable for absences from work, and higher percentages for the number of TANF recipients who must participate in work in each state. To adapt to these new rules, homeless families require new supports and allowances.
5. TANF's 2006 rules also reduce the viability of housing search activities as a TANF-accountable work or job readiness activity. This provision previously helped homeless families retain TANF in many states. The new rules make it difficult for state agencies to stay in compliance with federal rules to the extent that they allow these activities. As a result, new strategies will need to be tried by CoCs and their state TANF agencies to accommodate this loss.
6. Recent changes to the federal rules associated with the TANF Caseload Reduction Credit have increased expectations for all TANF recipients to engage in accountable work activity. As a result, all TANF recipients, including homeless families, will need more opportunities for work and work-related supports.
7. Until recently, several states had TANF Waivers that allowed them to operate their programs under somewhat different rules than the federal program. Today these Waivers have expired in all but one state and the national rules apply. Some provisions that helped homeless families, previously preserved under the Waivers, included policies that allowed variations in work requirements for some families and an exemption to the work requirement for heads-of-household with disabilities. Homeless families, who benefited from flexibility extended to them under these Waivers will now need assistance to help them meet the federal program rules.

¹⁵ This pattern was noted by Continuum of Care coordinators and grantees who were interviewed for a companion report Assessment of Continuum of Care Progress in Assisting Homeless Persons to Access Mainstream Resources.

Recommended Best Practices for CoCs

CoCs may adopt two kinds of best practices for improving homeless families' access to TANF: Systems Level Best Practices and Program Level Best Practices. Each of these is described below.

Systems Level Best Practices

Systems Level Best Practices are innovations that CoCs can recommend but their adoption is ultimately at the discretion of the state and local government agencies that administer the TANF program. With the 2006 TANF rule changes, the best practices found below are more relevant than ever. Homeless families in many states will soon face higher expectations in order to receive and retain TANF benefits. CoCs must be aware of their state's response to these recent federal changes and their impact on homeless families. They also can encourage their local TANF agency to consider adopting the Systems Level Practices outlined here.

1. Provide "Rapid Exit from Homelessness" Grants

TANF can be used to provide small, one-time grants to help those homeless families who need a single infusion of financial resources to exit homelessness rapidly. Such one-time grants can be in the form of a security deposit and/or a first month's rent or they could pay rent for the first few months and gradually diminish over time. Known as Housing Stability Plus in New York City, there is a similar program in Westchester County, New York. Chicago is also working on a similar TANF housing subsidy to help homeless families transition from homelessness.¹⁶

2. Include Benefits to Prevent Homelessness

Many states and counties include a variety of homeless prevention benefits as part of their TANF programs. These include eviction prevention, short-term rent assistance, assistance to prevent utility shut-offs, and other emergency services. Not only do these programs prevent homelessness but they also play an essential role in supporting formerly homeless TANF families to maintain stability once in housing. States offering prevention services through TANF such as those described here include Arizona, Florida, Minnesota, and Washington.¹⁷

3. Identify and Assess Homeless Families

As is the case for other mainstream resources, it is important that TANF applicants from homeless families are identified as such in order to track outcomes and identify special needs for this subgroup of TANF recipients. This can be incorporated as part of a broader approach to identifying and assessing families with significant challenges to work. For those identified as homeless, assessments of housing needs is key. Balance of State and local CoCs can work with their TANF agency to identify homeless families and create the related assessment tools. New Hampshire and Massachusetts are examples of states that identify and track homeless families that receive TANF.

¹⁶ National Alliance to End Homelessness. (2006). Promising Strategies to End Homelessness, Washington, DC: NAEH, p. 18.

¹⁷ Sard, B. (2001). Using TANF Funds for Housing-related Benefits to Prevent Homelessness. Washington, DC: Center for Policy and Budget.

4. Pay for Housing Search Needs

Searching for housing is a time consuming process that is not easily conducted with young children in tow. Homeless heads-of-household typically lack the childcare and transportation needed to complete an efficient and thorough housing search. TANF agencies can consider designating funds for this purpose. New York is an example of a state that authorizes the use of TANF funds to assist families to search for permanent housing.

5. Develop More TANF-Accountable Activities

States can improve the likelihood that families facing challenges to work, especially homeless families, avoid sanctions and disenrollment under the work participation obligations by developing more TANF-accountable work activities. Essentially, this involves creating subsidized employment for certain subgroups of families such as those experiencing homelessness. Massachusetts has tried a small program of this nature.

6. Create a Program to Retain Homeless Families on TANF

Local TANF agencies can develop special measures to protect homeless and recently housed families from sanctions. This can be done under the federally acceptable “good cause” allowance for failures to fulfill TANF’s work requirements. In Cincinnati, Ohio, the Family Shelter Partnership Program channels homeless families to a designated TANF worker. If a family fails to fulfill work requirements (often after becoming housed), the “good cause” designation excuses them and, in so doing, protects against a return to homelessness. This can be combined with other strategies such as enhanced shelter-based case management and community service work offered in lieu of traditional employment to homeless families on TANF. The community service work consists of tasks associated with resolving homelessness. By tailoring the TANF-related obligations to match homeless families’ unique experiences, limitations, and needs, homeless families can be successful TANF recipients. While the 2006 rules limiting TANF accountable work activity will require modifications to this approach, this remains an important best practice.

7. Exempt Homeless Families from Work

With the reauthorization of TANF in 2006, states must have higher percentages of TANF families participating in work than in the past. Each state must decide how it will meet its work quota set by the federal government. States may choose to make special allowances for homeless families, such as exempting them from work requirements and attempting to meet their increased work participation quota with heightened expectations for other, more work ready, families. For example, Michigan’s policy of deferring homeless families temporarily from work requirements is coupled with programs for homeless families where the head-of-household performs community service activity (associated with resolving homelessness) as a stand-in for work. Ohio is considering a two-month exemption from work requirements for sheltered families. This kind of exemption for homeless families is important because, under the new federal rules, community service activities are less likely to qualify as TANF accountable work.

8. Increase Expectations for Work-Ready Families

Another way to shift TANF’s work-related expectations away from families with challenges to work, such as homeless families, is for states to increase expectations for families that are less challenged. This strategy allows a state to temporarily protect homeless families from

the federal work expectations in order to allow them to focus on securing housing first. Many states are considering this strategy as they look for ways to respond to the new federal requirements.

9. Maintain More Working Families on TANF

A state may attempt to find new families to enroll in the TANF program and, in so doing, boost the state’s proportion of working families. This strategy allows the state to reduce the pressure to comply with work requirements on homeless families and others with challenges to work. Illinois, for example, allows working families who have reached the TANF time limits to remain on TANF. Other strategies include reaching out to assist new TANF-eligible families that are working.

