Introduction

Work Incentives Planning and Assistance (WIPA) is a key component of Social Security’s strategy to promote employment and economic self-sufficiency among disability beneficiaries and reduce dependence on SSI and Title II cash benefits. Over the past 19 years, the National Training and Data Center (NTDC) at Virginia Commonwealth University (VCU) has trained and certified more than 3,000 individuals to provide individualized work incentive counseling services to beneficiaries seeking to pursue their career goals and increase their financial independence. These highly skilled Community Work Incentive Counselors (CWICs) and Community Partner Work Incentive Counselors (CPWICs) have met the needs of more than 800,000 beneficiaries in all 50 states, the District of Columbia, and five U.S. territories. The CWICs and CPWICs assist beneficiaries to make employment and financial decisions, including:

1. Developing immediate and long term financial goals;
2. Understanding the effect of increased earnings on eligibility status and benefit amount of Social Security disability and other federal benefits;
3. Making decisions related to the use of public and private health care coverage options;
4. Obtaining employment services from Employment Networks (ENs), state Vocational Rehabilitation (VR) agencies, or other community organizations;
5. Accessing and benefiting from community resources such as credit repair services, tax preparation assistance, financial education services, and other related supports; and
6. Using Achieving a Better Life Experience (ABLE) accounts, Individual Development Accounts (IDAs), and other savings vehicles to achieve savings and asset acquisition goals.
The CWIC/CPWIC Certification Program

The NTDC provides training and certification to individuals wishing to acquire the knowledge and skills necessary to provide intensive WIPA services to Social Security beneficiaries. The certification process consists of five components:

**Component 1:** Individuals participate in a five-day (32-hour) face-to-face training class. The training class addresses each of the training competencies found in the National Training Curriculum. The NTDC conducts 10-12 Initial Training classes each year.

**Component 2:** Individuals engage in extensive self-study activities to prepare for and complete a series of required certification assessments. Self-study activities include review of the National Training Curriculum, review of other resource documents, and individual or group study calls moderated by NTDC trainers. Data reported by individuals completing the certification process reveal that, on average, they spend approximately 25 hours completing the self-study activities.

**Component 3:** Individuals complete competency-based assessments that address each of the modules of the National Training Curriculum. Individuals complete assessments entirely online using the Blackboard Learn platform. Assessments consist of objective test items, essay responses, and case studies.

**Component 4:** Individuals who complete the first set of assessments are eligible to begin Part II of the assessment process. During Part II, participants submit three Benefit Summary and Analysis reports over a 12-month period for review and evaluation. WIPA CWICs must also complete the Providing Effective Work Incentives Supports on Other Federal Benefits web course. Those who complete these requirements receive full certification.

**Component 5:** Finally, individuals completing the certification process participate in NTDC supplemental training and technical assistance activities. These activities include distance-based training, as well as individual, state, and regional technical assistance. Social Security requires certified WIPA CWICs and CPWICs to participate in ongoing NTDC training opportunities and accrue 18 Continuing Certification Credits (CCCs) annually to keep their certification.
The Structure of the National Training Curriculum

The National Training Curriculum is the foundation of all NTDC training and certification activities. We base the training activities and content in the curriculum on a comprehensive set of competencies that individuals must acquire to be certified to provide work incentives planning and assistance services to Social Security beneficiaries. We have grouped the Social Security-approved competencies into seven distinct competency areas. We identify and briefly describe these training modules below.

Major Work Incentives Counseling Competency Areas

1. Supporting Increased Employment and Financial Independence Outcomes for Social Security Disability Beneficiaries
2. Partnering with Community Agencies and Conducting Community Outreach
3. Understanding Social Security Disability Benefits and Associated Work Incentives
4. Healthcare Planning and Counseling
5. Understanding Other Federal Benefits and Associated Work Incentives
6. Providing Effective WIPA Services
7. WIPA Standards and Quality Considerations for CWICs

Major Competency Areas

Competency Area 1: Supporting Increased Employment and Financial Independence Outcomes for Social Security Disability Beneficiaries

Module 1 opens with a detailed description of WIPA services and the CWIC’s role in promoting employment and financial independence for Social Security beneficiaries. This module also provides an overview of Social Security’s recent efforts to promote employment and increase financial independence for disability beneficiaries, including the Ticket to Work and Self-Sufficiency Program (TtW), Social Security/VR Reimbursement program, WIPA program, and Protection and Advocacy
for Beneficiaries of Social Security (PABSS) program. This module addresses eligibility criteria, referral procedures, and services available from various entities such as state VR agencies, American Job Centers administered by state Workforce agencies, and other employment programs or key stakeholders in the disability services system.

**Competency Area 2: Partnering with Community Agencies and Conducting Community Outreach**

Module 2 focuses on providing effective outreach to Social Security beneficiaries as well as outreach activities directed toward community agencies, stakeholder groups, and partner agencies. Module 2 also describes how WIPA projects work collaboratively with the Ticket Program Manager (TPM) and the TtW Help Line to conduct outreach to Social Security disability beneficiaries who are eligible for the TtW program. Finally, the module addresses strategies CWICs can use to work collaboratively with other public and private community-based organizations such as Social Security field offices, Employment Networks (ENs), American Job Centers, state VR agencies, public schools, mental health organizations, and Individual Development Account (IDA) or asset-building organizations.

**Competency Area 3: Understanding Social Security Disability Benefits and Associated Work Incentives**

Module 3 presents detailed information on the Title II and SSI disability programs and work incentives, including how wage employment affects eligibility for benefits, cash payment amounts, and Medicare and Medicaid coverage; the impact of earned income on SSI and Title II disability benefits for concurrent beneficiaries; and the effect of Net Earnings from Self-Employment (NESE) on SSI and Title II cash payments. This module also provides technical information about all the relevant Social Security work incentives such as Plans to Achieve Self-Support (PASS), Student Earned Income Exclusion (SEIE), Blind Work Expenses (BWE), Trial Work period (TWP), Extended Period of Eligibility (EPE), Subsidy & Special Conditions, Impairment Related Work Expenses (IRWE), and Expedited Reinstatement (EXR). Finally, Module 3 offers a comprehensive description of the TtW program, including Ticket eligibility, assignment and unassignment procedures, reporting requirements, timely progress requirements, and making referrals to ENs and state VR agencies.
Competency Area 4: Healthcare Planning and Counseling

Module 4 provides detailed information on the availability of and eligibility for the Medicaid program, including optional Medicaid groups, Medicaid Buy-in programs, Medicaid waiver programs, Medicare Savings Programs, and Special Medicaid Beneficiaries. This module also covers eligibility for and the operations of the federal Medicare program, availability of alternate health insurance coverage options (employer-sponsored health plans and private plans for self-employed individuals), and federal legislation protecting the healthcare rights of persons with disabilities. Finally, Module 4 covers key provisions of TRICARE and the Department of Veterans Affairs (VA) healthcare programs for veterans and how these programs interact with Medicare and Medicaid, as well as key components of the Affordable Care Act (ACA) applicable to Social Security disability beneficiaries and their families.

Competency Area 5: Understanding Other Federal Benefits and Associated Work Incentives

Module 5 provides information on federal benefits programs and their associated work incentives, including Temporary Assistance to Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), Housing and Urban Development (HUD) subsidies, Workers’ Compensation, Unemployment Insurance (UI) benefits, veterans’ benefits, and IDAs. This module also describes the interaction of these programs with Social Security disability benefits.

Competency Area 6: Providing Effective WIPA Services

Module 6 addresses the practical application of public benefits and work incentives knowledge. It describes procedures for identifying eligible beneficiaries for the WIPA program and prioritizing initial contacts, conducting initial information gathering interviews, providing Information and Referral (I&R) services, developing written Benefits Summary & Analysis (BS&A) documents preparing written Work Incentives Plans (WIPs), and facilitating the use of necessary and appropriate work incentives. This module also discusses specific strategies for effective time management in the provision of WIPA services.

Competency Area 7: WIPA Standards and Quality Considerations for CWICs

Module 7 describes the minimum compliance requirements for WIPA projects as stated in the WIPA Cooperative Agreement Terms and
Conditions. It also includes a unit that identifies specific indicators of high-quality WIPA services and addresses the CWIC’s role in achieving these goals. Finally, the module provides information on delivering WIPA services that adhere to the highest ethical standards, fully comply with the Americans with Disabilities Act and the Rehabilitation Act, and accommodate linguistic and cultural differences.

The National Training and Data Center at Virginia Commonwealth University

The NTDC at VCU is a collaborative effort of several partnering agencies responsible for implementing a comprehensive program of training, certification, technical assistance, and ongoing professional development to individuals providing intensive work incentive counseling services to Social Security beneficiaries.

Susan O’Mara, the NTDC’s Director and Co-Principal Investigator, leads our team of trainers, technical assistance liaisons, technology and accessibility specialists, and administrative professionals. We identify these team members below.

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The production of a curriculum this size is a challenging task that requires a large number of people with a variety of skills. Lucy Miller serves as the primary author and coordinates the annual update of the curriculum content, and Julie Schall organizes and manages the final production process. As the manual has grown over the years, so has their patience with our many authors and their dedication to accuracy and ease of use.

Susan O’Mara

January 2020
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**Competency Unit 3 –Understanding the Disability Services System: Key Stakeholder Agencies that Fund or Provide Vocational/ Employment Services for Persons with Disabilities**

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Module 1 – Supporting Increased Employment and Financial Independence Outcomes for Social Security Disability Beneficiaries

Introduction

The primary objective of WIPA services is to assist Social Security beneficiaries with the transition from dependence on public benefits to paid employment and greater financial independence. To actively promote employment outcomes, CWICs must have a solid understanding of Social Security’s Ticket to Work program and various other work incentives, as well as the full array of vocational services available to individuals with disabilities. While you must be able to help beneficiaries understand the potential effect of certain employment outcomes on their benefits, you must also be proficient at connecting beneficiaries with the specific services and supports they need to obtain and maintain paid employment.

The content in this module begins by discussing the CWIC’s role in promoting employment and increased financial stability for Social Security beneficiaries with disabilities and in establishing functional collaborative partnerships with the community. In the second unit, we provide an overview of Social Security’s efforts to promote employment and increase financial independence for disability beneficiaries. The content in Unit 3 focuses on services available from various entities such as:

- State Vocational Rehabilitation Agencies (SVRA);
- Employment Networks (ENs) under the Ticket to Work program;
- State of local Workforce Investment Boards (WIB) and American Job Centers (AJCs);
- State local Intellectual/Developmental Disability (ID/DD) agencies;
- State local mental health, chemical dependency, or substance abuse agencies;
• Centers for Independent Living (CILs);
• State Protection and Advocacy (P&A) agencies;
• Public school systems;
• U.S. Department of Veteran’s Affairs (VA); and
• Agencies administering Individual Development Accounts (IDAs) or Asset Development Services.

**CWIC Core Competencies**

- Describes recent governmental efforts to increase community-based paid employment outcomes for people with even the most significant disabilities and current best practices in employment services and supports for persons with disabilities.

- Demonstrates knowledge of current Social Security efforts to promote employment and increase financial independence for disability beneficiaries, including the Ticket to Work and Self-Sufficiency Program, Social Security/Vocational Rehabilitation Reimbursement program, Work Incentives Planning and Assistance (WIPA) program, Protection and Advocacy for Beneficiaries of Social Security (PABSS) program, and demonstration projects sponsored by Social Security or other federal agencies operating in the service area.

- Describes to beneficiaries their rights and opportunities under Sections 503 and 504 of the Rehabilitation Act, the Americans with Disabilities Act (ADA), federal Schedule A employment, and other programs that provide protections to job seekers and employees with disabilities.

- Demonstrates knowledge of state VR agencies, American Job Centers, and other public or private programs that fund or provide employment services for Social Security disability beneficiaries, including the local employment services and supports available to assist Social Security beneficiaries in choosing, planning, securing, and maintaining employment over time.
Understanding the Problem – The Relationship between Poverty and Disability

Unfortunately, in the United States, poverty and disability go hand in hand. A number of recent studies have uncovered the following disturbing statistics:

- In the United States in 2017, the poverty rate of working-age people with disabilities was 26.1 percent (http://www.disabilitystatistics.org/reports/acs.cfm?statistic=7).
- Almost half of working-age adults who experience income poverty for at least a 12-month period have one or more disabilities.
- Nearly two-thirds of working-age adults who experience consistent income poverty — more than 36 months of income poverty during a 48-month period — have one or more disabilities.
- People with disabilities are also much more likely to experience material hardships — such as food insecurity; inability to pay rent, mortgage, and utilities; or not being able to get needed medical care — than people without disabilities at the same income levels. The same goes for families caring for a child with a disability.
- In addition to income poverty, individuals with disabilities are also nearly twice as likely to lack even modest precautionary savings in case of an unexpected expense or other financial shock. Seventy percent of individuals with disabilities responded
that they “certainly” or “probably” couldn’t come up with $2,000 to meet an unexpected expense, compared to 37 percent of individuals without disabilities. More than 50 percent of individuals with disabilities are “unbanked” with no access to financial services such as checking, savings, credit, and other opportunities. (See Disability Is a Cause and Consequence of Poverty at http://talkpoverty.org/2014/09/19/disability-cause-consequence-poverty/)

When we restrict our analysis to beneficiaries of the Social Security disability programs, the relationship of poverty and disability becomes even more distressing. Consider these facts:

- Approximately six million beneficiaries, more than 70 percent of Supplemental Security Income (SSI) beneficiaries, and 30 percent of Social Security Disability (SSDI) beneficiaries, are currently living below the federal poverty level.
- The average SSI benefit of $551 per month (September 2019) is only 52.9 percent of the 2019 federal poverty level for a family of one. The maximum federal SSI payment of $771 (in 2019) is 74 percent of the 2019 federal poverty limit for a family of one.
- The average SSDI monthly benefit of $1,236 (September 2019) is only 118 percent of the 2019 federal poverty level for a family of one.

Social Security’s Monthly Statistical Snapshot for September 2019 found online (https://www.ssa.gov/policy/docs/quickfacts/stat_snapshot/).


A major cause of poverty and material hardship among Social Security disability beneficiaries continues to be the low rates of employment within the population. A study conducted by Social Security in 2015 using 2011 data found that a relatively low percentage of disability program beneficiaries in current-pay status in December 2010 worked in calendar year 2011: 11.4 percent of SSDI-only beneficiaries, 5.4 percent of SSI-only recipients, and 6.9 percent of concurrent beneficiaries (individuals who receive both SSDI and SSI) were employed (defined as earning
$1,000 or more in the year). In addition, the study found that among beneficiaries who were employed in 2011, about three-quarters of SSDI-only and SSI-only beneficiaries and about eight-in-nine concurrent beneficiaries earned less than $10,000 in the year. Only a small fraction of beneficiaries earned more than the annualized Substantial Gainful Activity (SGA) level got that year ($12,000 in 2011). Only 2.2 percent of the SSDI-only beneficiaries had earnings above that level in 2011, as did 0.8 percent of SSI-only recipients and 0.5 percent of concurrent beneficiaries. This level of earnings remains below the federal poverty guidelines and does little to move beneficiaries toward financial stability.  

(employment, earnings, and primary impairments among beneficiaries of social security disability programs, 2015 found online at https://www.ssa.gov/policy/docs/ssb/v75n2/v75n2p19.html).

breaking the connection between poverty and disability – work incentives planning and assistance as part of the solution

Given the dismal statistics cited above, we still have a great deal of work to do to help Americans with disabilities avoid lives of poverty and hardship. The Work Incentives Planning and Assistance (WIPA) program is an important part of our national effort to break the connection between poverty and disability as it seeks to promote employment among Social Security disability beneficiaries. However, it’s important to understand that the WIPA program has a more comprehensive mission than simply helping disability beneficiaries get jobs. The larger goal of this national initiative is to enhance the long-term financial stability and independence of those the program serves. The program can only achieve this when beneficiaries work at their highest employment potential and reap the greatest financial rewards possible from working. Employment is an important means to this end — not the end in and of itself.

Important: Social Security describes the mission of the national WIPA program as promoting employment and increasing financial stability among Social Security disability beneficiaries. The specific goals of the service are to:
• Increase the number of Social Security disability beneficiaries who engage in paid employment or self-employment;

• Support beneficiaries in successfully maintaining employment (or self-employment) over time;

• Provide accurate and timely work incentives planning and assistance services that enable beneficiaries to increase their earnings capacity over time and maximize the financial benefit of working;

• Reduce beneficiary dependence on Social Security disability benefits and other income support programs; and

• Increase the financial independence and stability of beneficiaries through self-sustaining employment, asset development, and improved management of fiscal resources.

The Financial Stability Paradigm for Delivering WIPA Services

Achieving financial stability is the ultimate goal of WIPA services and drives all of the work that WIPA project personnel perform. In the context of WIPA services, financial stability means:

• Having earnings sufficient to avoid lifelong poverty, and reduce or eliminate dependence on Social Security disability benefits and other income support programs;

• Being able to meet basic expenses, including paying rent or mortgage, paying utility bills, obtaining food and nutrition, and meeting health care needs;

• Earning income sufficient to live independently and pursue a chosen lifestyle, including social, recreational, educational, or other activities;

• Obtaining and maintaining employment that meets the individual’s economic and personal goals, provides employer-sponsored fringe benefits, and offers opportunities for long-term security or advancement;
• Having the ability to manage one’s own finances, access bank and credit services, reduce or eliminate debt, save for the future, and access the information and support necessary to make sound financial decisions and long-term financial plans; and

• Managing one’s own Social Security benefits or other federal and state benefits, including monitoring the use of work incentives and reporting earnings to benefit programs.

A beneficiary seeking WIPA services may have never had the opportunity to explore what financial stability means, given his or her unique life circumstances and family situation. For some beneficiaries, the concept of financial stability may seem completely unrealistic, unattainable, or overwhelming. By engaging in discussions about financial independence, WIPA personnel (known as Community Work Incentives Coordinators or CWICs) provide beneficiaries with new knowledge and choices they never knew they had. WIPA counseling can present beneficiaries with an entirely new vision of economic independence with employment as the primary vehicle for achieving that vision.

What are WIPA Services?

While the mission of the WIPA program is to promote employment and enhance financial stability, the primary function of WIPA services is to provide beneficiaries with accurate and complete information about work incentives programs designed to support their efforts to obtain, retain, or enhance employment. WIPA services involve the following distinct components:

**Outreach:** Outreach is the process of marketing WIPA services to beneficiaries, local agencies, and other stakeholders. Outreach activity includes, but isn’t limited to, describing WIPA services prominently on the organization’s website; engaging in dialogue with local and state service providers to increase WIPA referrals; and meeting with diverse audiences to describe WIPA services. Social Security directs WIPA projects to target outreach efforts to reach underserved populations such as transition-aged youth, veterans, Native Americans, and other racial, ethnic, disability, and socioeconomically disadvantaged or minority populations. Social Security requires WIPA projects to limit time spent on outreach activity to no more than 10 percent of their total funding or work effort on outreach.
Detailed information about outreach in the WIPA program is contained in Module 2, Unit 1.

**Screening Requests for Services to Establish Eligibility and Priority for WIPA Services:** Social Security expects WIPA projects to provide the bulk of services to eligible, high-priority beneficiaries. This includes individuals who are employed (or engaged in self-employment), actively seeking employment, or otherwise preparing for employment. Not everyone who contacts a WIPA provider will meet the program eligibility criteria, nor will the WIPA provider consider him or her a high priority for individualized services. Because of this, WIPA projects need to establish methods for screening initial contacts and conducting triage.

**Providing Information and Referral (I&R) Services:** CWICs work with each beneficiary to determine his or her need and then provide the specific information and/or necessary service referrals to meet those needs. I&R services involve explaining how various complex systems work and providing support to successfully navigate those systems. This applies to the Social Security disability benefits, public and private health care, and the employment services system, as well as a large number of other income support and community service programs (housing, transportation, advocacy, financial services, etc.). In the WIPA program, some beneficiary’s situations do not meet the definition of high priority for individualized work incentives counseling. These beneficiaries will usually receive short term I&R services; typically delivered in one or two phone or email contacts. Beneficiaries requiring individualized WIPA services receive ongoing I&R services as part of their customized work incentives analysis and advisement. Unit 2 of Module 6 provides detailed information about providing I&R within the WIPA program.

**Information Gathering and Benefits Verification:** All Community Work Incentives Coordinators (CWIC) providing individualized WIPA services must gather a comprehensive set of information from the beneficiary before analysis and counseling begin. This information includes contact information, basic demographics, benefits received, future plans or goals with regard to employment, past work since entitlement, and a variety of other data based on the unique needs and circumstances of the individual. WIPA projects must complete a thorough benefits verification process to ensure that all information is correct, complete, and current. CWICs use this information to provide customized
benefits analysis and work incentives counseling. Detailed information about this function is available in Module 6, Unit 3.

**Providing Individualized Work Incentives Planning and Assistance:** This is the cornerstone of WIPA services and includes the following services:

- In-depth personalized benefits analysis covering all federal, state, and local benefits;
- Customized counseling about the effect of work on all federal, state, and local benefits and development of a comprehensive Benefits Summary & Analysis (BS&A) report;
- Assistance with identifying, developing, utilizing, and managing work incentives;
- Assistance with resolving problems related to benefits;
- Assistance with identifying and resolving barriers to obtaining or maintaining employment;
- Making referrals for needed services or supports with particular emphasis on meeting employment needs;
- Coordination with members of the beneficiary’s employment support team; and
- Training and support on effective reporting procedures and benefits management techniques;

We provide detailed information about individualized WIPA services in Module 6, Units 4 and 5.

**Ongoing Proactive Follow-Up Services:** Many beneficiaries require ongoing contact from WIPA personnel to avoid or resolve benefits problems over time. In the WIPA program, ongoing follow-up is the act of implementing, or facilitating the implementation of, the Work Incentives Plan (WIP). The action steps included in the WIP determine the type, intensity, and duration of follow-up services. Each beneficiary’s plan is unique and details the exact supports WIPA personnel will provide and the timeline for contacts. Action steps detailed in the WIP may involve intense assistance for a short period of time or lower levels of support spread out over months or years. Some beneficiaries may require long-term work incentives management on a scheduled,
continuous basis, allowing for the planning and providing supports at regular checkpoints, as well as critical transition points. Unit 5 of Module 6 provides a detailed discussion of WIPA follow-up services.

**Important Themes within the WIPA Program**

Social Security designed the WIPA program on a set of three core concepts or themes. These three concepts undergird the entire WIPA initiative and drive the services provided to Social Security disability beneficiaries.

1. **WIPA is all about WORK!**

   The clear purpose of the WIPA program is to provide the specific work incentives planning and assistance services that will directly assist Social Security disability beneficiaries to succeed in their return-to-work efforts. This program requires CWICs to provide a base level of informational support to all eligible beneficiaries contacting the program and to take significant steps to make sure that individuals with all types of disabilities, from every type of diverse ethnic background, and from varying age groups and geographic locations are able to access and benefit from the WIPA program. The goal is to ensure that beneficiaries who desire to seek, secure, or maintain employment have access to accurate and complete information that will allow them to benefit from all the current work incentives available in the Social Security disability programs, as well as other federal, state, or local programs that may assist them in their employment efforts. Being a passive dispenser of work incentives information isn’t sufficient to get the job done. CWICs must put information into action by providing direct assistance with applying work incentives and resolving issues related to benefits that create a barrier to employment.

   The WIPA program places great emphasis on the analysis of available work incentives. Assisting beneficiaries in accessing these work incentives will aid in the overall employment plan and support him or her in reaching their work goal. CWICs emphasize employment through the use of work incentives, and play a direct and active role in assisting beneficiaries to develop, monitor, and manage their work incentives effectively over time.

   For CWICs, there is more to actively promoting employment outcomes than merely assisting beneficiaries with work incentives. To truly be
effective in supporting beneficiaries in their efforts to attain paid work, CWICs must expand their counseling skills into areas not directly related to public benefits. These areas include the following:

- Helping beneficiaries determine what specific services and supports they may need to identify, select, or clarify their career goals;
- Helping beneficiaries determine what specific services, supports, or accommodations they may need to achieve the desired career goal;
- Explaining Social Security’s Ticket to Work program and the full array of vocational services and supports available to individuals with disabilities in the local service area;
- Connecting beneficiaries with the specific services and supports they need to obtain and maintain paid employment; and
- Assisting beneficiaries with disabilities to resolve problems related to work efforts, higher education, occupational skills training, and work attainment or continuation of work.

We provide detailed information about how WIPA personnel work with beneficiaries to promote employment in Unit 3 of Module 6.

2. **WIPA Services are Based on Collaborative Partnerships**

Social Security has designed WIPA services as a critical component of the agency’s comprehensive approach to assisting beneficiaries to achieve their employment and financial independence goals. In the WIPA service paradigm, CWICs are an essential partner on the employment service team. They play an active and direct role in supporting the long-term employment process. This includes providing information, guidance, and direct assistance in the vocational planning process and job development effort as well as in planning for and leveraging resources to meet the employment support needs of beneficiaries.

In particular, the WIPA program requires CWICs to be directly involved in the implementation of Social Security’s Ticket to Work program. Social Security requires CWICs to screen and refer beneficiaries with disabilities to appropriate Employment Networks (ENs) based on the beneficiary’s expressed needs and types of impairments. As a result of this
requirement, CWICs must have a comprehensive knowledge of the current employment service system for youth and adults with disabilities, and knowledge of the vocational assessment and planning process local employment agencies use, and be fully aware of the referral, eligibility, program planning, and service delivery approaches employment service agencies in their local community use.

CWICs must also understand that Social Security is an essential partner in the providing WIPA services. It’s impossible for CWICs to provide effective work incentives planning and assistance services without interacting with local Social Security offices and personnel. For WIPA projects to work collaboratively with Social Security, WIPA personnel need a general understanding of how this agency functions and what the various players do. The most effective CWICs maintain close relationships with their local Social Security offices, regional PASS (Plan to Achieve Self-Support) Cadres, and the Area Work Incentive Coordinator (AWIC). Locally, CWICs can establish important working relationships for reporting protocols with Claims Representatives and Work Incentive Liaisons (WILs). We provide specific information on how CWICs should work with these Social Security employees to help support beneficiaries in achieving their employment goals in Module 2.

Social Security also requires WIPA projects to develop collaborative working relationships with other community agencies and make referrals to community agencies for employment services. The program recognizes that to truly support the work efforts of beneficiaries, these services must integrate with other employment services and support services available to the beneficiary in the local community. Developing, managing, and maintaining effective collaborations with multiple organizations providing employment and employment support services are essential to the success of the national WIPA initiative. Critical employment support partner agencies for the WIPA projects include state VR agencies, American Job Centers (AJCs), ENs, state education agencies and local public school systems, mental health providers, and other community rehabilitation service agencies.

CWICs assume an important role in helping beneficiaries plan for employment and access the services and supports needed to make employment possible. This emphasis on return to work and employment outcomes requires that CWICs not only understand in great detail the array of employment services and resources in the community but that
they effectively partner and maintain strong working relationships with these agencies over time to support the work goals of beneficiaries.

To build strong working partnerships with local agencies providing services and supports, CWICs should focus on:

- Communicating directly with multiple agencies or organizations to build a more comprehensive understanding of their missions, eligibility rules, policies and procedures, and the services or supports they provide;
- Educating the employment service or support community on the purpose and role of WIPA in directly supporting the return-to-work and employment efforts of beneficiaries;
- Identifying, developing, and implementing formalized strategies and processes for joint employment and work incentive or support planning for beneficiaries;
- Implementing strategies to build general knowledge of the use of available work incentives to provide access to an array of employment services and supports, and incorporate these incentives into existing vocational planning, job development, and employment support efforts; and
- Maintaining and enhancing collaborative work with agencies or organizations by continuously assessing the effectiveness and quality of outcomes for beneficiaries.

3. **WIPA Services are Ongoing**

Social Security intends WIPA services to be proactive and expects CWICs to follow up with beneficiaries as needed throughout the entire process of preparing for employment, obtaining employment, and maintaining employment. CWICs not only provide initial planning and counseling services, but monitor and actively work with beneficiaries at key employment and work incentives transition points to ensure that they update information, analyses, employment, and work incentive plans to meet the changing needs and goals of each beneficiary.

The long-term nature of WIPA services creates many expectations for CWICs. This “case management” approach to service delivery anticipates that they will develop a defined caseload of beneficiaries for whom they will provide individualized, intensive, on-going services that will include:

- Individualized benefits analysis and counseling;
• Identification of relevant work incentives that will promote employment goals;
• Assistance in the development of a comprehensive Work Incentives Plan;
• Identification of employment supports or resources;
• Referral to appropriate employment support services; and
• Continuous updating of the Work Incentives Plan as an individual’s benefits, health care, and financial status change over time.

Because WIPA services target beneficiaries who are employed or progressing toward employment, CWICs need to proactively monitor the beneficiaries’ use of work incentives over time. This includes developing “contact systems” that will help beneficiaries detect potential problems before they occur. In addition, CWICs assist beneficiaries to obtain work supports from other agencies including preparing documentation or making phone calls in conjunction with the beneficiary to agencies such as the Public Housing Authority, Medicaid, or Vocational Rehabilitation.

Conclusion

The most important thing for CWICs to remember as they perform their jobs is that WIPA is all about WORK! When counseling beneficiaries, promoting employment and enhancing financial stability must stay solidly front and center. Supporting employment is the guiding principle that directs all their actions.

The determination, knowledge, experience, and focus of CWICs will be a deciding factor in the battle to enhance employment outcomes for persons with disabilities.

Conducting Independent Research

2015 WIPA Request for Application and other supporting materials
Information about WIPA services on Social Security’s website
(https://www.ssa.gov/work/WIPA.html)
Competency Unit 2 – Past and Current Social Security Efforts to Promote Employment for Disability Beneficiaries

Statement of the Problem – Growth of the Social Security Disability Programs

Supplemental Security Income (SSI) and the Social Security Disability programs authorized under Title II of the Social Security Act (SSDI, CDB, and DWB) are currently the largest federal programs providing cash payments to people with disabilities. In December 2016, more than 9.9 million people received Social Security benefits based on disability, and more than 4.8 million adults ages 18-64 received SSI due to blindness or disability. An additional 1.5 million people received both Social Security and SSI due to disability. This represents more than 15 million people across all programs (Social Security Annual Statistical Supplement 2017 found online https://www.ssa.gov/policy/docs/statcomps/supplement/index.html).

The steady growth pattern of the DI and SSI rolls seen over the past decade isn’t a new phenomenon. As early as 1994, the General Accountability Office (GAO) was investigating the growth in Social Security’s disability programs. In a study released in February 1994, the GAO reported that in the three years between 1989 and 1992, DI applications rose by a third, and almost half the applicants in 1992 succeeded in obtaining benefits. The GAO also found that once on the rolls, beneficiaries were staying longer. Between 1985 and 1992, the number of beneficiaries who had been on the rolls more than 15 years grew by an alarming 93 percent. In addition, while the total number of DI terminations continues to increase as the rolls swell, termination rates as a percentage of those on the rolls have steadily declined.

Terminations from the DI program averaged approximately 12 percent during the 1988-89 time period, but stood at only 9.5 percent by 1994. Social Security research concluded that termination rates were declining
for three main reasons: First, the younger average age of beneficiaries over the last 10 to 15 years has led to a lower number of conversions to retirement and terminations due to death. Secondly, the decline in the number and rate of medical continuing disability reviews (CDRs) has been a significant problem (Social Security Bulletin, 996). Finally, terminations from the disability programs due to employment are almost non-existent. Social Security statistics cited in a 2003 GAO report estimate that less than one of every 500 DI beneficiaries has left the rolls by returning to work.

Social Security and disability policy makers across the country are concerned about the expansion of the disability programs and the poor employment rates of adults with disabilities. Too often, society has perceived this alarming growth of the Social Security disability rolls as Social Security’s problem to solve in isolation, when in fact it’s a larger societal problem with myriad complex causes. Many people with disabilities receive Social Security disability benefits as merely the last stop on a long journey from the point of disability onset to the point at which their disability is so severe that self-sustaining work is no longer possible. All along this journey, beneficiaries encounter the policies and practices of the other systems involved in disability and employment issues. When these systems fail to stem a person’s movement onto the disability roles, or work at cross purposes with one another to prevent successful employment retention or return to work, the Social Security disability system bears the eventual brunt of this failure. Ultimately, however, all U.S. citizens bear the costs associated with having so many Americans leaving the productive workforce to lead lives of dependency on federal disability benefits.

Any meaningful effort to slow down or reverse this long-term increase in federal disability benefits will require significant and sustained collaboration and coordination between the Social Security Administration and the other federal agencies with a stake in developing disability and employment policy. Over the past two decades, Social Security has made a concerted effort to promote employment for disability beneficiaries by improving its own internal policies and practices as well as by partnering with other federal agencies. This unit will provide an overview of these efforts within the following areas:

- Public Healthcare Systems
- Vocational Rehabilitation System
• National Employment and Training System
• Public Education Systems
• Internal Changes Social Security has Made to Promote Employment

Collaborative Efforts Involving Public Health Care Systems

One of the most commonly cited reasons Social Security disability beneficiaries offer for not engaging in work activity is the perceived risk of losing health care benefits. For individuals with disabilities who may have significant health care needs or high costs, the thought of losing health care coverage can be particularly frightening. Health insurance considerations are also of paramount importance when beneficiaries make decisions about continuing to work versus applying for disability benefits. The desperate search for affordable health insurance fuels the increased SSI/DI application rates as it simultaneously diminishes the rates of termination due to employment. Social Security is well aware that health care concerns may represent the single most salient factor contributing to increasing rates of dependency on federal disability benefits and depressed rates of competitive employment for individuals with disabilities. For Social Security to make progress in promoting employment for beneficiaries with disabilities, it must partner with the public health care systems of Medicaid and Medicare to decrease employment disincentives. Some of the collaborative efforts Social Security has been involved with to date in this regard are described in the following sections.