10. Use State Funds for Homeless Families

States concerned about how to retain TANF families with challenges to work have the option of using state funds to carve out a separate program for more vulnerable subgroups that is free of federal work requirements. Massachusetts is planning a carve-out program for certain two-parent families, and California has a similar program for another subgroup. Other states are likely to consider this option given policy changes associated with the 2006 rules.

11. Outreach to Families That Are Noncompliant

TANF agencies can do much to minimize the damage caused by disenrollment and sanctioning of homeless families by actively reaching out to provide mediation and case management to those who have experienced penalties. By identifying families with challenges to work and supporting program compliance, homeless families or those in precarious housing situations can be stabilized in housing and helped to return to work more quickly.

Program Level Best Practices

The Program Level Best Practices presented here are strategies that CoCs and their grantees can implement without changes at the policy level. They rely on the resourcefulness and persistence of the CoC to take action and build momentum. The list below highlights practices with a proven track record or that are particularly relevant to recent TANF rule changes.

1. Initiate Cross-System Planning Bodies

CoCs can develop a task force or planning body to discuss and implement systems level changes in their jurisdiction. Made up of representatives from the CoC, the state TANF agency, and other mainstream resource agencies, this group can look at the experience of homeless families with TANF and other resources to identify specific challenges and devise strategies to address them. In Kalamazoo, Michigan, the CoC created a subcommittee of their 10 Year Plan to End Homelessness to consider and press for changes at the systems level.

2. Build Relationships with State or Local TANF Agencies

CoCs that are successful in helping homeless families overcome obstacles to TANF find that it helps to have a good working relationship with program representative in their local TANF office. By identifying an individual within the local TANF office on whom they can rely when questions or concerns arise, the CoC is better able to address the needs of homeless families. This relationship can be cultivated through phone calls, in-person meetings, thank

you letters when issues are resolved, and commendations to superiors for excellence in service delivery. CoCs in Tennessee report that this is an effective strategy to resolve issues pertaining to specific families.

3. Train CoC Direct Service Staff

CoCs can do much to increase the technical skills of their grantees' direct service staff concerning TANF eligibility and application procedures in their state. Grantees need training on eligibility issues, time limits, work requirements, definitions of TANF-accountable work, partial and full sanctions, and good cause exclusions. They also need to know specific provisions and services for homeless families in their state. In Michigan and other states, the CoCs sponsor training forums at regular intervals that are led by state and local TANF program staff.

4. Develop Cross-Training for CoC and TANF Staff

Local TANF offices can be called upon to train CoCs and their grantees on TANF eligibility rules, benefit levels, and requirements related to recipients' work requirements. Bringing case managers and social workers together with representatives from local TANF agencies in regular training forums of this kind can be helpful for other reasons as well. Specifically, CoCs can offer training to TANF workers on the needs of homeless families and local housing resources to which they can refer families in need. Smaller CoCs in Michigan and Maryland report that equipping TANF workers to respond to their clients' needs for affordable housing and housing search assistance is an effective collaborative strategy.

5. Ensure TANF Representation at CoC Meetings

Many CoCs have forged working relationships with local TANF offices as well as those of other mainstream resources by inviting representatives from these agencies to participate in regular CoC quarterly or monthly meetings. Grantees use the opportunity for face-to-face contact to ask questions related to the application process and trouble shoot problems encountered in their jurisdiction. At times, these meetings are used to problem solve individual cases with confidentiality protected. The recommended format is a simple roundtable where the public officials field questions or are asked to follow up on specific problems. CoCs in Michigan and Maryland report that this improves access to TANF and other mainstream resources.

6. Coordinate Case Plans with TANF

CoCs can encourage grantees who work with homeless families to coordinate case plans with their local TANF agency. This involves devising a process where the steps a homeless family must take to become housed are also sanctioned as an allowable work activity by the local TANF agency. While new TANF rules make this kind of collaboration more difficult, states have some flexibility to implement such arrangements. The Family Shelter Partnership in Cincinnati, Ohio is one example where the CoC developed programs for homeless families with realistic work options that were approved by their local TANF agents.

7. Enhance Shelter-Based Case Management

Most CoCs and the family shelters within their network provide case management to establish the initial link to TANF. By "enhancing" case management to help families meet TANF requirements, grantees can improve outcomes for the families they serve. This model is also used effectively with homeless families where the heads of household have

disabilities. Enhanced case management includes: individualized assessment, referral to the local TANF office, transportation, and individualized advocacy and mediation when needed. With this array of supports, families are more successful in applying for TANF. Enhanced case management also includes providing help obtaining documentation required for TANF. Needed are social security numbers, proof of citizenship or legal residency, income documents, proof of age for all family members, and verifications of immunization and school attendance. Other items, such as proof of participation in substance abuse treatment, may also be required. In addition, to maintain TANF eligibility, verification of work participation must be produced. Enhanced case management also involves following up with homeless families once they leave shelter and offering support and mediation to help families continue to meet TANF requirements. An increasingly widely practiced model, enhanced case management is carried out by CoC grantees in Boston, Massachusetts among many other locations.

First Steps for Action

Many replicable best practices are available for local CoCs seeking to improve access and retention of TANF for homeless families. As first steps, experienced CoCs recommend strategies that link CoCs with TANF agencies such as cross-system planning bodies. At the systems level, CoCs may want to first encourage their state TANF agency to consider initiatives such as Rapid Exit from Homelessness grants. Perhaps most needed are best practices that help homeless families overcome obstacles to work. Given the recent changes to TANF rules, brought about by the 2006 reauthorization of this program, the need for CoCs to help introduce such practices in their communities will be of increasing urgency for those who are committed to the interests of homeless families.

SOCIAL SECURITY DISABILITY PROGRAMS

Need for SSA Disability Benefits

The Social Security Administration (SSA) has two programs designed to provide cash benefits for persons who are determined to be disabled — Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). SSI provides benefits to low-income people who are disabled, blind or elderly. In some states, the SSI benefit is supplemented by the state providing more than the monthly allowance provided under the Federal SSI benefit rate.¹⁸ SSDI provides benefits to disabled or blind individuals who are “insured” based on contributions paid into the Social Security trust fund by their employer. To qualify for SSDI, an individual must have worked long enough and recently enough under Social Security to receive benefits.

Both SSI and SSDI use the same definition of disability. Disability is based on an inability to work at the level of substantial gainful activity¹⁹ due to a medical condition that has lasted or is expected to last at least a year or to result in death. Documentation of an individual’s disability is required and must meet strict criteria.²⁰ For more information on how to assist homeless people to access SSI and SSDI, see the online resource First Step.²¹

SSI and SSDI are limited, but reliable sources of income for people who are disabled. In addition, very low income persons who are age 65 or older are eligible for SSI²² whether or not they have a disability. In most states SSI recipients are automatically eligible for Medicaid and SSDI beneficiaries qualify for Medicare 24 months after becoming eligible for benefits. With these benefits, people who are homeless can begin to provide for their own basic needs, particularly when these benefits are coupled with subsidized housing and Food Stamps.