Medicaid Initiatives

Over the past 25 years, Social Security has made a significant effort to reduce the employment disincentives related to loss of Medicaid coverage. In 1987, Social Security, in collaboration with the Centers for Medicare and Medicaid Services (CMS), implemented the 1619(b) extended Medicaid coverage for SSI recipients who work. This provision provides continued Medicaid coverage for individuals whose incomes are too high to qualify for an SSI cash payment, but aren’t high enough to offset the loss of Medicaid or publicly funded attendant care. It allows Social Security to disregard earned income when determining Medicaid
eligibility up to the state’s designated threshold amount. This one provision is arguably the most powerful work incentive in the SSI program.

Social Security has also worked in close partnership with CMS to expand Medicaid Buy-in programs for individuals with disabilities who work. The Ticket to Work and Work Incentives Improvement Act of 1999 (legislation L.106-170) included two key provisions designed to expand authority originally granted to states under the 1997 Balanced Budget Act (BBA) to provide Medicaid coverage to working people with disabilities. The first of these is the Medicaid Buy-in program. Both the BBA and the Ticket legislation authorized states to require beneficiaries to pay small premiums for this coverage. The various programs target individuals who otherwise wouldn’t qualify for Medicaid coverage because their earnings or personal assets exceed established thresholds. Under the Ticket legislation, states have considerable flexibility in terms of establishing resource and income limits for working individuals with disabilities between the ages of 16-64. In addition, states can make the Medicaid Buy-in program available to individuals who may no longer meet Social Security medical criteria for disability.

In addition to the Medicaid Buy-in program, Section 203 of the Ticket legislation created a grant program through the Department of Health and Human Services (DHHS) that would encourage and support states in the development of a buy-in program. These grants, termed Medicaid Infrastructure Grants (MIG), permitted states considerable freedom to address a variety of work incentive issues in their state systems. State eligibility for MIG grants was based to a large extent on the state’s willingness to provide personal assistance services to employed individuals with disabilities. Funding for the Medicaid Infrastructure Grants ended in 2012.

**Medicare Initiatives**

Once again, Social Security has actively engaged CMS in developing solutions to the problem of beneficiaries fearing the loss of Medicare coverage due to paid employment. With the passage of the Ticket legislation in 1999, Congress expanded the Extended Period of Medicare Coverage (EPMC). This covers beneficiaries who still have a disability and lose cash benefits due to work. For these beneficiaries, free Medicare Part A continues for a minimum of 93 months after the end of the Trial
Work Period (TWP). In many instances, Medicare coverage may extend well beyond 93 months.

In addition, Social Security and CMS worked to create help for beneficiaries who buy into Medicare called Qualified Disabled and Working Individuals (QDWI). This provision allows eligible individuals to get help with purchasing Medicare Part A if they lost premium free Medicare benefits due to return to work at a substantial level. To be eligible for QDWI, an individual must have countable income below 200% of the Federal Poverty Level (FPL) and countable resources that do not exceed twice the current SSI resource limit. Eligibility for Medicaid benefits under the QDWI program is limited to payment of Medicare Part A premiums. Unit 2 of Module 4 provides more information about all of these important Medicare provisions.

Collaborative Efforts Involving the Vocational Rehabilitation System

The Social Security Administration has a long history of collaboration with the State Vocational Rehabilitation Agencies (SVRAs). Since 1981, Social Security has reimbursed SVRAs for services they provide to Social Security beneficiaries that result in specified employment outcomes. Social Security designed the Social Security VR Reimbursement Program to replace an earlier block grant program and improve outcomes and accountability. Under the VR Reimbursement program (prior to implementation of the Ticket to Work program), the State Disability Determination Service (DDS) applied a set of criteria to individuals awarded SSI or Title II disability benefits. DDS agencies subsequently referred individuals who appeared to be possible candidates for vocational rehabilitation (VR) to the state rehabilitation agency (SVRA). Social Security required beneficiaries selected for referral to the SVRA to participate in the VR program or risk benefit suspension. The program also allowed beneficiaries to apply for VR services on their own. The Ticket legislation repealed Social Security’s authority to refer disability beneficiaries to SVRAs or alternate providers for VR services in Ticket states. This legislation also removed all sanctions for beneficiaries who refused VR services.
The Ticket to Work and the VR System

The passage of the Ticket to Work and Work Incentives Improvement Act of 1999 significantly changed the relationship between Social Security and the SVRAs. The purpose of the Ticket to Work program is to provide eligible beneficiaries with greater choice and control of the employment support services they need to assist them in obtaining employment or returning to work. Under the Ticket program, eligible beneficiaries may receive services from either an approved Employment Network (EN) or from the Vocational Rehabilitation (VR) agency. When a beneficiary assigns a Ticket, he or she works with the EN to develop an Individual Work Plan (IWP) or an Individualized Plan for Employment (IPE) with the SVRA. The IWP/IPE identifies the beneficiary’s employment goals as well as the employment services and supports that the beneficiary will receive to achieve his or her employment goal. The SVRA may choose payment under the traditional cost reimbursement payment method or be paid by Social Security as an EN. For detailed information about the Ticket to Work Program, refer to Unit 10 of Module 3 in this manual.

The Substantial Gainful Activity (SGA) Project

The Substantial Gainful Activity (SGA) Project was a national project that attempted to build the capacity of the public Vocational Rehabilitation (VR) program to improve employment outcomes for individuals with disabilities receiving SSDI benefits. In 2014, the Institute for Community Inclusion (ICI) at the University of Massachusetts Boston, and its partner Mathematica Policy Research, Inc. received a five-year grant from the U.S. Department of Education, Rehabilitation Service Administration to study, test, and disseminate effective state VR agency practices for assisting VR customers collecting Social Security Disability Insurance (SSDI) to return to work at or above Substantial Gainful Activity (SGA) levels. The SGA Project generated a rigorously tested employment service-delivery model, manuals and processes for implementation, and adoption strategies, as well as cost analyses. The SGA project operated in Kentucky and Minnesota and ended in September 2017.

The project included four phases:

1. The identification of high-performing state VR agencies, leading to in-depth case studies of their practices;

2. The use of a Delphi Panel to review candidate practices and to design a VR employment services model that
enables SSDI recipients to return to employment at or above SGA;

3. Implementation, testing, and evaluation of the model in selected state VR agencies that will receive substantive training and technical assistance; and

4. Dissemination and replication, including the development of training materials, curricula, procedures, and on-demand technical assistance initiatives.

While Social Security didn’t provide funds for the SGA Project, the agency is highly supportive of the U.S. Department of Education, Rehabilitation Service Administration in this important research effort. Evaluation reports for the SGA Projects in Kentucky and Minnesota are available at Mathematica’s website (https://www.mathematica-mpr.com/our-publications-and-findings/projects/substantial-gainful-activity-sga-project-demonstration).

Collaborative Efforts Involving the State Protection and Advocacy Agencies – PABSS

In addition to the national WIPA program, the Ticket legislation also created a program called Protection & Advocacy for Beneficiaries of Social Security (PABSS). Beginning in 2000, Social Security awarded 57 grants to the designated Protection and Advocacy (P&A) systems in each of the 50 states, the District of Columbia, the U.S. Territories of American Samoa, Guam, Northern Mariana Islands, Puerto Rico, the Virgin Islands, and the P&A system for Native Americans. Social Security’s P&A Program serves Title II disability beneficiaries and Supplemental Security Income (SSI) beneficiaries who want to work despite their continuing disabilities. The purpose of the PABSS program is to assist beneficiaries with disabilities in obtaining information and advice about vocational rehabilitation and employment services and to provide advocacy or related services that beneficiaries with disabilities may need to secure, maintain, or regain gainful employment.

Services offered by the PABSS include but aren’t limited to:
• Securing services from community agencies, including employment networks providing services under the Ticket to Work program;

• Helping people who are entitled to benefits understand work incentives and issues with their disability benefits;

• Protecting beneficiaries’ rights regarding conditions of employment;

• Helping beneficiaries understand and protect their employment rights, responsibilities, and reasonable accommodations under the Americans with Disabilities Act (ADA) and other applicable laws;

• Protecting rights to transportation;

• Protecting access to housing assistance; and

• Obtaining vocational rehabilitation and employment related services and supports.

For more information and to locate state PABSS projects, go online to choosework.ssa.gov (https://choosework.ssa.gov/findhelp/).

Collaborative Efforts Involving the National Employment and Training System

Social Security has made a monumental effort to coordinate and collaborate with the U.S. Department of Labor’s Employment and Training Administration (DOL ETA). The Workforce Investment Act (WIA) of 1998 initiated a major reorganization of the nation’s employment programs intended to consolidate preparation and employment services into a unified system of support. Key to this reorganization, the Department of Labor created a national network of American Job Centers (formerly known as One-Stop Career Centers) throughout the United States and its territories to be a single place where job seekers can receive the services that they need to become employed or re-employed. Prior to the passage of WIA, formal interaction between Social Security and DOL was virtually non-existent.

The Workforce Investment Act significantly changed in July 2014 when President Barack Obama signed the Workforce Innovation and
Opportunity Act (WIOA) into law. WIOA is designed to help job seekers access employment, education, training, and support services to succeed in the labor market and to match employers with the skilled workers they need to compete in the global economy. Congress passed the Act by a wide bipartisan majority, and it’s the first legislative reform of the public workforce system in the last 15 years.

**Workforce Innovation and Opportunity Act (WIOA)**

The enactment of WIOA made some significant reforms to the former WIA legislation as described below:

**Requires States to Strategically Align Workforce Development Programs:**

WIOA ensures that the core programs coordinate and complement employment and training so that job seekers acquire skills and credentials that meet employers’ needs.

- Every state will develop and submit a four-year strategy — in the form of a single unified strategic plan for core programs — for preparing an educated and skilled workforce and meeting the workforce needs of employers.

- States can include other key partners in their plans such as Temporary Assistance for Needy Families (TANF) and Perkins career and technical education programs.

**Promotes Accountability and Transparency:**

WIOA ensures that federal investments in employment and training programs are evidence-based and data-driven, and accountable to participants and taxpayers.

- Core programs must report on common performance indicators that provide key employment information, such as how many workers entered and retained employment, their median wages, whether they attained a credentials, and their measurable skill gains.

- Core programs must measure the effectiveness of services to employers for the first time.
• DOL and DoE, with input from stakeholders, will establish a common performance accountability system for the core programs.

• Negotiated levels of performance for the common indicators will be adjusted based on a statistical model that takes into account economic conditions and participant characteristics.

• Performance reports for states, local areas, and eligible training providers will be publicly available.

• Independent third parties will evaluate programs at least every four years.

**Fosters Regional Collaboration:**
WIOA promotes alignment of workforce development programs with regional economic development strategies to meet the needs of local and regional employers.

• States will identify regions within their state.

• Local areas in regions will coordinate planning and service delivery strategies.

**Improves the American Job Center (AJC) System:**
WIOA increases the quality and accessibility of services that job seekers and employers receive at their local AJCs.

• States will establish criteria to certify AJCs at least every three years to ensure continuous improvement, access to services (including virtual access), and integrated service delivery for job seekers and employers.

• Key partners and services will be available at AJCs through the co-location of the Wagner-Peyser Employment Service and the addition of the TANF program as a mandatory partner.

• The workforce system will have a common identifier so workers that need employment or training services and employers that need qualified workers can easily find their local AJC.

• The Secretary of Labor, with input from a new advisory council, other Federal agencies, and states will develop and implement plans to improve the national workforce and labor market
information system and help job seekers make informed career choices.

- States and local areas are encouraged to improve customer service and program management by integrating intake, case management, and reporting systems.

- AJC partner programs will dedicate funding for infrastructure and other shared costs.

**Improves Services to Employers and Promotes Work-Based Training:**

WIOA contributes to economic growth and business expansion by ensuring the workforce system is job-driven, matching employers with skilled individuals.

- State and local boards will promote the use of industry and sector partnerships to address the workforce needs of multiple employers within an industry.

- State and local boards are responsible for activities to meet the workforce needs of local and regional employers.

- Local areas can use funds for demonstrated effective strategies that meet employers’ workforce needs, including incumbent worker training, Registered Apprenticeship, transitional jobs, on-the-job training, and customized training.

- Employers are incentivized to meet their workforce needs and offer opportunities for workers to learn with increased reimbursement rates for on-the-job and customized training.

**Provides Access to High Quality Training:**

WIOA helps job seekers acquire industry-recognized credentials for in-demand jobs.

- WIOA emphasizes training that leads to industry-recognized post-secondary credentials.

- States and local areas will use career pathways to provide education and employment and training assistance to accelerate job seekers’ educational and career advancement.

- Local areas have additional procurement vehicles for training to increase customer choice and quality, including individual
training accounts, pay for performance contracts, and direct contracts with higher education.

Enhances Workforce Services for the Unemployed and Other Job Seekers:
WIOA ensures that unemployed and other job seekers have access to high-quality workforce services.

- WIA service categories of core and intensive services are collapsed into “career services,” and there is no required sequence of services, enabling job seekers to access training immediately.
- Local areas have flexibility to serve job seekers with the greatest need by transferring up to 100 percent of funds between the Adult and Dislocated Worker programs.
- Job seekers who lack basic skills, in addition to those who are low-income, have a priority for services from the Adult program.
- Unemployment insurance claimants can receive eligibility assessments and referrals to an array of training and education resources through the Wagner-Peyser Employment Service program.

Improves Services for Individuals with Disabilities:
WIOA increases individuals with disabilities’ access to high-quality workforce services and prepares them for competitive integrated employment.

- AJCs will provide physical and programmatic accessibility to employment and training services for individuals with disabilities.
- Youth with disabilities will receive extensive pre-employment transition services so they can successfully obtain competitive integrated employment.
- State vocational rehabilitation agencies will set aside at least 15 percent of their funding to provide transition services to youth with disabilities.
- A committee will advise the Secretary of Labor on strategies to increase competitive integrated employment for individuals with disabilities.
VR state grant programs will engage employers to improve participant employment outcomes.

**Makes Key Investments in Serving Disconnected Youth and Other Vulnerable Populations:**

WIOA prepares vulnerable youth and other job seekers for successful employment through increasing the use of proven service models services.

- Local areas must increase the percentage of youth formula funds used to serve out-of-school youth to 75 percent from 30 percent under current law.
- Local areas must spend at least 20 percent of youth formula funds on work experience activities such as summer jobs, pre-apprenticeship, on-the-job training, and internships so that youth are ready for employment.
- YouthBuild participants can get training in growing fields in addition to construction, expanding career opportunities for these youth.
- Key programs serving Native Americans and migrant and seasonal farmworkers remain AJC partners, ensuring that these program participants can access and receive employment and training services from AJCs.

**Enhances the Job Corps Program:**

WIOA increases the performance outcomes and quality of Job Corps.

- Job Corps will report on the Youth program’s common performance measures to increase alignment between the programs.
- Job Corps will establish community networks with employers, labor organizations, and state and local boards to improve services to and outcomes for participants.
- DOL will use competition to increase performance and quality so Job Corps is serving students well.
Streamlines and Strengthens the Strategic Roles of Workforce Development Boards:

WIOA makes state and local boards more agile and well positioned to meet local and regional employers’ workforce needs.

- State and local boards must coordinate and align workforce programs to provide coordinated, complementary, and consistent services to job seekers and employers.
- Business continues to contribute to strategic development and other activities by maintaining a leadership role on the boards and forming the majority of workforce board members.
- State and locals boards are more strategic and flexible as board membership streamlines.

For more information, refer to:
www.doleta.gov/wioa/about/overview/

Section 503 of the Rehabilitation Act of 1973

Social Security is working closely with the U.S. Department of Labor’s Office of Federal Contract Compliance Programs (OFCCP) to implement important changes in the federal regulations governing Section 503 of the Rehabilitation Act of 1973. Section 503 prohibits employment discrimination against individuals based on disability by federal contractors and subcontractors. Section 503 also requires that federal contractors and subcontractors take affirmative action to recruit, employ, train, and promote qualified individuals with disabilities.

The framework articulating contractors’ Section 503 responsibilities has been in place since the 1970’s. However, both the unemployment rate of working-age individuals with disabilities and the percentage of working-age individuals with disabilities who aren’t in the labor force remain significantly higher than for those without disabilities. A substantial disparity in the unemployment rate of individuals with disabilities continues to persist despite years of technological advances that have made it possible for people with disabilities, sometimes severe, to apply for and successfully perform a broad array of jobs.

The new Section 503 regulations are an important tool for reducing barriers to equal employment opportunity for individuals with disabilities and addressing income inequality and poverty. In addition, the Final Rule
implements changes necessitated by the passage of the ADA Amendments Act (ADAAA) of 2008. The ADAAA amends the definition of disability in Section 503 to the same extent that it amends the ADA, and became effective on January 1, 2009.

**Highlights of the Final Rule**

The Final Rule introduces a variety of changes to the Section 503 regulations. Some of these changes revise the nondiscrimination provisions to incorporate the requirements of the ADAAA. Others are designed to strengthen the affirmative action provisions. The Final Rule:

- Establishes, for the first time, a 7 percent utilization goal for individuals with disabilities. This utilization goal, applied at the job group level, isn’t to be used by contractors as a quota or a ceiling that limits or restricts the employment of individuals with disabilities. Instead, the goal is a management tool that informs decision-making and provides real accountability. Failing to meet the disability utilization goal isn’t a violation of the regulation, and it won’t lead to a fine, penalty, or sanction.