Access to SSA Disability Benefits

Despite the high levels of disability estimated among people who are homeless, many potentially eligible homeless persons never apply for SSA disability benefits.²³ Among those who do apply, the chance of getting an SSI or SSDI application approved – without someone taking an active

¹⁸ In 2006, the monthly Federal benefit rate for SSI was \$603. This amount is adjusted annually for cost of living changes. A list of states that provide supplementary SSI payments can be viewed at: www.ssa.gov/notices/supplemental-security-income/text-benefits-ussi.htm.

¹⁹ Rosen, J. and Perret, Y. (2005). *Stepping Stones to Recovery: A Case Manager’s Manual for Assisting Adults Who Are Homeless with SSD and SSI Applications*. DHHS Pub. No. SMA 05-4051. Rockville, MD: Substance Abuse and Mental Health Services Administration.

²⁰ These criteria are known as “The Listings” or the “Blue Book” and can be found on SSA’s website at: www.ssa.gov/disability/professionals/bluebook.

²¹ First Step is online at <http://www.cms.hhs.gov/apps/firststep/index.html>

²² In 11 states, known as 209(b) states, the state uses at least one criterion that is more restrictive than the SSI program’s criteria for determining eligibility. The 11 states are: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.

²³ General Accounting Office (2000). *Homelessness: Challenges to Using Mainstream Programs*. Washington, DC: U.S. GAO.

role to assist with the documentation of their disability – is very low.²⁴ Once an SSA disability application is denied, the appeals process can take years.

Challenges

To understand how to increase access to SSA disability benefits for people who are homeless, it is important to first understand the challenges they face. For many reasons, homeless people face more challenges than other applicants for SSA disability benefits.²⁵ These challenges generally fall into two types. Those that related to characteristics of homeless persons and the nature of homelessness; and those that relate to more systemic issues.

Challenges related to characteristics of homeless persons and the nature of homelessness

1. People who are homeless are more likely to have serious mental illnesses alone or in combination with other qualifying disabilities, such as cognitive disorders, chronic physical health conditions, and substance use disorders. Disability based on a mental illness or cognitive disorder is more difficult to document than some other disabilities because of the lack of treatment histories, difficulty in finding medical records for people who may have moved about over time, etc.
2. People who are homeless for long periods of time are often poor historians and are not good record keepers. They often don't remember when or where they were hospitalized or for what. Many do not know, do not understand, or are reluctant to admit that they have a mental illness.
3. Many people do not apply or are discouraged from applying because they believe incorrectly that if they have a substance use problem they are not eligible for SSA disability programs regardless of their other disabling conditions. While it is true that persons disabled solely on the basis of substance use without any other qualifying disabling condition are not eligible for SSA disability programs, many homeless persons with substance use disorders have co-occurring conditions that qualify them for these benefits.
4. Most homeless people with disabilities need assistance to apply for SSA benefits in order to be successful. Denials of SSA disability benefits for homeless persons are typically the result of SSA's inability to contact the individual when they need further information in order to process the case, missed appointments for SSA scheduled medical examinations, and, more generally, the lack of adequate documentation to support the case for a finding of disability.
5. Homeless persons tend to miss medical exams (called Consultative Exams or CEs) scheduled by SSA. Missing one or two of these appointments can result in denial of benefits.

²⁴ In some localities where data is kept on homeless applicants for SSI, the proportion of applications approved range between 10 and 15 percent. With active assistance by case managers or other benefits specialists, this can rise to 65 or higher. See for example, Dennis, D., Perret, Y. and Seaman, A. (2006). *Expediting Access to SSA Disability Benefits: Promising Practices for People Who Are Homeless*. Delmar, NY: Policy Research Associates, Inc.

²⁵ Rosen, J., Hoey, R., and Steed, T. (2001). Food Stamp and SSI benefits: Removing access challenges for homeless people. *Journal of Poverty Law and Policy*, March-April.

Systems challenges

1. Most case managers are unable to assist homeless people with SSI and SSDI applications because they have neither the time nor an understanding of how to assist applicants effectively. Case managers who try to help applicants are frustrated by a lack of contact with SSA and a lack of understanding about what they can do to make the process work better for them and their clients.
2. The CE exam is typically conducted by a SSA-contracted physician or psychologist who has never seen the applicant before. For persons who have mental illnesses or cognitive disorders, the history of symptoms and treatment is difficult to convey effectively in a brief face-to-face encounter with a stranger. Many times, these applicants do not keep appointments for CEs or, when they do, they deny or minimize their mental illness and the examiner has no choice but to report that no disabling condition was found.
3. Since most homeless persons are denied SSI and SSDI at least initially, they can spend years in the appeals process.²⁶ Usually this time is spent in shelters or on the streets with no income or health insurance, making it nearly impossible for CoCs to meet their needs for treatment, housing and other support.

Recommended Best Practices for CoCs

Efforts to address long-term homelessness on the part of states and communities have led to a focus on benefits for homeless persons who are disabled. As part of the technical assistance offered to states participating in the Federal interagency Policy Academies on Homelessness, 24 States and Los Angeles County are participating in the SSI/SSDI Outreach Access and Recovery (SOAR) Technical Assistance Initiative. CoC representatives from these states are using information and collaboration (with each other and with SSA and DDS) to combat myths about access to disability benefits for people who are homeless. They understand that their clients, many of whom have mental illnesses and/or cognitive disorders and lack a stable address, can not access benefits by themselves.

There are two kinds of best practices that CoCs may adopt for improving access to SSI and SSDI. These are Systems Level Best Practices and Program Level Best Practices. By implementing these practices, CoCs can increase approvals (also called allowance rates) for SSI on initial application from less than 15 percent to 65 percent or higher. It is important to understand that the practices below are not a menu that CoCs can pick and choose from in order to achieve these kinds of allowance rates. Implementing some, but not all, of these practices can help, but it takes attention to all components below to reach maximum allowance rates. Appendix B provides an overview of these critical components and strategies for implementing them.²⁷

²⁶ Nationally, the average wait for a decision at the appeals level is about two years. Social Security Advisory Board. (2006). *Disability Decision Making: Data and Materials*. Washington, DC: Social Security Advisory Board (www.ssab.gov).

²⁷ Dennis, Perret and Seaman, op cit. Other tools and resources can be found at www.prairc.com/soar.