- Requires contractors to invite applicants to voluntarily self-identify as an individual with a disability at the pre-offer stage of the hiring process, in addition to the existing requirement that contractors invite applicants to voluntarily self-identify after receiving a job offer. This data collection should provide contractors with useful information about the extent to which their outreach and recruitment efforts are effectively reaching people with disabilities.

- Requires contractors to invite incumbent employees to voluntarily self-identify on a regular basis. The status of employees may change, and a regular invitation to self-identify provides employees a way to self-identify for the first time, or to change their previously reported status. Providing a regular invitation should contribute to increased self-identification rates. Improving data collection is important to assessing employment practices.

- Requires contractors to maintain several quantitative measurements and comparisons for the number of individuals with disabilities who apply for jobs and the number of individuals with disabilities they hire in order to create greater
accountability for employment decisions and practices. Having this data will enable contractors and OFCCP to evaluate the effectiveness of contractors’ outreach and recruitment efforts, and examine hiring and selection processes related to individuals with disabilities.

- Requires prime contractors to include specific, mandated language in their subcontracts in order to provide knowledge and increase compliance by alerting subcontractors to their responsibilities as federal contractors.

- Implements changes necessitated by the passage of the ADA Amendments Act (ADAAA) of 2008 by revising the definition of “disability” and certain nondiscrimination provisions of the implementing regulations.

For more information, go to [www.dol.gov/ofccp](http://www.dol.gov/ofccp).

### Collaborative Efforts Involving Public Education Systems

Social Security has become increasingly aware of the importance of working with educational systems, particularly public high schools, in its efforts to promote employment with younger beneficiaries. The agency has collaborated with the U.S. Department of Education and other federal entities on a variety of projects including the Youth Transition Demonstration (YTD) projects and the current PROMISE Initiative.

### Youth Transition Demonstration (YTD) Projects

In 2003, Social Security initiated Youth Transition Demonstration (YTD) projects designed to test the effect of a comprehensive package of services and SSI waivers on the post-secondary educational and employment outcomes of SSI beneficiaries ages 14-25. Social Security awarded seven cooperative agreements in six states: California, Colorado, Iowa, Maryland, Mississippi, and New York. The demonstration projects applied interventions that included services and supports such as benefits counseling, service coordination, Disability Program Navigators, enhanced Individual Development Accounts (IDAs), and job placement and training services.

In addition, Social Security waived five SSI program rules:
• Participants whom Social Security determined by their age 18 reviews to be no longer eligible for SSI benefits were permitted to retain those benefits as long as they participate in the project; 

• Participants were permitted to receive the student earned income exclusion (SEIE) through the age of 25; 

• Participants benefited from a $1-for-every-$4 benefit offset for earnings above the general earned income exclusion; 

• Participants were allowed greater flexibility in the establishment and implementation of IDAs; and 

• Social Security allowed participants to establish goals for PASS accounts that target either postsecondary education or employment outcomes.

The Youth Transition Demonstration projects involved significant interaction with the state VR systems, the WIPA projects, and the American Job Centers. Social Security is fully aware of the importance of early intervention with the younger beneficiaries in any efforts to enhance employment outcomes for adults with disabilities. The earlier schools expose students to employment and the more that school reinforces and supports the expectation of work, the greater the likelihood that the students will have jobs upon graduation. Focusing on transition from school to employment is intelligent public policy and represents a sound investment of resources.

All sites (Colorado; Bronx, NY; Erie, NY; Florida; Maryland; and West Virginia) completed their YTD participation and services as of March 2012. Social Security awarded a national evaluation contract to Mathematica Policy Research in September 2005 with evaluation activities completed in 2014. The final evaluation reports can be found online at Mathematica’s website (https://www.mathematica-mpr.com/our-publications-and-findings/projects/youth-transition-demonstration).

**Promoting Readiness of Minors in SSI (PROMISE)**

PROMISE is a joint project with the Departments of Education, Labor, and Health and Human Services and Social Security to promote positive outcomes for children who receive Supplemental Security Income (SSI) and their families. The goal of PROMISE is to improve the provision and coordination of services to promote education and employment outcomes resulting in long-term reductions in the child’s reliance on SSI. The
Department of Education awarded cooperative agreements to States to implement PROMISE, and Social Security will evaluate the project. The Department of Labor and the Department of Health and Human Services will also provide support for the project. The Department of Education’s Office of Special Education and Rehabilitation Services (OSERS) awarded grants to the following five states: Arkansas, California, Maryland, New York, and Wisconsin; and one consortium of states made up of Utah, South Dakota, North Dakota, Montana, Colorado, and Arizona.

The states designed and implemented their own unique models, but all PROMISE project interventions include the following, at minimum:

- Partnerships among State agencies responsible for programs that play a key role in providing services to the target populations;
- Family outreach, recruitment, and involvement; and
- Services including:
  - Case management;
  - Benefits counseling;
  - Career and work-based learning experiences; and
  - Parent/guardian training and information.

The first states began enrolling youths and providing services in the spring of 2014. Project enrollment continued through spring 2016, and services continued through late 2018. Social Security awarded a contract to Mathematica Policy Research (MPR) to evaluate the programs and these evaluation efforts will continue through 2022.

For more information about the PROMISE evaluation, visit Social Security’s PROMISE website (https://www.ssa.gov/disabilityresearch/promise.htm).

For more information on the PROMISE projects, see the Department of Education’s PROMISE website (https://promiseneighborhoods.ed.gov/).
Social Security’s Internal Efforts to Promote Employment of Beneficiaries with Disabilities

In recent years, Social Security has introduced an array of internal improvements in its disability programs. These improvements are too numerous to describe fully in this unit because they include everything from updated work incentive regulations to enhanced internal record-keeping processes to increased staff training and new job functions. These improvements also include the creation of the Work Incentives Planning and Assistance (WIPA) initiative, which is the basis for this entire training manual. Social Security has created several staff positions focused on work incentive issues that warrant discussion here.

Area Work Incentives Coordinators (AWICs)

Social Security has initiated the Area Work Incentives Coordinator (AWIC) position in all 58 Area offices. The AWIC positions are filled by individuals dedicated to providing assistance to personnel in field offices on employment support and outreach issues. Their duties include:

- Coordinating or conducting local public outreach on work incentives;
- Providing, coordinating, or overseeing training for all personnel regarding Social Security’s employment support programs;
- Handling some sensitive or high-profile disability work-issue cases; and
- Monitoring the disability work-related issues in their respective areas.

The current AWIC position actually arose out of an earlier experiment Social Security conducted in designating internal work incentives experts. This original initiative was known as the Employment Support Representative (ESR). In part, the ESR strategy was a response to criticisms from the disability and vocational rehabilitation communities as well as monitoring groups such as the GAO) and Social Security’s Inspector General. These groups expressed concerns that disability beneficiaries didn’t always get accurate, comprehensive information from Social Security about employment support provisions, commonly called “work incentives.” These difficulties in obtaining accurate, reliable information about the effect of work and earnings on entitlement to
monthly cash benefits and health insurance protection create an environment of uncertainty for disability beneficiaries. Social Security recognized that this uncertainty created another barrier for disability beneficiaries to overcome in trying to work and become more financially independent and less dependent on benefit programs.

**Work Incentive Liaisons (WILs)**

AWICs have been a very positive addition to Social Security’s employment support personnel, but they don’t operate in isolation. The AWICs coordinate with the 1,335 Work Incentives Liaisons (WILs) housed in local field offices around the country. The Work Incentives Liaison is a special designation given to a Social Security employee with significant expertise in the disability programs and associated work incentives. The WIL acts as an internal resource for other Social Security personnel within that local office. The WIL is the “go-to” person in each local field office for questions about how earned income from wage employment or self-employment affects Social Security disability benefits. Depending on the Social Security office, the WIL may be also the primary contacts on work incentives issues for CWICs.

**Other Social Security Demonstration Projects Related to Beneficiaries with Disabilities**

Social Security conducts numerous research and demonstration projects to study ways to improve services to current and future beneficiaries, and supports a number of demonstrations and projects intended to address the broad needs of beneficiaries with disabilities. These projects can lead to ways to better serve individuals with disabilities, including potentially changing program rules to allow for better coordination among other federal and state programs. Social Security also receives funding for projects through specific congressional mandates. These projects support specific program changes or outreach activities targeted to populations in particular need.

Social Security is currently working on the following demonstration projects or pilots:
Benefit Offset National Demonstration (BOND)

The purpose of the BOND project is to determine the effect of various interventions, in combination with a benefit offset, on employment outcomes including wages, benefits, hours worked, and job retention. In addition, Social Security recently modified this project to include a test of an early intervention strategy that will focus on disability applicants.

The Social Security Administration has contracted with Abt Associates to help design, implement, and evaluate the Benefit Offset National Demonstration. Abt Associates is a policy research firm with headquarters in Cambridge, MA. In addition to Abt Associates, the team for this project includes: Center for Essential Management Services, Mathematica Policy Research, University of Illinois, and Virginia Commonwealth University. The BOND project became operational early in 2011.

The benefit offset demonstration is testing different program variants for current SSDI beneficiaries around the country. In some of the models, Social Security will gradually reduce benefits when the beneficiary has earnings over a specific amount instead of cutting benefits to $0 (as under current law). Those who earn less than that specific amount will receive the same benefit as under current law. Some models are testing enhanced benefits assistance, along with information and referral to employment supports. Social Security developed these models with input from four state pilot offset demonstrations in operation since 2005.

Social Security randomly selected 10 of their area office jurisdictions around the country for this test. The demonstrations are being fielded in these entire states: Arizona, Colorado, Wyoming, Alabama, District of Columbia, Wisconsin, Vermont, Maine, and New Hampshire; and in parts of these states: California, Texas, Florida, Massachusetts, Virginia, Maryland, Michigan, and New York.

Social Security will rigorously evaluate the tested programs in the benefit offset demonstration. Social Security has randomly assigned SSDI beneficiaries in the BOND sites to a group Social Security notifies is eligible for a benefit offset if beneficiaries return to work, or groups that can enroll in one of the program variants, or a control group that won’t be eligible for these programs but will remain eligible for SSDI benefits and services under existing program rules. Social Security will measure effects of the program interventions on employment, SSDI benefits, and a range of other outcomes by measuring differences in outcomes among
the program and control groups. The agency will also evaluate the operation of the programs and their costs to federal, state, and local governments, as well as any cost savings and additional revenues. The evaluation will use data from surveys of program and control group members, Social Security, other administrative records, and other information sources.


More information about the BOND project can be found online (http://www.socialsecurity.gov/disabilityresearch/offsetnational.htm).

**Promoting Opportunity Demonstration (POD)**

The Promoting Opportunity Demonstration (POD) will test simplified work incentives and a benefit offset in the Social Security Disability Insurance (SSDI) program to determine its effects on outcomes such as earnings, employment, and benefit payments. Section 823 of the Bipartisan Budget Act of 2015 directs the agency to carry out POD.

In POD, Social Security will reduce benefits by $1 for every $2 earned above the POD threshold, which is the greater of the current Trial Work Period level or the amount of a participant’s itemized impairment-related work expenses (up to Substantial Gainful Activity). POD includes a random assignment design to assign 9,000 volunteers to three groups of approximately 3,000 beneficiaries each, a control group and two treatment groups. The control group continues under usual rules. Treatment group 1 is subject to the offset and benefits will be suspended for any months SSDI benefits are reduced to zero. Treatment group 2 is subject to the offset and SSDI entitlement will terminate when benefits are reduced to zero for 12 consecutive months. Both treatment groups are eligible for POD-specific benefits counseling.

Social Security awarded contracts to Abt Associates for the implementation and to Mathematica Policy Research for the evaluation of POD. Abt Associates awarded subcontracts to 8 states or areas to deliver work incentives planning and assistance services to POD participants. Enrollment began January 2018 and continued on a rolling basis through
December 2018. Recruitment ended in December 2018 and as of January 2019, Social Security had enrolled over 10,000 volunteers for POD. The project will end for all remaining participants on June 30, 2021.

For more information, refer to **Promoting Opportunity Demonstration (POD) on Social Security's website** (https://www.ssa.gov/disabilityresearch/pod.htm).

**Supported Employment Demonstration**

The Consolidated and Further Continuing Appropriations Act of 2015 (Pub. L. 113-235) appropriated funds to design, develop, and implement an early intervention demonstration to test innovative strategies aimed at helping people with disabilities remain in the workforce.

In August 2016, SSA awarded a contract to Westat, Inc. to implement and evaluate whether offering evidence-based interventions of integrated vocational, medical, and behavioral health services to individuals with behavioral health challenges can significantly reduce the demand for disability benefits and help individuals remain in the labor force.

The Supported Employment Demonstration (SED) uses a random assignment design to assign 3,000 participants to one of two treatment groups (Full Services or Basic Services) or to a control group (Usual Services). For 36 months, participants will receive varying degrees of services based on their assignment. These services include systematic medication management, health care management and care-coordination services, and long-term employment services following the evidence-based Individual Placement and Support (IPS) model.

An important component of the SED is providing Community Mental Health Center personnel with intensive training about Social Security disability benefits and associated work incentives. This training is provided by VCU’s NTDC and is closely aligned with the required WIPA training.

Eligibility for the SED is restricted to individuals aged 18 to 50 years who want to work; who applied for disability benefits (DI or SSI) alleging mental impairment in the past 30-60 days; and who received an initial denial decision from Social Security. Thirty urban and rural-urban mixed catchment areas at community mental health agency sites across the U.S. are enrolling participants in the demonstration and are providing the interventions. SED sites are located in these states: California, Colorado,
Florida, Illinois, Kansas, Kentucky, Massachusetts, Maryland, Michigan, Minnesota, New York, North Carolina, Ohio, Oklahoma, Oregon, South Carolina, Tennessee, Texas, Washington, and Wisconsin.

The SED period of performance is from August 2016 through August 2022.

Additional information about the SED is available (https://www.westat.com/project/evaluating-supported-employment).

Conclusion

The objective of this unit is to illustrate the sustained effort Social Security has made in a variety of areas over the past 20 years to support the return-to-work efforts of its beneficiaries with disabilities. These efforts have included changing Social Security’s internal staffing patterns and work incentives policies, collaborating with other federal stakeholder agencies, and implementing critical components of the Ticket to Work and Work Incentives Improvement Act.

The Social Security Administration no longer defines its role as being limited to processing initial claims and making sure that the right check in the right amount gets to the right person by the right date. The expanded role of Social Security includes actively developing and implementing policies and practices that encourage disability beneficiaries to work and decrease their dependence on public income support programs. WIPA services are an important part of the larger solution to the worrisome problem of our ever-expanding disability benefit programs. The Social Security Administration encourages and supports CWICs to join this effort to enhance the economic independence and financial stability of disability beneficiaries.

Conducting Independent Research

Social Security’s Office of Research, Demonstration, and Employment Support
(http://www.socialsecurity.gov/disabilityresearch/index.html)
Introduction

As a CWIC, you are an integral partner on the employment service team. You play an active role in supporting the long-term employment process, including providing information, guidance, and direct assistance in vocational planning. You also help identify and leverage resources to meet the employment support needs of beneficiaries. To be effective in this role, you must have a comprehensive knowledge of the current employment service system for youth and adults with disabilities, and knowledge of the vocational evaluation and planning processes used by local employment agencies. You must also be fully aware of the referral, eligibility, program planning, and service delivery approaches employment service agencies use in their local community.

This unit will provide an overview of the major stakeholders in the vocational service system for persons with disabilities. The following agencies serve as collaborative partners in promoting employment and enhancing financial independence of Social Security disability beneficiaries:

- State Vocational Rehabilitation Agencies (SVRAs)
- Employment Networks (ENs) under the Ticket to Work program
- State or local Workforce Investment Boards (WIBs) and American Job Centers (AJCs)
- State or local Intellectual/Developmental Disability (ID/DD) agencies
- State or local mental health, chemical dependency, or substance abuse agencies
While this unit will provide a basic overview of these agencies and describe the most common services they provide to persons with disabilities, it won’t provide suggestions on how WIPA programs can work collaboratively with key stakeholders to support Social Security disability beneficiaries in achieving their employment goals. For specific information about your role in partnering with each of these agencies, please refer to Module 2, Unit 3.

Understanding the Disability Service System

The disability services system may seem very confusing to those with no prior experience in the field. There are so many different agencies involved, and each agency has its own distinct eligibility criteria, menu of services, and restrictions on what assistance it can provide. In many ways, it isn’t a coherent or coordinated “system” at all, but rather a loose affiliation of multiple systems and agencies.

To start, it’s important to understand the two main categories of systems or agencies that serve persons with disabilities. These categories are:

1. Disability Specific System:

These agencies generally provide a wide range of services to persons who meet the definition of a specific disability type. For example, the mental health system may provide psychiatric services, mental health counseling, day programs, residential support, or even employment services to certain individuals who have mental illnesses. Similarly, the intellectual disability or developmental disability system generally provides a variety of services to persons who meet the definition of having an intellectual disability or a developmental disability including case management, residential support, vocational training, or supported employment. In addition to these relatively large state
systems, smaller agencies such as the Brain Injury Association, United Cerebral Palsy Association, or the Down Syndrome Association often provide a more limited menu of services to more narrowly defined populations. In some cases, individuals may meet the eligibility criteria to receive services from multiple systems or agencies simultaneously.

2. Service Specific System:

These agencies typically serve persons with many different types of disabilities, but only provide one type of service, or a group of related services. For example, State Vocational Rehabilitation Agencies (SVRAs) provide services across many different disability types, but the services all focus primarily on preparing for, obtaining, and maintaining paid employment. Similarly, the local American Job Center funded by the Department of Labor serves a broad spectrum of people, but it too is focused on employment-related services. Some individuals may meet the eligibility criteria of multiple agencies, so several agencies may serve them simultaneously.

The best way to begin is by conducting research to find out what agencies exist in your service delivery area in each of the two broad categories identified above. You will need to know a few basic things about each agency such as who they serve, what specific services they provide, and what restrictions or limits they place on services. It may be possible to find listings of disability service organizations in the phone book, by accessing the Internet, or even by contacting umbrella groups such as the United Way. When working with specific beneficiaries with disabilities, it’s helpful to ask which agencies they are or were involved with or getting services from.

It will take time to get to know all of the agencies involved in serving persons with disabilities in any given community. The best advice is to start with the larger state systems and ask for contact information for any other service providers with whom these agencies work or of which they are aware. The information in this unit will help you know which specific agencies WIPA programs are most likely to need to collaborate with and, as a result, where you should start in the information-gathering process.
Understanding Employment Services and Supports Available to Individuals with Disabilities

The following descriptions offer some background information on the most common types of employment services and supports.

**Supported Employment**

The Rehabilitation Act defines supported employment as “competitive work in integrated work settings, or employment in integrated work settings in which individuals are working toward competitive work, consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals, for individuals with the most significant disabilities:

- For whom competitive employment hasn’t traditionally occurred;
- or
- For whom competitive employment has been interrupted or intermittent as a result of a significant disability; and
- Who, because of the nature and severity of their disability, need intensive supported employment services.”

Supported employment providers facilitate competitive work in typical community business settings for individuals with the most severe disabilities (i.e., psychiatric impairments, intellectual disabilities, learning disabilities, traumatic brain injury) for whom competitive employment hasn’t traditionally occurred, and who, because of the nature and severity of their disability, need ongoing support services in order to perform their job. Supported employment provides assistance such as job coaches, transportation, assistive technology, specialized job training, and individually tailored supervision. The jobs involve pay at a competitive wage and may be part-time or full-time.

Supported employment entails intensive and long-term employment supports. In most cases, the supported employment professional helps individuals find jobs by conducting individualized job development services in the local business community. When the beneficiary secures an appropriate job match, the supported employment professional will typically provide direct job site training to the individual for as long as it
takes that person to master the job functions. Even after the individual masters the job functions, the supported employment professional will stay in close contact with the individual and the employer to make certain employment progresses smoothly.

Private non-profit community rehabilitation agencies generally provide supported employment services, but there are exceptions to this. In some states, the state VR agency delivers supported employment services directly instead of or in addition to purchasing these services from community providers. Some agencies may provide supported employment services as well as sheltered employment services. In most areas, the best way to locate the supported employment providers is to contact the local state VR agency personnel.

**Customized Employment Services**

Customized employment may best be described as a type of supported employment that involves a specialized relationship between job seekers and employers in ways that meet the needs of both. Customized employment is based on a specific approach to client assessment that examines the strengths, requirements, and interests of a person with a complex life — a process often referred to as “discovery.” In addition, in customized employment great care is taken to analyze the employment site, the job functions, and the availability of natural support from supervisors or co-workers. Jobs are often specially created or negotiated with the employer to accommodate the unique needs of the employee. Successful customized employment opportunities are built on four key elements:

- Meeting the job seeker’s individual needs and interests;
- Using a personal representative to assist and potentially represent the individual. This can be a counselor, job developer, advocate, employment specialist, or other qualified professional;
- Negotiating successfully with employers; and
- Building a system of ongoing supports for the job seeker.

Like supported employment, customized employment opportunities include the expectation that accommodations and supports will be available to the job seeker and the employer as necessary over time. Supports may include (but aren’t limited to) benefits counseling, personal assistance, transportation coordination and assistance, and adaptive
equipment. These individualized supports should be flexible to reflect the unique needs of both the job seeker and employer.

Sheltered Employment Services

Agencies known as “sheltered workshops” generally provide sheltered employment services. State vocational rehabilitation, mental health, or developmental disabilities agencies often provide funding. Sheltered employment environments tend to be segregated facilities, meaning that all or most of the employees except supervisory personnel experience a disability of some type. Employees generally earn less than minimum wage, making it highly unlikely that beneficiaries will be able to use earnings from sheltered employment to enhance their financial independence. Many states are establishing initiatives to limit the use of sheltered employment and promote an “Employment First” policy that relies on placement into competitive jobs.

Agencies can also provide sheltered employment services in community-based settings such as businesses. For example, a manufacturing company may have a specific function that it contracts with a sheltered workshop to perform. The agency will provide the employees who typically will all experience disabilities and will often send a non-disabled staff person to supervise the work on a day-to-day basis. While working at the manufacturing company, the individuals with disabilities are generally employees of the rehabilitation facility, which pays them sub-minimum wage based on productivity.

Day Habilitation Services

Day Habilitation services provide individualized assistance to persons with significant disabilities who wish to acquire and maintain life skills that would enable them to become and remain a productive member of our community. In general, the services they offer focus on the development, retention, and improvement of self-help, socialization, adaptive skills, and development of manual or perceptual motor skills. The services correspond with the person’s individual strengths and needs. A variety of Day Habilitation activities include:

- Mobility training
- Development of social behaviors
- Development of communication skills
• Training and assistance in developing basic safety skills
• Training and assistance in developing competency in housekeeping skills
• Training and assistance in developing competency in personal care skills
• Training and assistance in developing health care skills
• Training and assistance in developing money management skills
• Providing individual and group social, health-related, and recreation activities
• All necessary transportation

For the most part, Day Habilitation services are non-vocational in nature. This means that they generally don’t provide employment and job skill training. There are certainly exceptions to this, and some Day Habilitation programs also provide both sheltered employment and supported employment services. The most common funding source for Day Habilitation Services is state Medicaid waiver programs, although the services may also use some state general funds. State VR agencies don’t fund Day Habilitation services. Professionals may deliver Day Habilitation services within a facility, in community-based settings, or a combination of both.

State Vocational Rehabilitation Agencies

Vocational Rehabilitation (VR) is a nationwide federal-state program that provides medical, therapeutic, counseling, education, training, work-related placement assistance, and other services to eligible individuals with disabilities. Specifically, the system of state VR agencies was established to provide the services and supports that individuals with disabilities might need to overcome barriers to employment. The Rehabilitation Services Administration (RSA) of the U.S. Department of Education is the federal agency responsible for overseeing the grant programs that help individuals with physical or mental disabilities to obtain employment and live more independently through the providing such supports as counseling, medical and psychological services, job training, and other individualized services. RSA’s major Title I formula grant program provides funds to state vocational rehabilitation (VR)
agencies to provide employment-related services for individuals with disabilities, giving priority to individuals who are significantly disabled. VR agencies cover the following services:

- Assessment to determine eligibility and needs, including (if appropriate) by someone skilled in rehabilitation technology;
- Counseling, guidance, and job placement services, and (if appropriate), referrals to the services offered by WIOA providers;
- Vocational and other training, including higher education and the purchase of tools, materials, and books;
- Diagnosis and treatment of physical or mental impairments to reduce or eliminate impediments to employment, to the extent financial support isn’t available from other sources, including health insurance or other comparable benefits;
- Maintenance for additional costs incurred during rehabilitation;
- Transportation, including adequate training in the use of public transportation vehicles and systems that is provided in connection with the providing any other service described in this section and that the individual needs to achieve an employment outcome. Transportation may include vehicle purchase. Under the regulations, transportation is defined as “travel and related expenses that are necessary to enable an applicant or eligible individual to participate in a VR service”;
- Personal assistance services while receiving VR services;
- Interpreter services for individuals who are deaf, and readers, rehabilitation teaching, and orientation and mobility services for individuals who are blind;
- Occupational licenses, tools, equipment, initial stocks, and supplies;
- Technical assistance for those who are pursuing telecommuting, self-employment, or small business operation;
- Rehabilitation technology, including vehicular modification, telecommunications, sensory, and other technological aids and devices;
• Transition services for students with disabilities to facilitate the achievement of the employment outcome identified in the Individual Plan for Employment (IPE);

• Supported employment;

• Services to the family to assist an individual with a disability to achieve an employment outcome; and

• Post-employment services necessary to assist an individual to retain, regain or advance in employment.

To be eligible for state VR services, a participant must meet certain criteria. First, he or she must have a physical or mental impairment that results in a substantial barrier to employment. However, the disability doesn’t need to be so severe that it qualifies the person for Social Security disability benefits. SSI and DI beneficiaries can receive VR services, assuming they intend to achieve an employment outcome. Second, individuals must be able to benefit from VR services. Finally, they must eventually be able to achieve an employment outcome. State VR agencies can deny benefits if they can show that a person can’t benefit from the services. To make determinations, state VR agencies use existing data, such as medical reports, Social Security records, and education records and, to the extent that the existing data is insufficient to determine eligibility, an assessment by the VR agency.

The State Vocational Rehabilitation agency assigns a VR counselor to those eligible for services. The counselor will develop and coordinate the types of assistance a person with a disability needs for employment, including the development of an Individual Plan for Employment (IPE). The IPE is a written agreement between VR and the individual to achieve the individual’s employment goal, and must be consistent with his or her interests, unique strengths, priorities, abilities, and capabilities. The VR counselor provides some services directly to the eligible individual and arranges for or purchases other services from providers in the community. Before providing certain services, the VR counselor must consider the availability of comparable services and benefits for which the individual is eligible through other sources, such as Medicaid.

For VR participants who don’t receive Social Security disability benefits, the payment method for VR services varies by state. Based on the individual’s available financial resources, the state VR agency may require an eligible individual to help pay for services. All eligible and accepted VR
participants have access to the following services at no cost: assessments to determine eligibility and VR needs, vocational counseling, guidance, referral services, and job placement services.

To access contact information for all of the state VR agencies, go to: choosework.ssa.gov/

**Employment Networks (ENs)**

An Employment Network (EN) is an organization or group of organizations that Social Security has deemed qualified to provide or coordinate the delivery of necessary services and other types of employment-related services and supports to assist Social Security beneficiaries with disabilities to enter, maintain, and advance towards self-supporting employment.

The EN assumes responsibility for the coordination and delivery of employment services, vocational rehabilitation services, or other support services to beneficiaries who have assigned their Ticket to that EN. ENs provide services either directly or by entering into agreements with other providers and take measures to ensure that provided services meet the requirements of individual work plans. Under the Ticket program, all ENs are required to develop Individual Work Plans (IWP) for each beneficiary the program serves. The Individual Work Plan (IWP) is an agreement between a beneficiary and an Employment Network (EN) outlining the specific employment services, vocational rehabilitation services, and other support services that the two parties determine are necessary to achieve the beneficiary’s stated employment goal and provide a road map for financial independence.

ENs must:

- Inform and educate Ticket holders that the purpose of the Ticket Program is to provide individuals with the opportunities and supports they need to go to work, increase earnings, and become self-sufficient through financial independence by leaving cash benefits to the maximum extent feasible;

- Fairly and objectively advise each Ticket Holder on the benefits and risks of leaving cash benefits and becoming self-sufficient;
• Provide employment services that afford Ticket holders the opportunity and supports necessary to prepare for, obtain, and retain career ladder jobs that will realistically enable them to leave and remain off cash benefits;

• Avoid even the appearance of advising or condoning the practice of artificially manipulating a beneficiary’s work and earnings to remain on cash benefits; and,

• In light of the above, an EN must choose a business model that provides opportunities and supports to beneficiaries that enable them to progress towards self-sufficiency and financial independence through work, rather than encourage and promote indefinite part-time employment.

Organizations must apply to become ENs and are required to meet certain criteria as determined by Social Security. Organizations must apply to become ENs by responding to the EN Request for Application (RFA). Once approved, the organization must sign a Ticket Program Agreement (TPA) and key staff must complete a suitability determination and orientation training before operating as an EN. ENs can be for-profit or non-profit service providers, state, and local government agencies, or a group of providers working together as a single EN. Federal agencies can’t be ENs.

To learn more about the EN requirements, go to yourtickettowork.ssa.gov (https://yourtickettowork.ssa.gov/web/ttw/en-home)

Traditional ENs are community-based service providers that have been involved in promoting employment for individuals with disabilities. Examples of these providers are community rehabilitation programs such as Goodwill Industries and United Cerebral Palsy organizations, community mental health programs, independent living centers, habilitation providers, disability student services at community colleges, and vocational training schools. This is the largest pool of organizations currently operating as ENs.

Over the years, a variety of other EN models have emerged. The Ticket to Work program defines the Employer Employment Network (EN) model as a business model that includes the EN serving as the beneficiary’s employer or an employer’s agent. The program describes an employer’s agent as a group or individual who is working with an employer under an
agreement or other arrangement to locate and place suitable job candidates with that employer.

Social Security’s EN application package requires that Employer ENs:

- Identify the jobs they have available;
- Pay wages at or above the amount that Social Security defines as Substantial Gainful Activity (SGA);
- Identify where the EN plans to place beneficiaries; and
- Describe how the EN plans to provide beneficiaries with the supports and opportunities to permit them to keep a job that pays SGA-level earnings.

The business plan a perspective Employer EN submits must include:

- A promise to maintain an active program for hiring and providing ongoing services and supports to their workers with disabilities;
- A plan for placing Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) beneficiaries in jobs that pay at or exceed the annual SGA amount; and
- A provision for paying SSI or SSDI beneficiaries in a timely manner for work performed.

The salaries Employer ENs pay to beneficiaries can’t be contingent on the EN’s receipt of Milestone or Outcome payments under the Ticket program. Earnings, for purposes of the Employer EN’s request for payment under the Ticket program, means actual wages the employer pays to a beneficiary prior to the EN’s payment request.

For a detailed description of how ENs operate under the Ticket to Work Program, refer to Module 3 of this manual. For a listing of current ENs, go to choosework.ssa.gov (https://choosework.ssa.gov/findhelp/)

**American Job Centers (AJCs) and Workforce Investment Boards (WIBs)**

**American Job Centers (AJCs)**

The Workforce Investment Act of 1998 (WIA) provided the original framework for a national workforce preparation and employment system
designed to meet both the needs of the nation’s businesses and the needs of job seekers as well as those who want to further their careers. This legislation created an entirely new national Workforce Development System, which replaced programs and services provided under the former Job Training Partnership Act (JTPA).

The key guiding principles of the Workforce Investment Act included:

- **Streamlining Services**: Programs and providers co-locate, coordinate, and integrate activities and information, so that the system as a whole is coherent, accessible, and easy to use.

- **Empowering Individuals**: Eligible adults have the financial power to use Individual Training Accounts (ITAs) at qualified institutions.

- **Universal Access**: Through the creation of the American Job Centers (AJCs) all individuals have access to core employment-related services. This includes information about job vacancies, career options, student financial aid, relevant employment trends, and instruction on how to conduct a job search, write a resume, or interview with an employer.

- **Employer Involvement**: Businesses provide information and leadership and play an active role in ensuring that the American Job Center system prepares people for current and future jobs.

The principles described above were refined and reauthorized in the **Workforce Innovation and Opportunities Act of 2014 (WIOA)**. The enactment of WIOA provides opportunity for reforms to ensure the American Job Center system is job-driven—responding to the needs of employers and preparing workers for jobs that are available now and in the future. Of particular note to Help Line Agents is that WIOA increases individuals with disabilities’ access to high quality workforce services and prepares them for competitive integrated employment. The following requirements of the legislation are of significance:

- **Youth with disabilities** will receive extensive pre-employment transition services so they can successfully obtain competitive integrated employment.

- **State VR agencies** will set aside at least 15 percent of their funding to provide transition services to youth with disabilities.
• A committee will advise the Secretary of Labor on strategies to increase competitive integrated employment for individuals with disabilities.

• VR state grant programs will engage employers to improve participant employment outcomes.

• American Job Centers will provide physical and programmatic accessibility to employment and training services for individuals with disabilities.

For more information about WIOA go to www.doleta.gov/wioa/

“One-Stop” Approach

The current national Workforce Development System is based on a “one-stop” concept where information about and access to a wide array of job training, education, and employment services is available for customers at neighborhood locations called American Job Centers (AJC). A virtual American Job Center (AJC) is available online (https://www.americasvos.com/vosnet/Default.aspx.)