Systems Level Best Practices

The systems level practices in this section are ones that can be undertaken by CoC agencies working together as a group. Short of changing SSA rules and regulations (something that can only be done by an act of Congress), there is a great deal that CoCs can do to increase access to SSI and SSDI. To accomplish these systems level changes, CoCs will need to partner with SSA, the state Disability Determination Service (DDS), and local medical providers.

1. Start An SSI Outreach Project in Your CoC

Many CoCs have started one or more projects to assist homeless people to apply for SSA disability benefits. In Ohio, for example, six CoCs made a commitment to implement SSI outreach in their local areas. They are following the steps outlined in next section and in Appendix B. Other CoCs already have SSI outreach projects in their area that were funded by SSA’s HOPE (Homeless Outreach and Program Evaluation) program.²⁸ They are building on these programs and helping to find ways to continue them once SSA funding ends.

2. Establish Working Relationships with SSA and the DDS

As part of their SOAR initiative, Nashville is working with local SSA Field Office staff and the state DDS to designate staff that will identify and process applications from people who are homeless. DDS will track applications from homeless persons so that they will know how long it takes to process these applications and what the outcomes are for applications from people who are homeless. The Nashville CoC will use this information to understand whether their efforts are resulting in improved results for homeless applicants. Among the things that SSA and DDS have done for SSI outreach projects for people who are homeless are:

- Flag applications from assisting agencies,
- Expedite the review,
- Assign claims representative to assist and disability examiners who specialize in applications from homeless people
- Communicate directly with assisting agencies about their information needs for particular applications, and
- Contact the assisting agency if a CE is needed.

3. Provide Training That Addresses the SSI Application Process from the Community Provider’s Perspective

Continuing training and support related to SSA disability benefits for case managers and benefits specialists can help improve allowance rates for homeless people who apply for SSI or SSDI. In Ohio, the State’s HUD technical assistance provider became trained in the *Stepping Stones to Recovery* curriculum, which is specifically designed to increase access to SSI for homeless persons.²⁹ They then trained local staff in six CoCs throughout Ohio and are tracking outcomes for applicants assisted following the training. Through SOAR, both Tennessee and Maryland will conduct training using the *Stepping Stones to Recovery*

²⁸ See www.socialsecurity.gov/homelessness/outreach.

²⁹ Perret, Y. and Dennis, D. (In Press) *Stepping Stones to Recovery: A Training Curriculum for Case Managers Assisting Adults Who Are Homeless with SSD and SSI Applications*. DHHS Pub. No. SMA 06-4208. Rockville, MD: Substance Abuse and Mental Health Services Administration.

curriculum to help case managers better understand the process and the role that they can play to increase access to these benefits.

4. Form Collaborative Arrangements with Medical Providers

CoCs can work with local medical providers to provide two services critical to disability applications. First, by working with local physicians and psychologists in Health Care for Homeless programs, other clinic or hospital settings, or through local medical schools, CoCs can educate the medical community about the need for assessments and documentation for homeless people applying for disability benefits. Local physicians and psychologists need to be trained so that they understand what SSA and DDS need to document impairments for the purposes of a SSA disability claim. Nashville and a number of other CoCs are using the National Health Care for the Homeless Council's (NHCHC's) *Documenting Disabilities* training curriculum to help physicians understand what SSA and DDS need in order to support a finding of disability.³⁰

Second, collaborations with medical records departments at key hospitals and clinics are crucial to getting the medical records to support claims of disabling impairments. Medical records directors and/or other administrative staff can collaborate by providing access to needed medical records (assuming that the proper releases are in hand) at reduced or no fees. Helping them to understand “what’s in it for them” is critical to gaining cooperation and collaboration. Hospital and clinics can be reimbursed by Medicaid for health care costs up to 90 days prior to an individual’s date of eligibility for SSI. This can be a powerful incentive for hospital and clinic administrators to collaborate with CoCs.

5. Track Outcomes

In order to know whether access to SSI is improving or staying the same, CoCs need to know the SSI *allowance rate* for homeless persons in their state or local area. The allowance rate is the proportion of SSI applications approved by SSA out of the total number of initial decisions made over a given period of time. SSA does not keep this information separately for applicants who are homeless unless they “flag” these applications as they enter the system. Once applications from homeless persons are identified as such, SSA can report on the allowance rate for people who are homeless.

If the local SSA Field Office is not willing or able to flag applications for homeless persons, the CoC or the provider agency that is conducting SSI outreach can keep track of this. A number of state and local agencies have developed simple ways to know whether their attempts to increase access to SSI are being successful. In Virginia, a simple Excel spreadsheet is used by PATH providers to record the date of application submission, SSA decision, and the outcome of that decision (approval or denial). In Ohio, the state-wide TA provider, Partnership for the Homeless, has developed a Web-based tracking program that local providers use to enter data on SSI applications. In Oregon, a paper grid is used to track outcomes of SSI applications so that the state and local parties can work with SSA, DDS, and local providers to make system improvements and provide additional training.

Data elements could also be added to existing HMIS systems to track outcomes for SSI applications. At a minimum, three data elements are needed: the date the SSI application was filed, the date the initial decision was rendered by SSA, and the outcome of the initial

³⁰ <http://www.nhchc.org/documentingdisabilities.html>.

decision (approved or denied). Of course, this requires that case managers or someone must know these dates (not likely if they aren't the applicant's representative; see #4 below) and record them as the SSI application is filed and, later, after the initial decision by SSA is made. To date, we are not aware of any CoC that keeps track of allowance rates using HMIS, but the potential remains.

6. Grow and Sustain Successful Efforts

Several CoCs have used outcome data to make the case for sustaining or expanding SSI outreach. In San Francisco, the Department of Public Health estimates that for every \$1 spent on SSI outreach, they recoup \$6 in uncompensated health care costs and general assistance benefits from Medicaid and SSI respectively. In Los Angeles, a CoC provider is using outcome data from other localities to make the case to foundations for funding a major SSI outreach initiative in Skid Row. Collaborating partners who have a stake in SSI outreach include primary and behavioral health providers, such as clinics and hospitals, who can recover uncompensated health care costs up to 90 days retroactive from the date of SSI eligibility. Once health and behavioral health partners are aware of the benefits of increasing access to SSI and Medicaid, they can become key players in accessing needed medical evaluations and/or medical records for documentation. County or state agencies responsible for general assistance benefits (where these benefits are available) can also be partially reimbursed by SSA for people who become eligible for SSI. In Washington State, for example, training and other infrastructure support for SSI outreach is supported by the State Department of Human Services.

Program Level Best Practices

There are also best practices that individual CoC provider agencies can put in place to help homeless people better access SSA disability benefits. Many of these can be effective independent of the larger systems-level changes suggested for the CoC, but a more comprehensive and community-wide approach (e.g., particularly establishing relationships with SSA, DDS, and medical providers) will yield better results than one that is more agency-specific. As noted earlier, the practices below can not be implemented selectively. Each of the practices in this section are critical components for significantly increasing access to SSI and SSDI.³¹

1. Conduct Street and Shelter Outreach Focused on Identifying and Assisting Persons to Apply for SSI/SSDI

The Baltimore Continuum of Care uses a HUD Supportive Services grant to fund an SSI outreach project that assists homeless persons who would otherwise not apply for SSI on their own. By focusing on accessing benefits while also trying to help people meet basic needs for shelter, housing and treatment, they are able to reduce the time that people are homeless and increase access to housing, treatment and supports. Over a 12-year period, 96 percent of the applications filed for people the staff thought would be eligible were approved on initial application. As a result of their city's plan to end homelessness, the City of Nashville provided funding to a CoC provider agency to create an SSI outreach project with two full-time staff persons who assist with applications taken directly from the street or shelters. Six months after starting this project, 100 percent of 14 SSI applications filed have been approved on initial application and the time it takes for SSA and DDS to reach a determination has averaged less than three months.

³¹ See Appendix A and Dennis, Perret, and Seaman, op cit.

2. Designate a Staff Person to Assist with SSI/SSDI Applications

By having staff who understand the benefits acquisition process and who can assist homeless applicants, CoC agencies can be more effective in helping people access SSI and SSDI. Case managers with clinical and writing skills are essential since it is important to engage and assess people over time and develop written documentation for SSA. In Maryland, the state is using a \$17,000 PATH grant to support a benefits specialist at the Baltimore Health Care for the Homeless program. This person will be responsible for working with applicants until they are approved and facilitating the process along the way.

3. Focus on the Initial Application

By focusing on the initial SSI application, rather than on appeals, CoCs can help eligible people get benefits in two to three months rather than two to three years. SSI and SSDI applications must be complete and the disability must be fully documented before submission to SSA using the techniques below. CoCs in Ohio, Denver, Nashville and others are increasingly focused on providing intensive assistance with the application process and disability documentation.

4. Become the Applicant's Representative

The Nashville SSI outreach project requires all providers participating in SOAR to use the SSA 1696 Appointment of Representative form for applicants they assist. Using this form allows the case manager to “stand-in” for the applicant and receive copies of all correspondence that SSA sends to the applicant. It also allows the SSA and DDS staff to speak directly to the case manager so that inquiries can be made, for example, about the need for additional information, status of the application, and coordination of arrangements for CEs. Without this form, many SSI and SSDI applications are denied simply because the SSA or DDS cannot locate the applicant or because they have missed a rescheduled CE.

5. Gather Medical Documentation to Support the Application

Staff that assist homeless people to apply for SSI and SSDI need to be “clinical Columbo”³² in their efforts to find and document prior treatment. Relationships with medical records directors of local hospitals and clinics can be crucial to accessing existing documentation of impairments. SSA and CoC agency release forms need to be signed by the applicant for each treatment source. Seeking out and establishing relationships with hospital and clinic medical records directors can help educate them on what records are needed and can provide access to CoC staff to these records. Hospital and clinic staff are more open to collaborating when they understand how getting people on SSI and the accompanying Medicaid benefit will help their organization provide better care and possibly recover retroactive costs for uncompensated medical expenses. Offering to copy records once a relationship is established or negotiating free copies of records are two key strategies related to gathering medical documentation required to support an SSI or SSDI application.

6. Arrange for Needed Medical Evaluations

If it looks like there is not enough medical documentation to support a finding of disability, the assisting agency should provide or arrange for a medical assessment by a physician or psychologist. This assessment may need to take place on an outreach basis. Health Care for the Homeless programs and other clinics and community physicians or psychologists can

³² Yvonne Perret, personal communication, November 7, 2006.

help by providing diagnostic and functional assessments that may be able to be reimbursed retroactively once the patient is approved for SSI and Medicaid.

Having assessments done before the application is submitted, can help to avoid CEs that the DDS requires when they don't have enough information to make a disability determination. CEs typically do not work well for people who are homeless. Often they do not keep the appointment, have difficulty getting to the appointment, or fail to mention key aspects of their conditions to a doctor who they've never met before. If a CE is required, a case manager can request that the applicant's treating physician (preferred according to SSA guidelines) be allowed to conduct the exam. Regardless of who conducts the exam, make sure the applicant gets to the exam and accompany him or her if possible. Missing one or more of these appointments could result in denial of benefits.

7. Write a Medical Summary Report Co-Signed by a Physician or Psychologist

Case managers can play an active role in helping homeless people access SSA disability benefits by gathering medical records and drafting a letter summarizing the person's disabling conditions and the reasons why the person is unable to work. It is important that this letter specifically address the SSA criteria for a finding of disability based on the applicant's diagnosis (see <http://www.socialsecurity.gov/disability/professionals/bluebook>). It is also important that this letter be co-signed by a physician or psychologist who has seen the applicant. Having the letter co-signed by a physician or psychologist gives it more weight in the DDS decision about whether or not the person is disabled. CoC provider agencies in Nashville, Virginia, Washington and Ohio among others are using this strategy to help homeless people with disabilities to access benefits. A sample medical summary report can be found at <http://www.prainc.com/SOAR/tools/pdfs/MedicalSummarySample>.

8. Review Applications for Completeness Before Submitting to SSA

Having someone review each application for completeness prior to submission to SSA can increase the likelihood that the application will be approved more quickly. An agency supervisor or skilled benefits specialist can do this for case managers who may not assist with applications on a regular basis. See http://www.prainc.com/SOAR/tools/quality_review for an application quality review checklist that can be used to check applications for completeness.

9. Provide or Arrange for Representative Payee Services

Once an applicant is approved for benefits, he or she may need a representative payee to help manage his or her benefits. This is an extremely critical gap in most communities, as many people who are homeless often need assistance managing their benefits, at least at first. Where this service is not available, people may have difficulty retaining housing and benefits over time.

10. Track Results

Knowing the outcome of applications for SSI and SSDI is crucial information for providers to have. This can help them know whether to undertake an SSI outreach initiative and to know whether their efforts are being successful. Even if the state or local system does not track outcomes for applications filed with SSA, individual providers can do this so that they can monitor their efforts. CoC providers in Covington, Kentucky and Columbus, Georgia are among those that are monitoring the dates when applications have been filed, when a

decision is made by SSA, and the outcome of that decision. By constantly trying to improve upon the strategies above, this provider has seen steady increases in the number of applications approved and decreases in the length of time that it took to get approvals.