By using the American Job Center system, job seeking customers are able to easily:

• Receive a preliminary assessment of their skill levels, aptitudes, abilities, and support service needs;

• Obtain information on a full array of employment-related services, including information about local education and training service providers;

• Receive help filing claims for unemployment insurance and evaluating eligibility for job training and education programs or student financial aid;

• Obtain job search and placement assistance, and receive career counseling;

• Access up-to-date labor market information, which identifies job vacancies and skills necessary for in-demand jobs, and provides information about local, regional, and national employment trends; and

• Get information about accessibility and special accommodations for people with disabilities.
In addition, through the local American Job Centers, employers have a single point of contact to provide information about current and future skills needed by their workers and to list job openings. **Find the nearest AJC** by going online (https://www.careeronestop.org/localhelp/americanjobcenters/find-american-job-centers.aspx).

**Eligibility and Service Requirements**

WIOA specifies three funding streams to the states and local areas: adults, dislocated workers, and youth.

The American Job Center system provides most services for adults and dislocated workers, and most customers use their individual training accounts to determine which training program and training providers fit their needs. The Act authorizes “core” services available to all adults with no eligibility requirements and “intensive” services for unemployed individuals who aren’t able to find jobs through core services alone. In some cases, the intensive services are also available to employed workers who need more help to find or keep a job.

Core services include job search and placement assistance (including career counseling); labor market information (that identifies job vacancies; skills needed for in-demand jobs; and local, regional and national employment trends); initial assessment of skills and needs; information about available services; and some follow-up services to help customers keep their jobs.

Intensive services include more comprehensive assessments, development of individual employment plans, group and individual counseling, case management, and short-term pre-vocational services.

In cases where qualified customers receive intensive services but are still not able to find jobs, they may receive training services that are directly linked to job opportunities in their local area. These services may include occupational skills training, on-the-job training, entrepreneurial training, skill upgrading, job readiness training, and adult education and literacy activities in conjunction with other training.

If adult funds are limited in an area, recipients of public assistance and low-income clients get priority for services. The Act also authorized the providing supportive services (e.g., transportation) to assist participants receiving the other services and the providing temporary income support to enable participants to remain in training.
WIOA enacted a comprehensive youth employment program for serving eligible youth, ages 14-24, who face barriers to education, training, and employment. Funds for youth services are allocated to states and local areas based on a formula. The WIOA program focuses primarily on out-of-school youth (OSY), requiring local areas to expend a minimum of 75% of WIOA youth funds on OSY. The program includes 14 program elements that are required to be made available to youth participants. WIOA prioritizes work experience through a 20% minimum expenditure rate for the work experience program element. Local programs provide youth services in partnership with the WIOA American Job Center System and under the direction of local Workforce Development Boards. For more information visit About Youth Services through the US Department of Labor’s website (http://www.doleta.gov/Youth_services/about_oys.cfm)

State and Local Workforce Investment Boards

Under WIA each state established both state and local workforce investment boards. The state Workforce Investment Board (WIB) helps the Governor develop a five-year strategic plan describing statewide workforce development activities, explaining how the requirements of the Act will be implemented by the boards, and outlining how special population groups will be served. Local workforce investment boards must submit the plan, which must also include details about how local employment service and job service activities fit into the new service delivery structure, to the Secretary of Labor. The state WIB advises the Governor on ways to develop the statewide workforce investment system and a statewide labor market information system. The state WIB also helps the Governor to monitor statewide activities and report to the Secretary of Labor.

Local workforce investment boards, in partnership with local elected officials, plan and oversee the local system. These boards submit local plans for the Governor’s approval. Local boards designate AJC operators and identify providers of training services, monitor system performance against established performance measures, negotiate local performance measures with the state board and the Governor, and help develop the labor market information.
State/Local Intellectual/Developmental Disabilities (ID/DD) Agencies

Individuals with intellectual or other developmental disabilities generally enter the state ID/DD system at an early age and stay in this system during their post-school transition and through adulthood. State ID/DD agencies work cooperatively with local governments, voluntary organizations, service providers, and families to provide necessary services for persons with a diagnosis of intellectual disabilities or developmental disabilities. In most states, ID/DD agencies provide or fund an array of services including after-school programs; services for the aged; housing and residential options; counseling; day habilitation services; developmental programs; family support services; financial assistance; health care; respite care; transportation; waiver programs; research, prevention and intervention programs; and supported and sheltered employment.

States generally define developmental as a severe, ongoing, mental or physical disability that was present before 22 years of age. It’s important to note that some states vary age of onset of disability requirements. For example, Arizona requires onset of disability before age 18.

A service delivery-planning construct similar to the Individualized Education Plans (IEPs) used in Special Education programs at public schools guides the ID/DD system. The Individual Service Plan (ISP) requires specific services, supports, roles, responsibilities, and time frames for assisting individuals in meeting their objectives. In most cases, ID/DD practitioners develop the ISP with assistance from counselors, case managers, or others with administrative oversight.

ID/DD agencies are funded in a variety of ways. The state typically allocates general funds through the state ID/DD agency, and a growing portion of funding for ID/DD services comes from Medicaid. ID/DD agencies typically access these funds through special programs known as “Medicaid waivers.” While Medicaid historically financed long-term institutional care, there have been recent movements to place persons with ID/DD in community settings. For example, Medicaid Home and Community Based Services (HCBS) waiver programs have been effective at reducing institutionalization and providing Medicaid funds for community-based services. For more information about the Medicaid
Home and Community-Based Services waivers, refer to Unit 1 of Module 4.

State/Local Mental Health and Substance Abuse Agencies

People with mental health support needs may access a relatively independent and loosely coordinated public and private service system. The system’s four major components include:

- **Specialty Mental Health Sector:** Consists of mental health professionals such as psychiatrists, psychologists, psychiatric nurses, and psychiatric social workers trained to treat people with mental disorders. Mental health professionals provide services in this sector in outpatient settings such as private office-based practices or in public or private clinics.

- **General Medical/Primary Care Sector:** Consists of health care professionals such as general internist, pediatricians, and nurse practitioners. The general medical sector is often the first point of contact for adults with mental disorders.

- **Human Services Sector:** Social services, school-based counseling services, residential rehabilitation services, VR, criminal justice-based services, and religious professional counselors are part of this sector. For children, school mental health services are a major source of care, as are services in the child welfare and juvenile justice systems.

- **Voluntary Support Network Sector:** Consists of self-help groups such as 12-step programs and peer counselors. The network is an established component within the mental and addictive disorder treatment system as adult usage of services has increased since the early 1980s.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the federal agency in charge of the state mental health systems. The Center for Mental Health Services (CMHS), one of the three centers under SAMHSA, awards state grants for providing mental health services to people with mental illnesses. These grants improve access to community-based health care delivery systems for people with serious
mental illnesses who don’t have private health insurance. CMHS works closely with each state to design a customized service delivery plan that addresses the unique needs of the state’s populations. Each state administers its public mental health budget and authorizes services in several broad areas, including: system leadership for state and local county mental health units; systems oversight, evaluation and monitoring; administration of federal funds; and operation of state mental health programs, hospitals, or institutions.

Medical professionals, human service agencies, or schools refer people into the mental health system. Individuals with mental impairments gain access to these services by meeting specific state medical criteria usually related to the Diagnostics Statistical Manual (DSM). Because the largest provider of mental health services to children and adolescents is the school system, most youth with mental illnesses will contact the mental health system before their exit from school. Individuals with mental health impairments may enter this system during their schooling years through the Comprehensive Community Mental Health Services for Children program in several states or local collaborative programs administered jointly by schools and county mental health services. Upon leaving school, some youth may continue to use services.

To find local providers of mental health or substance abuse treatment, go to samhsa.gov (https://www.samhsa.gov/find-treatment).

Centers for Independent Living (CILs)

The Centers for Independent Living (CIL) program provides grants for consumer-controlled, community-based, cross-disability, nonresidential, private nonprofit agencies that individuals with disabilities design and operate within a local community. These centers provide an array of independent living services. At a minimum, centers are required to provide the following core services:

- Information and referral;
- Independent living skills training; and
- Peer counseling;
- Individual and systems advocacy; and
• Services that support transition from nursing homes and other institutions to the community, provide assistance to those at risk of entering institutions, and facilitate transition of youth to postsecondary life.

Most CILs are also actively involved in one or more of the following activities: community planning and decision making; school-based peer counseling, role modeling, and skills training; working with local governments and employers to open and facilitate employment opportunities; interacting with local, state, and federal legislators; and staging recreational events that integrate individuals with disabilities with their non-disabled peers. Many CILs also provide vocational services such as job development and placement. Some CILs are also actively involved in providing WIPA services.

The Centers for Independent Living program is funded and administered by the Rehabilitation Services Administration (RSA). This program provides support for the planning, conduct, administration, and evaluation of centers for independent living that comply with the standards and assurances in Section 725 of the Rehabilitation Act, consistent with state plans for establishing statewide networks of centers. The purpose of the Independent Living Program is to maximize the leadership, empowerment, independence, and productivity of individuals with disabilities and to integrate these individuals into the mainstream of American society. The Independent Living Program through RSA provides financial assistance to provide, expand, and improve independent living services; develop and support statewide networks of centers for independent living; and improve working relationships among state independent living rehabilitation programs, Centers for Independent Living, statewide Independent Living Councils (SILCs), Rehabilitation Act programs outside of Title VII, and other relevant federal and non-federal programs.

A directory of local CILS is available online (http://www.virtualcil.net/cils/). More information about the independent living movement is available online at: www.ncil.org.

The State Protection and Advocacy System

The Protection and Advocacy (P&A) system is the one longstanding and institutionalized system of disability-related advocacy services available,
free of charge, in every state. The P&A system has the capacity to provide a wide range of advocacy services to persons with disabilities through several specific federally funded P&A grants. Each P&A grant establishes a program with its own unique mandate.

Each state has a designated state P&A agency. Typically, this is an independent, not-for-profit agency such as Advocacy, Inc. in Texas or Protection and Advocacy, Inc. in California. In some states, the designated P&A agency will be part of the state government such as the Indiana Protection and Advocacy Services program. Most P&A systems deliver services through employees of the state-designated P&A agencies. However, some state P&A agencies will provide grants or subcontracts to other agencies to provide all or part of the services mandated under a particular P&A program.

All state P&A agencies employ, directly or through subcontractors, attorneys and other advocates to deliver services to eligible individuals with disabilities. The non-attorney advocates typically carry the title of advocate; some carry the title of paralegal.

The sections below describe the P&A programs that exist in each state. These include:

- Protection and Advocacy for the Developmentally Disabled (PADD)
- Protection and Advocacy for Individuals with Mental Illness (PAIMI)
- Protection and Advocacy for Individual Rights (PAIR)
- Protection and Advocacy for Assistive Technology (PAAT)
- Protection and Advocacy for Beneficiaries of Social Security (PABSS)
- Protection & Advocacy for Individuals with Traumatic Brain Injury (PATBI)
- Protection & Advocacy for Voting Accessibility (PAVA)
- The Client Assistance Program (CAP)

Although CAP doesn’t carry the P&A name, most consider CAP a part of the P&A family of programs. Like the P&A programs, it’s a federally funded advocacy program that exists in every state to serve persons with
disabilities. In many states, the same agencies that deliver services under the other P&A grants offer the CAP program.

The services of the seven P&A programs and the CAP program will, in all states, typically fall under one of the following categories:

- Information and referral services;
- Individual representation, including pursuit of client objectives through negotiation, mediation, administrative appeals, and court actions;
- Investigation of allegations of abuse and neglect (primarily a function of the PADD and PAIMI programs); or
- Outreach and community education (e.g., speaking, dissemination of print and web-based materials).

In addition, many P&As dedicate staff time to activities such as sitting on boards and committees where they make decisions concerning disability service delivery and policy within a state, or region of a state.

In the descriptions below, some of the more typical P&A services are outlined with an emphasis on the type of services that would most likely help an SSI or SSDI beneficiary overcome a barrier to employment. Although individual P&A programs discuss typical services or advocacy cases, there is great overlap among the P&A programs regarding the types of services each offers to eligible individuals. For example, each of the four traditional P&A programs may become involved with Americans with Disabilities Act (ADA) issues. Each state P&A system develops its own set of priorities on how best to use its limited resources, and some state P&A programs don’t provide the full range of services described below. In addition, many P&A agencies provide valuable services other than those described, including services they provide through additional, non-P&A sources of funding.

**Description of the Individual P&A Programs**

**The Protection and Advocacy for Persons with Developmental Disabilities (PADD) Program** was created by the Developmental Disabilities Assistance and Bill of Rights (DD) Act of 1975. The Act requires P&A programs to pursue legal, administrative, and other appropriate remedies to protect and advocate for the rights of individuals with developmental disabilities under all applicable federal and state laws.
The governor in each state designated an agency to act as the P&A system, and provided assurance that the system was and would remain independent of any service provider. The 1994 amendments to the DD Act expanded the system to include a Native American P&A program. Administration for Children Youth and Families, Administration on Developmental Disabilities (ADD) administers the PADD program.

**The Protection and Advocacy for Individuals with Mental Illness (PAIMI) Program** was established in 1986. Each state has a PAIMI program that receives funding from the national Center for Mental Health Services. Agencies must protect and advocate for the rights of people with mental illness and investigate reports of abuse and neglect in facilities that care for or treat individuals with mental illness. Agencies provide advocacy services or conduct investigations to address issues that arise during transportation or admission to, the time of residency in, or 90 days after discharge from such facilities. The system designated to serve as the PADD program in each state and territory is also responsible for operating the PAIMI program. SAMHSA CMHS administers the PAIMI program.

**The Protection and Advocacy for Individual Rights (PAIR) Program** was established by Congress as a national program under the Rehabilitation Act in 1993. PAIR programs protect and advocate for the legal and human rights of persons with disabilities. Although PAIR is funded at a lower level than PADD and PAMI, it represents an important component of a comprehensive system to advocate for the rights of all persons with disabilities. The system designated to serve as the PADD program in each state and territory is also responsible for operating the PAIR program. OSERS RSA administers PAIR.

**The Protection & Advocacy for Assistive Technology (PAAT) Program** was created in 1994 when Congress expanded the Technology-Related Assistance for Individuals with Disabilities Act (Tech Act) to include funding for P&As to “assist individuals with disabilities and their family members, guardians, advocates, and authorized representatives in accessing technology devices and assistive technology services” through case management, legal representation, and self-advocacy training. Originally passed by Congress in 1988, the Tech Act set up a lead agency in each state to coordinate activities to facilitate access to, providing, and funding for assistive technology devices and services for individuals with disabilities. The Office of Special Education and Rehabilitative Services,
National Institute on Disability and Rehabilitation Research (NIDRR) administers PAAT.

The Protection and Advocacy for Beneficiaries of Social Security (PABSS) is the P&A program that was developed as a component of the Ticket legislation when it was passed in 1999. PABSS projects provide legal advocacy services to Social Security beneficiaries that support their efforts to obtain and maintain employment. Services can include assisting beneficiaries in disputes with ENs or WIPA projects, enabling beneficiaries to access and benefit from employment services such as VR or AJCs, and advocating for beneficiary rights regarding wage and hour disputes. PABSS projects investigate and support beneficiaries in situations involving representative payees.

Created by the Traumatic Brain Injury (TBI) Act of 1996 (Public Law 104-166) as amended, the Protection and Advocacy for Individuals with Traumatic Brain Injury (PATBI) program is designed to improve access to health and other services for all individuals with brain injury and their families through grants to State Agencies and Protection and Advocacy Systems. PATBI serves to protect the rights of adults with TBI and ensures access to services for students with TBI.

The Help America Vote Act, which was signed into law on October 29, 2002, will overhaul federal elections in the United States through new set of minimum voting standards that each state and territory must follow. The Act also authorizes the Secretary of Health and Human Services to provide funds to the P&A of each state and territory to ensure full participation in the electoral process for individuals with disabilities, including registering to vote, casting a vote, and accessing polling places. These funds created the Protection & Advocacy for Voting Accessibility (PAVA) program operated by the state Protection & Advocacy agencies.

The Client Assistance Program (CAP) was established as a mandatory program by the 1984 Amendments to the Rehabilitation (Rehab) Act. Every state and territory, as a condition for receiving allotments under Section 110 of the Rehab Act, must have a CAP. CAP services include assistance in pursuing administrative, legal, and other appropriate remedies to ensure the protection of persons receiving or seeking services under the Rehab Act. The Rehabilitation Services Administration (RSA) also administers CAP.
More **information about the state protection and advocacy system** is available online (https://acl.gov/programs/aging-and-disability-networks/state-protection-advocacy-systems)

**Public School Systems**

**Special Education**

National and state laws govern special education services and supports for children with disabilities attending public schools. Congress passed the landmark legislation of the Education for All Handicapped Children Act (PL 94-142) in 1975 establishing a national policy for the education of all children with disabilities. In 1990, the law became the Individuals with Disabilities Education Act (IDEA), and Congress has reauthorized it twice, most recently in 2004. The law mandates a free appropriate public education (FAPE) for all children regardless of their disability. The federal law specifies children to receive services age three through 21. However, some states have authorized services beginning at an earlier age and extending past the age of 21. A free and appropriate public education (FAPE) means that special education and related services:

- Are provided at public expense, under public supervision and direction, without charge;
- Meet the requirements established by a state board of education;
- Include preschool, elementary school, middle school, or secondary education in a state; and
- Are provided in keeping with an individualized education program (IEP).