First Steps for Action

Creating a community-wide or state-wide SSI outreach initiative can help CoCs increase access to SSI, SSDI and, in most states, Medicaid. CoCs need to reach out to new partners, including SSA and DDS as well as the larger medical community for access to medical records and for medical evaluations. But even a single CoC provider can implement best practices that will significantly impact local access to SSI and SSDI. It is important to remember that these best practices are a package deal – they are not intended to be implemented piecemeal and efforts to do so will result in lower overall effectiveness. By increasing allowance rates and reducing the time it takes to receive these benefits, CoC providers can help reduce the time that people with disabilities remain on the street and in our nation's shelters.

FOOD STAMPS

Need for Food Stamps

The Food Stamp Program is designed to alleviate hunger and malnutrition by providing low-income individuals and households coupons or Electronic Benefits Transfer (EBT) cards that can be used to purchase food in authorized retail food stores. In some areas, restaurants can be authorized to accept Food Stamps from people who are homeless, elderly, or disabled in exchange for low-cost meals. The benefits may be used for food alone and may not be exchanged for cash. The online resource First Step provides detailed information on how to assist people who are homeless to obtain Food Stamps.³³

Access to Food Stamps

For most people who are homeless, the Food Stamp Program is easier to access than other programs, such as Medicaid, Social Security, and TANF. Despite this relative success, many eligible people are not enrolled. A 2001 study found that only 60 percent of people eligible for the Food Stamp Program overall were enrolled.³⁴ Among people who are homeless, this rate may be even lower, and CoCs report multiple challenges associated with matching the unpredictability of life on the streets or in shelters with the Food Stamp program. To lessen this difficulty, CoCs would do well to consider implementing some of the best practices found in this guide.

Challenges

In choosing among best practices related to Food Stamp access, CoCs must first understand typical challenges to this resource that people who are homeless encounter. While policy makers have been recently successful in reducing wastefulness and cost overrides in the Food Stamp program, there remain a number of significant challenges that prevent eligible persons from applying. Presented here are the most notable challenges experienced by people who are homeless.

1. Homeless people with low levels of literacy may make errors on Food Stamp application forms. Omissions or inaccurate information are common reasons for benefits being delayed.
2. Although many states are streamlining their application process, many state applications remain lengthy and challenging to complete. This is typical in states that offer households an opportunity to apply for multiple assistance programs at the same time. People who are homeless can benefit from this combined application if they need cash and medical assistance in addition to food assistance. However, if a person who is homeless only wants to apply for Food Stamps, he or she must take the time to identify only those questions pertaining to Food Stamp eligibility in the application.

³³ First Step is online at <http://www.cms.hhs.gov/apps/firststep/index.html>

³⁴ "Reaching Those in Need: Food Stamp Participation Rates in the States in 2001," United States Department of Agriculture: Food and Nutrition Service.

3. Although a Food Stamp applicant does not have to prove he or she is homeless, Food Stamp caseworkers may request verification of an applicant's living situation. These verification procedures can be a burden for people who are homeless and a deterrent to completing the application. Under Food Stamp Program rules, an individual is considered homeless when he or she has no regular nighttime residence or resides in a supervised shelter, half-way house, doubled up living situation, or a place not designed for overnight accommodation such as a hallway, bus station, or lobby. The need to obtain a written or oral statement, when required, from a homeless shelter or other party can delay an application or, in some cases, derail the process.
4. The Food Stamp program rules require all states to have provisions for issuing expedited or emergency Food Stamp benefits as well as making accommodations for recipients who are homeless. Some local eligibility offices, however, do not follow the required expedited provisions, or do not always reach homeless applicants with related announcements. CoCs in these communities are not always positioned to bridge this gap in communication.
5. Recertification procedures for Food Stamps are a challenge for homeless people. When a Food Stamp applicant is found eligible for benefits, he or she is entitled to receive Food Stamps for a certain number of months known as a "certification period." Most states certify applicants for three months. When the certification period ends, the individual must re-certify. If they fail to do so, their Food Stamp benefits end. The Food Stamp office is required to notify recipients by mail when the certification is going to end, but receiving notices by mail is difficult for those who lack a permanent address. Food Stamps recipients who are homeless are challenged by the need to track their certification periods and recertify on time. Furthermore, too few states allow two-year certification periods for individuals who are disabled.
6. The Food Stamp program allows states flexibility in determining a homeless household's income, and states may decide to use a "homeless household shelter deduction." This deduction accounts for personal expenses that people who are homeless have difficulty documenting. Unfortunately, most states have not made use of this option. If used more often, more homeless people would get the deduction of up to \$143 per month, which, in most cases, would translate to a larger Food Stamp allotment.
7. There is a lack of outreach and education to community-based soup kitchens, shelters, and group living settings, such as group homes, that can be authorized to accept Food Stamps. Many of these providers do not know that they can request such authorization. As a result, this provision of the Food Stamp program, which could be of enormous benefit to homeless people, is underutilized.
8. In many states, there is a lack of outreach and education to local restaurants that can be authorized by a state to serve meals to people who are homeless at reduced prices in exchange for Food Stamps. As with the soup kitchen provision of the Food Stamp program, the restaurant provision, which also could be of enormous benefit to homeless people, is underutilized.

Recommended Best Practices for CoCs

There are two kinds of best practices for CoCs to consider adopting to improve access by homeless individuals and families to the Food Stamp Program: Systems Level Best Practices and Program Level Best Practices.

Systems Level Best Practices

Systems Level Best Practices are innovations that can be encouraged by CoCs but are ultimately at the discretion of the state and local government agency that administers the Food Stamp program. CoCs can recommend such practices to local Food Stamp agency representatives and sensitize them to the needs of homeless applicants. Since CoCs have tended to focus more on other mainstream resources, the practices described below are generally derived from examples of efforts by other community-based stakeholders with an interest in improving access to Food Stamps for marginalized and under enrolled groups.

1. Create Combined Public Program Applications

The time-consuming Food Stamp application, which is often a deterrent to potential applicants, can be streamlined. It can also be combined with applications for related services, such as SSI, TANF, Medicaid, subsidized child-care, emergency assistance, and medical programs. Several states have developed such combined applications that include Food Stamp programs. Oregon, for example, implemented a streamlined application with an additional page that can be added if the applicant wants to apply for TANF. In addition, South Carolina's demonstration program, which was started in 1995, combines the SSI application with the Food Stamp application. Massachusetts also has a similar joint application for SSI and Food Stamps.

2. Reduce Waiting Periods

Several innovations can be implemented to reduce both the length of time that applicants wait to apply at the Food Stamp office and the time it takes for the benefit to be approved and issued. Both can be reduced by tracking wait times and implementing policies to avoid extended waiting periods for all applicants. Towards this end, Food Stamp workers can be assigned "buddies" so that if a staff person is absent, a colleague can serve as backup for their caseloads. In addition, team-building for Food Stamp staff can help them be more invested in their productivity. Also beneficial is a policy where all applicants must be seen by a caseworker within 20-30 minutes of arrival. Under this policy, applicants receive a card with the check-in time. When they meet with the Food Stamp caseworker, the time is recorded. Supervisors track these times to ensure that applicants are receiving expedient and efficient services. States implementing these types of initiatives include Arkansas, Michigan (Saginaw County), and Kansas.

3. Extend Office Hours

Extending office hours for the Food Stamp Program, including evening and Saturday hours, can increase flexibility for applicants who are homeless. Accommodations in this area have been implemented at the city, county, or state levels in Phoenix, Arizona, Sacramento County, California, and the state of Massachusetts.

4. Create Access Centers

Access Centers – also known as “one stop” centers – are joint efforts of Food Stamps agencies and multiple other public resources to provide a centralized setting for individuals and families, including homeless people, to apply for multiple programs at a single location. A one stop center includes opportunities to apply for Food Stamps together with other services such as employment, family services, temporary cash assistance, and child support services, among others. Drop-in child care on site at the one stop center can also be established to give parents the flexibility to more easily meet with representatives from service programs. Hennepin County, Minnesota, for example, has built a wide network of such centers.

5. Promote Efficiencies

Several small efficiencies can be used to assist homeless people to access Food Stamps. These include creating multiple satellite Food Stamp offices in various communities that offer other social services, providing drop boxes outside the office where Food Stamp recipients can return program forms after hours, adding a drop box in the lobby to alleviate crowds during busy times of the day, and implementing the use of a computerized interpreter scheduling system, where Food Stamp applicants can request interpreters who are on-call for appointments. Ramsey County, Minnesota has implemented these practices to improve access.

6. Educate Recipients

A simple but effective practice is for food stamp offices to design programs to teach potential applicants in their community about Food Stamps before they apply so as to avoid misconceptions. This may take the form of Food Stamps orientation sessions offered multiple times throughout the year. Homeless service networks, including shelters, could host such sessions. Orientations of this nature take place at various sites across the states of Maine and Wyoming.

7. Create Educational Materials Using Innovative Technology

Shelters and other homeless service network providers can use innovative technology, such as educational CD ROMs, to educate CoC case workers about eligibility and application procedures associated with Food Stamps. The states of Idaho and Oklahoma have used CD ROMs as part of marketing campaigns to increase utilization of the Food Stamp Program. The Illinois Hunger Coalition has used another form of technology, creating an Internet-based eligibility tool, to generate applications for Food Stamps and other mainstream resources at food banks, schools, and other sites where Food Stamp eligible recipients might be found. The State Department of Human Services in Illinois accepts these applications by fax or personal delivery and has identified staff in each office as contacts for advocates.

8. Increase Outreach to People Who Are Homeless

There are a number of options for creating effective Food Stamps outreach programs. Many states work with community based organizations to do outreach at churches, food banks, and food pantries where they target specific underserved populations, including people who are homeless, immigrants, elderly people, disabled persons, low income workers, and ex-prisoners. In Tennessee for example, Food Stamp Program staff use laptop computers to take applications at community-based organizations.

Program Level Best Practices

This section outlines Program Level Best Practices that CoCs and their grantees can implement independent of leadership from state agencies. These strategies do not rely on change at the policy level but on the resourcefulness and persistence of the CoC.

1. Train CoC Grantees about Food Stamp Access

CoCs can do much to increase the technical skill level of grantee case managers and social workers concerning Food Stamp eligibility and application procedures in their state. CoCs can offer training on Food Stamp eligibility and how to more fully engage people who are homeless in utilizing these resources. Some communities conduct monthly or bi-monthly in-service trainings for staff of local CoC providers. At these trainings, representatives from the Food Stamp Program are invited to attend, discuss specifics of the Program, and answer questions from grantees. In Michigan, the Grand Rapids CoC regularly conducts such training sessions.

2. Add New Staff Positions

CoCs and their grantees can create new staff positions to provide one-on-one assistance to homeless people applying for Food Stamps and other mainstream resource programs. In Grand Rapids, Michigan, the CoC has created several new advocacy positions for this purpose.

3. Link with HUD Field Offices

When engaged by CoCs on this issue, local HUD field offices can help draw attention to the need for better access to Food Stamps. The local HUD field office in Northern California that services Nevada, Northern California, and Arizona has been enlisted in this way. Santa Clara County, California is a community where this HUD field office took the initiative to increase Food Stamps accessibility to homeless people in their community. In Alameda County, California, this same HUD field office initiated trainings for homeless service providers on Food Stamps and hosted a series of meetings on increasing accessibility to various mainstream programs throughout the County.

4. Collaborate with Hunger Organizations and Others

Local and statewide hunger organizations and non-profit legal service organizations are also important allies for CoC providers interested in increasing access to Food Stamp. These organizations provide training and legal advocacy to CoC providers and homeless individuals and have a strong interest in ensuring that anyone eligible for Food Stamps receives them. In Illinois, the state's Hunger Coalition takes applications for Food Stamps at food banks, food pantries, and other service agencies that homeless people frequent. In Tennessee, a local legal service organization receives funding to do outreach to Food Stamp recipients.

First Steps for Action

Although Food Stamps are generally more accessible to homeless people than other mainstream resources, there are still many qualified individuals and families who are not participating in this program. Thus, improving access to Food Stamps remains a priority for CoCs. Experienced CoCs recommend that all CoCs educate their grantees about the Food Stamps Program and

promote more targeted outreach to their community's homeless populations. In addition, CoCs are encouraged to bring more Food Stamp eligibility workers out of conventional offices and into community settings where homeless people are found. Finally, it is recommended that CoCs negotiate with their local Food Stamps representatives to extend office hours to evenings and Saturdays to accommodate people who are homeless.

APPENDICES

Appendix A: SSI and State Medicaid Programs 1

Figure 7. 1634 States

In 1634 states, SSA makes Medicaid eligibility determinations and—essentially—authorizes Medicaid when a person is approved for SSI.

Alabama	Kentucky	New Jersey	Tennessee
Arizona	Louisiana	New Mexico	Texas
Arkansas	Maine	New York	Vermont
California	Maryland	North Carolina	Washington
Colorado	Massachusetts	Pennsylvania	Washington DC
Delaware	Michigan	Rhode Island	West Virginia
Florida	Mississippi	South Carolina	Wisconsin
Georgia	Montana	South Dakota	Wyoming
Iowa			

Figure 8. SSI Criteria States

SSI criteria states use SSI eligibility criteria for Medicaid but, beyond those criteria, may make their own Medicaid determinations or ask SSA to determine eligibility.