Children in special education receive specifically designed instruction to meet their unique needs. The five-step special education process begins with identifying a child through reevaluation every three years to determine continuing need for special education and related services.

1. **Identification and referral:** When a child is suspected of having a disability, a referral, either written or oral, is given to the school requesting an evaluation.
2. **Evaluation:** The school then evaluates the child to determine whether or not the child has a disability as well as the nature and extent of the special education and related services needed.

3. **Determination of eligibility:** Based on the results of the evaluation, a team determines if a child is eligible to receive special education and related services.

4. **Development of an individualized education program (IEP) and determination of services:** If a child is found eligible to receive special education and related services, a team then develops and implements an appropriate IEP to meet the needs of the child. The IEP must be reviewed and revised at least annually.

5. **Reevaluation:** At least every three years, a team must reevaluate a child to determine whether he or she continues to need special education and related services.

Beginning in 1990, the Individuals with Disabilities Education Act (IDEA) required transition services for all children with disabilities. Secondary education transition is a results-oriented process focused on improving the academic and functional achievement of the child with a disability to facilitate the child’s movement from school to post-school activities including postsecondary education, vocational education, integrated employment (including supported employment), continuing and adult education, adult services, independent living, and community participation. The IEP must contain transition goals and activities no later than the first IEP to be in effect when the child is 16 and updated annually. The law states that special education and related services prepare students for employment and independent living that makes it clear that educators, parents, and students must consider adult outcomes as they plan for students’ school experiences.

**U.S. Department of Veterans Affairs (VA)**

A completely separate system of services provided by both the VA and the U.S. Department of Labor helps veterans re-enter the civilian workforce. Some programs are for veterans with disabilities, while other programs or services are available to all veterans. It’s important to
understand that individuals may receive services from BOTH the veterans system and the general service system, and CWICs should explore all potential options.

The following section will describe the major vocational rehabilitation and employment support programs offered by the VA to veterans with disabilities. For more information about VA services, refer to www.va.gov/.

Also, keep in mind that a wide range of employment services and supports are available to all veterans of the U.S. armed forces, which are also not covered in this unit. For more information about these services, go to the Department of Labor website at: www.dol.gov/vets/

The Vocational Rehabilitation and Employment (VR&E) Program

The Vocational Rehabilitation and Employment (VR&E) Program assists veterans who have service-connected disabilities with obtaining and maintaining suitable employment. This program is also referred to as the Chapter 31 program because Congress authorized it under Title 38, Code of Federal Regulations (CFR), Chapter 31. Services that the VR&E program may provide include:

- Comprehensive rehabilitation evaluation to determine abilities, skills, and interests for employment;
- Vocational counseling and rehabilitation planning for employment services;
- Employment services such as job-training, job-seeking skills, resume development, and other work readiness assistance;
- Assistance finding and keeping a job, including the use of special employer incentives and job accommodations, on-the-job training (OJT), apprenticeships, and non-paid work experiences;
- Post-secondary training at a college, vocational, technical, or business school;
- Supportive rehabilitation services including case management, counseling, and medical referrals; and
- Independent living services for veterans unable to work due to the severity of their disabilities.
Eligibility for the VR&E Program

The VR&E program is only available to certain individuals who meet very specific eligibility criteria. Active duty service members are eligible if they:

- Expect to receive an honorable discharge upon separation from active duty;
- Obtain a memorandum rating of 20 percent or more from the VA; and
- Apply for Vocational Rehabilitation and Employment (VR&E) services.

Veterans are eligible if they:

- Have received, or will receive, a discharge that is other than dishonorable;
- Have a service-connected disability rating of at least 10 percent, or a memorandum rating of 20 percent or more from the Department of Veteran Affairs (VA); and
- Apply for Vocational Rehabilitation and Employment (VR&E) services.

VR&E services are only available to eligible individuals for a certain period of time, the “basic period of eligibility.” The basic period of eligibility in which veterans may use VR&E services is 12 years from the latter of the following:

- Date of separation from active military service, or
- Date the VA first notified the veteran of a service-connected disability rating.

The VA may extend the basic period of eligibility if the agency determines that a veteran has a serious employment handicap.

Applying for VR&E Services

Veterans and active duty service members can apply for VR&E benefits using the Internet (https://www.ebenefits.va.gov/ebenefits/homepage).

Veterans may also apply for VR&E services by mail by completing VA Form 28-1900, Disabled Veterans Application for Vocational
**Rehabilitation** (http://www.va.gov/vaforms/). Veterans should mail the completed form to the nearest VA regional office.

**VR&E Entitlement Determinations**

Once an eligible veteran has applied for VR&E services, the VA schedules him or her to meet with a Vocational Rehabilitation Counselor (VRC) for a comprehensive evaluation to determine if he or she is entitled for services. A comprehensive evaluation includes:

- An assessment of the veteran’s interests, aptitudes, and abilities;
- An assessment of whether service-connected disabilities impair the veteran’s ability to find or hold a job using the occupational skills he or she has already developed; and
- Vocational exploration and goal development leading to employment or maximum independence at home and in the veteran’s community.

During the entitlement determination, a Vocational Rehabilitation Counselor (VRC) works with the veteran to determine if an employment handicap exists. An employment handicap exists if the veteran’s service connected disability impairs his or her ability to obtain and maintain a job. The VCR establishes entitlement to services if the veteran has an employment handicap and is within his or her 12-year basic period of eligibility and has a 20 percent or greater service-connected disability rating.

If the service-connected disability rating is less than 20 percent, or if the veteran is beyond the 12-year basic period of eligibility, then the VRC must find a serious employment handicap to establish entitlement to VR&E services. The VRC bases the serious employment handicap on the extent of services the veteran requires to overcome his or her service and non-service connected disabilities, permitting the return to suitable employment.

**VR&E Services**

Once the VRC determines a veteran is entitled for VR&E services, the veteran and VRC work together to:

- Determine transferable skills, aptitudes, and interests
- Identify viable employment or independent living services options
- Explore labor market and wage information
- Identify physical demands and other job characteristics
- Narrow vocational options to identify a suitable employment goal
- Select a VR&E program track leading to an employment or independent living goal
- Investigate training requirements
- Identify resources the veteran needs to achieve rehabilitation
- Develop an individualized rehabilitation plan to achieve the identified employment or independent living goals

A rehabilitation plan is an individualized, written outline of the services, resources, and criteria that the veteran will use to achieve employment or independent living goals. The plan is an agreement signed by the veteran and the VRC and is updated by the VRC as needed to assist the veteran in achieving his or her goals.

Depending on their circumstances, veterans will work with their VRC to select one of the following five tracks of services:

1. **Reemployment with Previous Employer:** This option is designed for those individuals who wish to return to work with a former employer. Services under this option may include advice about reemployment rights, consultation with the employer, work adjustment services, job accommodations, job modifications, short-term training, licensure, and certifications.

2. **Rapid Access to Employment:** This option is designed for those veterans who already possess most of the necessary skills to compete for suitable employment opportunities and wish to obtain employment as soon as possible. Services under this option may include short-term training, licensure, certifications, job readiness preparation, resume development, job search assistance, job accommodations, and post-employment follow-up.
3. **Self-Employment:** This option is designed for individuals who have limited access to traditional employment, need flexible work schedules, or need a more accommodating work environment due to their disabling conditions or other life circumstances. Services under this option may include analysis of the viability of a business concept, development of a business plan, training in the operation of a small business, marketing and financial assistance, and guidance on obtaining adequate resources to implement the plan.

4. **Employment through Long-Term Services:** This option is designed for those individuals who need specialized training or education to obtain and maintain suitable employment. Services under this option may include on-the-job training (OJT), apprenticeships, post-secondary education such as college, vocational or technical school, internships, job shadowing, work monitoring, work-study, and public-private job partnering.

5. **Independent Living Services:** This option is designed for individuals whose disabilities are so severe that they are currently unable to pursue an employment goal. These individuals may need rehabilitation services to live more independently and to increase their potential to return to work. Services under this option may include independent living skills training, assistive technology, services at special rehabilitation facilities, and connection to community-based support services.

After the VRC and veteran work together to develop and sign a plan, a VRC or case manager will continue to work with the veteran to implement the plan to achieve suitable employment or independent living. The VRC or case manager will provide ongoing counseling and assistance, and coordinate services such as tutorial assistance, training in job-seeking skills, medical and dental referrals, adjustment counseling, payment of training allowance, if applicable, and other services as required to help the veteran achieve rehabilitation.

**Independent Living Services Provided by VR&E**

The Independent Living program ensures that each eligible veteran is able, to the maximum extent possible, to live independently and
participate in family and community life, increasing his or her potential to return to work.

The independent Living program is designed for veterans whose service-connected disabilities are so severe they are currently unable to pursue an employment goal. Services may include the following:

- Assistive technology
- Specialized medical, health, or rehabilitation services
- Services to address any personal or family adjustment issues
- Independent living skills training
- Connection with community-based support services

When a VRC determines that employment goals aren’t currently feasible, he or she will need to conduct an evaluation of the veteran’s independent living needs. The VRC and veteran will work together to identify the veteran’s needs and the services required to address the identified needs. The VRC will write an individualized Independent Living Program Plan providing the services necessary to meet the veteran’s identified needs. Referral to specialized rehabilitation facilities or for consultation with other rehabilitation professionals may be necessary to development and implement the veteran’s ILP.

**The VetSuccess on Campus Program (VSOC)**

The VSOC program aims to help student veterans and their qualified dependents succeed and thrive through a coordinated delivery of on-campus benefits assistance and counseling, leading to completion of their education and preparing them to enter the labor market in viable careers. VSOC Counselors may provide the following services:

- Community and on-campus outreach;
- Communication with student veterans and their dependents to address questions regarding VA education benefits, health services, and general VA benefits;
- Educational and vocational assessments and counseling designed to help an individual choose a vocational direction and determine the course of action needed to achieve the chosen goal; assistance may include interest and aptitude testing; occupational exploration; setting occupational goals; locating the
right type of training program; and exploring educational or training facilities that might help achieve an occupational goal;

- Survivors and Dependents Assistance, which provides education and training opportunities to eligible dependents of certain veterans;

- Adjustment counseling to resolve problems that interfere with completion of education programs and entrance into employment;

- Referrals for more intensive health services, including mental health treatment through VHA medical centers, Community-Based Outpatient Clinics, or Vet Centers;

- Assistance to veterans applying for other VA benefits; and

- Referrals to community organizations as needed.

Additional information on VetSuccess on Campus can be found online on the U.S. Department of Veterans Affairs (https://www.benefits.va.gov/vocrehab/vsoc.asp)

Educational and Career Counseling Services Provided by VR&E

VA’s Education and Career Counseling program is a great opportunity for service members and veterans to get personalized counseling and support to help guide their career paths, ensure most effective use of their VA benefits, and achieve their goals.

Eligibility:

- Transitioning service members within six months prior to discharge from active duty

- Veterans within one year following discharge from active duty

- Any service member or veteran currently eligible for a VA education benefit

- All current VA education beneficiaries

Services include assisting the service member or veteran with:

- **Career choice:** Understanding the best career options based interests and capabilities.
• **Benefits coaching:** Guidance on the effective use of VA benefits and/or other resources to achieve education and career goals.

• **Personalized support:** Academic or adjustment counseling and personalized support to help remove any barriers to success.

**Veterans may apply by following these steps:**


2. Pull up VA Form 28-8832. Print, complete, and mail the form to the nearest VA regional office.

3. Eligible individuals will be invited to attend an orientation session at the nearest VA Regional Office.

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**Community Agencies Administering Individual Development Accounts (IDAs) and Other Asset Development Programs**

In the past, our best efforts to help American families living in poverty focused almost exclusively on providing income supports, such as TANF and SSI monthly cash payments. In recent years, there has been a growing emphasis on moving beyond these methods. While monthly cash payments provide much-needed assistance to meet basic living needs, they do very little to help poor families save for their future and become more self-sufficient. Some of the most current thinking in poverty reduction focuses on the accumulation of “wealth,” not just on cash flow. This approach encourages people to save money and invest in assets that increase in value over time based on the theory that asset development has the capability to both move people out of poverty and keep them out over time. Unfortunately, this population has historically been left out of asset building programs for a variety of reasons, including lack of information. This is beginning to change, and the new way of thinking about asset development is gaining a foothold in the disability services community.
Achieving a Better Life Experience (ABLE) Accounts

A new asset-building opportunity for beneficiaries is the Achieving a Better Life Experience (ABLE) Act. This Act, signed into law in December 2014, provides an opportunity for certain individuals with disabilities to establish a tax-favored savings account that is excluded from the SSI resource limit, up to $100,000, and from certain other means-tested federal programs, up to the ABLE program limit.

The beneficiary can use the funds in the account to pay for qualified disability expenses. The expenses must relate to blindness or disability, including expenses for maintaining or improving health, independence, or quality of life. These expenses may include education, housing, transportation, employment training and support, assistive technology and related services, personal support services, health, prevention and wellness, financial management and administrative services, legal fees, expenses for ABLE account oversight and monitoring, funeral and burial, and basic living expenses.

The ABLE Act addresses the significant costs that individuals with disabilities have in living or working in the community. For more information on ABLE accounts, go to the ABLE National Resource Center (https://ablenrc.org/)

Individual Development Accounts (IDAs)

Individual Development Accounts (IDAs) are a great example of public policy that supports asset development. IDAs are special accounts that allow members of low-income groups (including persons with disabilities) to save for specific goals such as home ownership, small business ownership, or post-secondary education while also receiving matching funds and financial counseling. An IDA participant identifies a specific asset that he or she would like to acquire and works with the IDA program to develop a savings plan that will make it feasible to reach the goal and ultimately purchase the asset. The individual then begins to deposit a certain amount of earned income on a regular basis, typically monthly, into an IDA account based on his or her plan.

What defines the IDA savings account is that participants are eligible to receive matching funds if they use their savings to purchase an eligible asset. The match rate is the amount that the IDA program contributes for each dollar that a participant saves. The rate varies greatly across IDA programs and can range anywhere from $1 to $8 of match for every
$1 of earnings saved. For example, if a program has a $2 match rate for every $1 saved, each time a participant deposits $25 in his or her IDA account, the IDA program allocates an additional $50 in matching funds for their savings. Match dollars for IDAs come from many different places such as government agencies, private companies, churches, or local charities. In most cases, donors can get a tax deduction for contributions to IDAs. Depending on the program, the participant may not actually place the matching funds into the IDA account during the savings period, but could put them in a separate account until he or she is ready to purchase the asset. When the account holder is ready, he or she uses both the savings and the match to purchase the asset. By leveraging saved dollars against matched dollars, individuals can grow their savings more quickly and be successful in purchasing an asset with long-term return potential.

IDAs are usually offered through programs that involve partnerships between local non-profit organizations and financial institutions. The IDA program recruits participants, and provides or arranges with community partner organizations to provide financial education classes for participants. They may also provide or arrange for IDA participants to receive one-on-one counseling and training. After signing up for an IDA program, each participant opens up an account with the partnering bank or credit union. The bank or credit union handles all transactions to and from the IDA, just as they do with other types of savings accounts. Each month, IDA participants receive a report telling them how much money (individual savings plus match plus interest) is accumulating in their IDA. An IDA program can be as short as one year or as long as five years. IDA participants may have the money dispersed as soon as they have reached their savings goal and as long as they have approval from the IDA program sponsor. Some IDA participants choose one big savings goal, such as a home, but others save for a number of related goals, such as textbooks and college tuition.

There are two kinds of IDAs. Some are federally funded; some have funding provided by other organizations. The Department of Health and Human Services, Administration for Children and Families (ACF) oversees the Assets for Independence (AFI) federal grant program, which has historically been one of the primary federally funded IDA programs. In fiscal year 2017, no funds were appropriated for the AFI program and ACF will not be making new grant awards. At this time, grantees are fading out their programs, however, organizations operating AFI projects
with existing grants are responsible for continuing to operate those projects for the funded project period indicated on the notice of their grant award. All federal funding for AFI IDA projects will cease after federal fiscal year 2021. IDA programs with other funding continue to operate.

For more information on IDA programs that may be available in your area, go to: prosperitynow.org/map/idas

For detailed information about how ABLE accounts, IDAs, and other asset development programs operate and how funds set aside in these programs may affect Social Security disability benefits, refer to Module 5, Unit 7.

**Conclusion**

This unit provided brief overviews of the services offered by the most common agencies that assist individuals with disabilities. It’s important to recognize that there will be variance among states and local areas in terms of which agencies are operational and how they provide services. In addition, we did not discuss many small service providers in this unit. You will need to scan your local communities and note all providers of services that could potentially help Social Security disability beneficiaries achieve their employment goals. You should maintain and update regularly any contact information for all potential service providers. WIPA Project Managers need to ensure that they maintain agency information in a centralized location accessible to all team members. We also recommend that personnel receive training on the various service systems so that they will understand all of the local rules governing who is eligible for services, which agencies provide services, and how beneficiaries can access them.
Module 2 – Partnering with Community Agencies and Conducting Community Outreach
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Module 2 – Partnering with Community Agencies and Conducting Community Outreach

Introduction

CWICs don’t promote employment outcomes for beneficiaries of Social Security disability programs in isolation. WIPA services are only one piece of the employment puzzle; combine them with vocational counseling, job search assistance, job accommodations, and other employment-focused services and supports to achieve significant gains.