Alaska	Kansas	Nevada	Oregon
Idaho	Nebraska	Northern Mariana Islands	Utah

Figure 9. 209(b) States

209(b) states use at least one criterion that is more restrictive than the SSI program's criteria for determining eligibility.

Connecticut*	Indiana	New Hampshire*	Oklahoma
Hawaii	Minnesota	North Dakota	Virginia
Illinois	Missouri*	Ohio	

** Indicated states do not include individuals who are not blind and who are under the age of 18 in their definition of disability.*

Appendix B: Critical Components for Assisting Homeless SSI/SSDI Applicants

Critical Components	Requirements	Strategies
1. Case managers and/or outreach workers; possibly benefits specialists	<ul style="list-style-type: none"> ▪ Provide sufficient staff to do outreach and engagement and assist applicants ▪ Professional clinical and writing skills are needed for case managers ▪ If benefits specialists assist, ensure they have the skills to assist homeless applicants 	<ul style="list-style-type: none"> ▪ Provide continuing training, locally-based, for case managers assisting applicants ▪ Arrange for local/state capacity to provide training by having trainers attend a <i>Stepping Stones to Recovery</i> Train-the-Trainer program and assign them to continuing training functions, area wide
2. Case manager maintains contact and communication with applicant	<ul style="list-style-type: none"> ▪ Interest in doing outreach ▪ Flexibility and ongoing effort to maintain contact ▪ Clarity on SSI/SSDI process 	<ul style="list-style-type: none"> ▪ Provide housing and other essential services ▪ Provide eligibility assistance to homeless people in hospitals and jails ▪ Provide immediate response to access services so applicants feel heard and understood and contact is maintained
3. Applicant signs for case manager to be his/her representative	Use SSA 1696 Appointment of Representative form	<ul style="list-style-type: none"> ▪ Provide training for case managers on how to engage applicants ▪ Provide assistance to applicants who appoint case manager as their representative; offer others information on how to apply for SSI on their own
4. Staff who assist applicants obtain records of prior treatment	<ul style="list-style-type: none"> ▪ Assign trained staff to work pro-actively with medical records directors ▪ Inform them of information needs ▪ Offer to copy records ▪ Ensure medical providers are aware of what needs to be sent 	<ul style="list-style-type: none"> ▪ Use SSA and agency release for each treatment source ▪ Provide cover letter regarding sending information to SSA ▪ Ensure agency release is HIPAA compliant
5. Assisting agency staff provides/arranges for medical assessment by physician or psychologist	If needed, provide or arrange for physicians or psychologist to conduct assessments, including diagnosis and functioning, for applicants on an outreach basis	Arrange for training of physician or psychologist regarding information needed by DDS
6. Agency reviews application prior to submission	Expert uses protocol to review application for accuracy, completeness and clarity	Expert receives special training regarding review techniques.
7. Agency submits information electronically to DDS	<ul style="list-style-type: none"> ▪ Access by case managers to hardware and software needed to do electronic submissions ▪ Clarity on electronic submission process 	Provide training on the use of SSA's electronic process
8. Agency communicates and	Request that SSA and DDS: <ul style="list-style-type: none"> ▪ Flag cases from assisting agencies 	Request that SSA and DDS: <ul style="list-style-type: none"> ▪ Flag cases from assisting agencies

Replicable Best Practices for CoCs

<p>collaborates with SSA and DDS</p>	<ul style="list-style-type: none"> ▪ Expedite the review ▪ Assign claims representatives to assist and disability examiners who specialize in applications from homeless people ▪ Communicate directly with assisting agencies about their information needs for particular applications ▪ Contact assisting agency if CE needed 	<ul style="list-style-type: none"> ▪ Expedite the review ▪ Assign claims representatives to assist and disability examiners who specialize in applications from homeless people ▪ Communicate directly with assisting agencies about their information needs for particular applications ▪ Contact assisting agency if applicant needs CE
<p>9. Avoid need for Consultative Examinations (CEs)</p>	<ul style="list-style-type: none"> ▪ Provide or arrange for physicians and psychologists (outdoors, if needed) to conduct needed evaluations prior to submitting all documentation to DDS so that CEs are not necessary ▪ Ensure collection of all existing medical and functional information that is relevant to the claim. <p><i>If CE is required:</i></p> <ul style="list-style-type: none"> ▪ Re-examine approach to all components above. ▪ Request that applicant’s treating physician (preferred, according to SSA policy guidelines) be allowed to conduct the exam ▪ Make sure applicant gets to the exam; have representative accompany if possible 	<ul style="list-style-type: none"> ▪ Provide and train the physician or psychologist who will conduct the thorough evaluation SSA needs to determine disability ▪ Prepare for needed diagnostic evaluations by having other clinical staff and case managers assist in collection of historical information ▪ Make least use of most expensive clinicians
<p>10. Need for representative payee must be resolved.</p>	<p>Develop representative payee services in existing or future SSI initiative programs.</p>	<p>Initially, many homeless adults with mental illness need payees. Goal is to become own payee</p>
<p>11. Agency provides integrated employability strategy</p>	<ul style="list-style-type: none"> ▪ Incorporate in case management training strategies for encouraging consideration of and participation in employment at earliest possible time. ▪ Ensure case managers are aware of work incentives under SSI and SSDI <i>using Stepping Stones to Recovery</i> training 	<p>Invite DOL, vocational service providers to be part of SOAR initiative and to assist in helping case managers assist homeless adults in accessing and keeping employment</p>
<p>12. Assessment of results</p>	<p>Track key data elements:</p> <ul style="list-style-type: none"> ▪ Date initial application submitted ▪ Date initial decision rendered ▪ Outcome of initial decision (approved/ denied) ▪ Housing status at time of application (housed/homeless) ▪ Use of Appointment of Representative Form 1696 (Yes/No) 	<ul style="list-style-type: none"> ▪ If SSA and DDS flag cases, they will have these data and can provide periodic reports on outcomes – allowance rates, length of time to decision, etc. ▪ Add data elements to existing HMIS ▪ Adapt/adopt tracking systems used for this purpose by other states (e.g., Ohio, Oregon)
<p>13. Sustaining your effort</p>		<ul style="list-style-type: none"> ▪ Use outcome data to make the case for sustaining or expanding SSI

Replicable Best Practices for CoCs

		<p>outreach</p> <ul style="list-style-type: none">▪ Explore using retroactive Medicaid payments to fund reimbursement for medical evaluations▪ Work with hospitals, State Medicaid and General Assistance offices to recoup money spent on uncompensated care and general assistance benefits; bring them to the table with the explicit understanding that as they benefit, their assistance in continuing or expanding SSI outreach efforts is needed
--	--	--