Content in this module begins by focusing on how to provide effective outreach. It includes descriptions of activities that target Ticket-eligible beneficiaries and other Social Security beneficiaries with disabilities in the geographic area, as well as outreach activities designed for community agencies, stakeholder groups, and partner agencies. The second unit of this module provides information on how WIPA personnel should interact and work collaboratively with the Ticket to Work Help Line, a major source of WIPA referrals. Finally, content focuses on how to work with other public and private community-based organizations such as Social Security field offices, American Job Centers, state Vocational Rehabilitation (VR) Agencies, Employment Networks (ENs), public schools, mental health organizations, and IDA/Asset Building organizations.

CWIC Core Competencies

- Designs and implements outreach strategies targeted toward transition-age youth and young adult beneficiaries, including individuals in secondary and post-secondary education, school-to-work transition, and vocational training programs to increase access to and benefit from WIPA services and the Ticket to Work program.

- Develops and implements outreach strategies designed specifically to increase WIPA service delivery to traditionally
underserved populations within the catchment area such as veterans with disabilities, homeless individuals, beneficiaries in rural or dense urban areas, and individuals from diverse ethnic or linguistic backgrounds.

- Collaborates with Employment Networks (ENs) or other public and private community-based organizations (e.g., state VR agencies, American Jobs Centers) through interagency agreements or other information or resource-sharing mechanisms to support employment outcomes and increased financial stability for beneficiaries.

- Works collaboratively with the Ticket Program Manager (TPM) and the Ticket to Work Help Line to conduct outreach to Social Security disability beneficiaries eligible for the Ticket to Work program. Works collaboratively with the Help Line to ensure timely response to referrals, and effective and accurate responses when referred beneficiaries aren’t appropriate for services.

- Interacts effectively with Social Security field office personnel and Area Work Incentives Coordinators (AWICs) in the provision of WIPA services.

- Collaborates with local financial services and asset development agencies, such as banking, financial education, credit repair, Individual Development Account (IDA) programs, tax assistance, and other services to promote the successful participation of beneficiaries in programs designed to increase financial stability.
Competency Unit 1 – Performing Outreach to Social Security Beneficiaries with Disabilities, Community Agencies, and Other Key Stakeholders

The Importance of Outreach

Outreach activities introduce WIPA services to potential users including Social Security disability program beneficiaries and the agencies most likely to refer them. The outreach process is primarily a marketing or sales function. The outreach activities you perform are similar to what salespeople in the business world do. The objective of this specialized marketing effort is three-fold:

1. Raise awareness of WIPA services within the disability community; educate beneficiaries and agency personnel about what WIPA services include and who Social Security intends them to assist.

2. Promote employment of people with disabilities by educating beneficiaries and agency personnel on how earned income affects public benefits and how work incentives can help achieve employment goals.

3. Establish relationships with other agency personnel who support individuals with disabilities in their efforts to obtain and maintain paid employment. These disability professionals are helpful partners in your mission to increase employment outcomes for persons with disabilities.

Begin marketing WIPA services by finding ways to reach the targeted customer base — Social Security beneficiaries with disabilities who are interested in employment. You can reach eligible beneficiaries by contacting agencies that serve them, particularly agencies that provide vocational or employment services.
This unit includes marketing and sales methods for contacting these agencies. The main goal of these marketing activities is to solicit appropriate referrals from partner agencies in the local community. CWICs are responsible for informing and encouraging community agencies to refer eligible, high-priority individuals for WIPA services and to encourage beneficiaries to utilize work incentives planning services in their efforts to enter the workforce.

Outreach activities also include educating beneficiaries and community agencies about the effect of employment on the various public benefit programs. Education is critical because so much misinformation and misunderstanding surrounds this issue. Unfortunately, much of this misinformation is spread within the disability services community by well-intentioned but uninformed agency personnel. An important objective of outreach to disability services agencies is to increase community awareness of the many work incentives available to beneficiaries. The message of this educational effort is that employment and public benefits aren’t necessarily mutually exclusive. It’s quite possible for Social Security beneficiaries with disabilities to work and retain cash payments as well as medical benefits. It’s also possible to work and have an overall better financial outcome than by remaining solely dependent on public benefits. Increasing awareness of Social Security work incentives can ease the fear and uncertainty about employment many beneficiaries and the professionals who serve them feel. Knowledge of Social Security work incentives truly is power in this instance.

Finally, CWICs perform outreach to establish networks with key community stakeholders. WIPA services won’t be successful if CWICs provide them in a vacuum. Many other players should participate in the process of work incentives planning for real change to occur. We describe the primary stakeholder groups in Unit 3 of Module 1, but they include:

- State Vocational Rehabilitation Agencies (SVRAs);
- Employment Networks (ENs) under the Ticket to Work program;
- State or regional Workforce Investment Boards (WIBs) and American Job Centers (AJCs);
- State or local intellectual disability or developmental disability agencies;
- State or local mental health or substance abuse agencies;
Outreach activity must be a two-way street that builds reciprocal relationships. It’s not just about stakeholders knowing what WIPA services entail. It’s equally important to build relationships with key players and understand their roles. You will rely on these stakeholders as you work with beneficiaries to promote employment and enhance financial independence. The more you interact and collaborate with other community stakeholders, the more successful WIPA services will be. Unit 3 of this module contains more details about how to work collaboratively with these stakeholder groups.

**WIPA Outreach Considerations**

Plan carefully before you conduct outreach to make sure you achieve effective results. Before you review specific strategies, consider the following important factors of the outreach function.

**Social Security’s Expectations for WIPA Outreach Activities**

WIPA personnel must understand Social Security’s expectations for WIPA outreach activities. Social Security defines outreach as activities that include but aren’t limited to: describing WIPA services prominently on the organization’s website; engaging in dialogue with community, local, and state service providers to increase WIPA referrals; and meeting with diverse audiences to describe WIPA services. Based on specifications in the WIPA Terms and Conditions document, WIPA projects meet the following requirements:

- Limit outreach to 10 percent of work effort and expenditures.
- Limit travel costs associated with outreach efforts and, as feasible, coordinate outreach events with community partners.
including Area Work Incentives Coordinators (AWICs), Protection and Advocacy for Beneficiaries of Social Security (PABSS) grantees, State VR agencies, American Job Centers (AJCs), and other programs that may benefit WIPA participants.

- Include the Ticket to Work Help Line as the primary contact for beneficiaries on websites, in brochures, and within outreach presentations to the greatest extent possible consistent with the WIPA business model and Help Line referral protocols. When the Ticket to Work Help Line refers beneficiaries to WIPA projects, serve the beneficiaries on a priority basis. Unit 2 of this module includes more information about how you should collaborate with the Ticket to Work Help Line.

- Outreach targeting transition age youth between the ages of 14 to 25, should include communication with schools, vocational rehabilitation programs, and parents.

Social Security conducts significant outreach for its work incentives programs through a Ticket Program Manager (TPM) contractor. Examples include Work Incentives Seminar Events (WISE), operating the Ticket to Work Help Line, and disseminating information through social media outlets. Social Security doesn’t require WIPA projects to schedule and conduct WISE webinars, but values WIPA participation in these events. Social Security encourages WIPA project managers to support staff when invited to present on a WISE.

**Budgeting Staff Time to Perform Outreach**

Marketing WIPA requires staff time and the ability to handle increased demand from beneficiaries who hear about services through your outreach. If WIPA personnel do too much outreach, there may not be enough time for personnel to serve beneficiaries. Increasing demand for WIPA services in excess of program capacity to deliver them isn’t a desirable outcome. To avoid this, WIPA Project Managers must allocate no more than 10 percent of WIPA contract resources to outreach.

Managers must also consider how to deploy staff resources for outreach activity. Will all WIPA staff members share in this responsibility, or only designated staff? You will need to consider and frequently reassess the advantages and disadvantages to both strategies. Some CWICs might have more skills or interest in marketing. Others might be so skilled at work incentives counseling that it wouldn’t make sense to have them
perform outreach while beneficiaries are waiting for service. Pay close attention to allocated staff resources to achieve the best overall results.

Outreach is an ongoing activity. The target population for services is fluid, with new customers continuously joining the disability rolls. In addition, community-based service agencies often have high rates of staff turnover, and current beneficiaries as well as existing staff also need regular information updates to keep WIPA services in the forefront. Busy disability services workers sometimes forget about community resources, and WIPA services are no exception. Contact community agencies frequently to help them stay aware of your services.

**Developing and Following an Outreach Plan**

The outreach function may overwhelm CWICs who haven’t performed this role in the past. The key to successful outreach is staying organized and planning carefully. Develop a written outreach plan that lists agencies prioritized for outreach and how you’ll market to them. If outreach directly targets Social Security beneficiaries, clearly describe how to conduct those activities, too.

**Effective Outreach Techniques for WIPA Projects**

Once you determine staff and timing for outreach, focus on how you will perform the outreach activity. Which strategies or techniques are most effective for your local stakeholder groups? A combination of techniques can maximize your chances of reaching the target audience. Remember, the objective is to spread the word about WIPA services to as many people as possible in collaboration with partner agencies. WIPA stakeholder groups include Social Security beneficiaries and professionals who provide services to them. Make sure to broadly disseminate information across this community. We provide brief descriptions of common CWIC marketing and public awareness activities below. This is by no means an exhaustive list. You know your local community best and should devise creative ways to market your services.

**Outreach Activities Directly Targeting Social Security Beneficiaries with Disabilities**

Although there is no single mailing list of all Social Security disability beneficiaries, there are still ways to directly contact beneficiaries. One is to work with local agencies that have extensive mailing lists to send out
mass mailings, fliers, or email blasts announcing WIPA services. Some agencies distribute this information for free as a service to their clients. Agencies serving individuals with disabilities are prohibited by law from sharing their clients’ contact information with any other entity.

Public school systems might be able to help you reach beneficiaries who are still in school. When possible, provide fliers to special education teachers, school counselors, or family resource centers to send home to parents. Schools might even mail fliers to students and their families or send an email message. WIPA projects could announce not only their services, but also invite students and families to attend an informational session about Social Security disability benefits and employment. Repeat the process every year to catch new students entering the system and to reinforce messages to students or families who have attended past informational sessions.

The VCU NTDC website also contains several useful resource documents and sample PowerPoint presentations WIPA personnel may use when performing outreach. Some materials are specifically designed for the transition age youth audience. (https://vcu-ntdc.org/resources/resourceDetail.cfm?id=7)

In addition, WIPA projects may directly reach beneficiaries via traditional mass marketing techniques such as television or radio advertisements, public service announcements, or use of social media such as Facebook or Twitter. Remember, Social Security must approve all WIPA project-marketing materials.

Marketing Presentations to Community Agencies and Groups

It’s not enough to send letters of introduction to stakeholder agencies and then wait for referrals to arrive. You need to facilitate in-person meetings to explain what services you offer and how these services can help beneficiaries achieve their career goals. Providing marketing presentations to stakeholder groups and community agencies is an essential component of any outreach plan. WIPA projects need to plan all face-to-face outreach meetings very carefully.

**REMEMBER:** Social Security expects WIPA projects to limit travel costs associated with outreach efforts and, as feasible, coordinate outreach events with community
partners including Area Work Incentives Coordinators (AWICs), Protection and Advocacy for Beneficiaries of Social Security (PABSS) grantees, State VR agencies, America’s Job Centers, and other programs that directly benefit WIPA candidates. Limit face-to-face outreach activity to events that will maximize the number of appropriate referrals. Avoid outreach activity that isn’t likely to generate high-priority referrals.

Face-to-face outreach meetings should never be impromptu. Carefully plan them with agency management to include the largest audience possible. In some cases, the audience will only include professionals, but in other cases, the audience may include beneficiaries, family members, caregivers, and service providers. WIPA projects should seek to attract the largest and most diverse group possible. Hold meetings at various times to accommodate different schedules. Many family members won’t be able to attend during standard work hours. Hold some meetings on nights or weekends to attract the most people possible.

Focus on general awareness of WIPA services during these meetings. Key information to provide includes:

• Description of services provided and any limitations on these services;
• Identification of the main objective of WIPA services;
• Description of who is eligible for services and which beneficiaries are a high priority for services; and
• Instructions on how to make referrals for services.

You must be clear about who isn’t eligible for services to attract appropriate referrals. Don’t assume the audience knows who to refer or who would benefit from WIPA services. Provide written information listing eligibility and criteria. The more you educate your referral sources, the less time you will waste handling inappropriate referrals.

Be clear about the goal of WIPA services during your presentations. Referral sources often think the program is designed to maximize public benefit payments or to keep beneficiaries from losing benefits due to employment. Neither of these perceptions is correct. In fact, the objective is to provide WIPA services that promote employment and enhance financial stability for Social Security disability beneficiaries. Put
this objective in writing to clearly identify the goal of WIPA services and avoid misconceptions.

When describing services, include examples of what types of assistance you don’t provide. Community agencies frequently think WIPA projects provide representative payee services or actively manage benefits by reporting beneficiary income to Social Security. WIPA personnel should never engage in these functions. If referral sources have unrealistic expectations about what the program does, they will make inappropriate referrals or be disappointed in the services offered. Manage expectations by providing clear written information during presentations.

To find sample Social Security approved PowerPoint presentations you may use when you conduct outreach, go to the VCU NTDC website Resources – WIPA Outreach (https://vcu-ntdc.org/resources/resourceDetail.cfm?id=7)

**Participation in Resource Fairs**

Another useful strategy is to staff a booth at local resource fairs, conferences, or other large gatherings of stakeholder groups. These events may include state rehabilitation association meetings, conferences for special education teachers, or advocacy group meetings. You can reach a significant number of people in a relatively short time by attending these events. Even more effective is securing a place on the agenda to make a public awareness presentation. Staff these events with trained CWICs because beneficiaries commonly ask questions about their own situations. Prepare to provide information about the effect of work on benefits to beneficiaries attending these events, and hand out Social Security publications that describe work incentives (such as the Red Book) as well. You can find the current version of the Red Book online (https://www.ssa.gov/redbook/).

**Dissemination of Marketing Materials**

CWICs often disseminate marketing materials to spread the word about work incentives counseling services. Materials often include brochures, fliers, posters, or other printed materials. Dissemination methods could include mass mailings, email blasts, brochures left at Social Security or VR office waiting rooms, or displaying posters where beneficiaries are likely to see them. Displaying posters prominently at the local Social Security office or in the waiting rooms of the local Medicaid or welfare
agencies is particularly effective. Be creative, and think about where your marketing materials will attract the most eligible people.

**IMPORTANT:** Social Security must approve in advance all WIPA project-marketing materials. The current Terms & Conditions document contains the following directive:

“WIPA grantees shall not distribute brochures, materials, articles, or website materials without first requesting review and approval from the designated Social Security Project Officer. Any approved publications shall contain the following disclaimer:

“This document is funded through a Social Security cooperative agreement. Although Social Security reviewed this document for accuracy, it doesn’t constitute an official Social Security communication.”

In all cases, any public-facing documents, website, brochures, etc., must also include the phrase “at taxpayer expense”. WIPA projects have some latitude with the phrasing, for example, “We developed this website at U.S. taxpayer expense” or “We published this brochure at U.S. taxpayer expense”.

If your WIPA project is developing outreach materials, contact your VCU Technical Assistance Liaison to see if approved examples are available for reference. VCU has created several outreach presentations or WIPA projects to use. You will find these WIPA outreach materials on the VCU NTDC website (https://vcu-ntdc.org/resources/resourceDetail.cfm?id=7).

**Websites for WIPA Projects**

Maintaining a website for your WIPA project is a great way to disseminate information without incurring travel or postage expenses. Use a website to describe services and limits on services, communicate eligibility criteria, and explain how WIPA projects prioritize beneficiaries for services. Be sure to include specific information about how to request services or refer someone for services. You can also highlight success stories and provide summary information about work incentives. In today’s information-driven world, a Web presence is an absolute necessity.

WIPA projects must adhere to Social Security requirements when developing websites. First, the Office of Employment Support (OES)
Project Officer must approve all content in advance. Second, websites and other electronic communications must comply with Section 508 of the Rehabilitation Act. Contact your VCU NTDC TA Liaison for assistance with the presentation, accessibility, and readability of websites.

**Using Social Media for Outreach**

In today’s technological world, companies often use social media as part of their overall marketing and outreach plan. Social media platforms are web-based communication tools that enable people to interact with each other by both sharing and consuming information. The social media platforms most people are familiar with include Facebook, Twitter, Instagram, Snapchat, YouTube, and Blogs.

The Social Security Administration uses social media extensively to communicate with the public. You can learn more about these efforts by going to Social Security’s social media hub (https://www.ssa.gov/socialmedia/). This web page also contains lots of written guidance about how to use social media in ways that protect privacy and meet all federal requirements.

WIPA projects may also use social media to get the word out about their services, share benefits counseling success stories and even provide information about how disability benefits are affected by paid employment. It’s important to understand, however, that Social Security requires WIPA projects to submit all social media content for review and approval prior to posting it publicly.

**Developing Effective Marketing Presentations**

Before presenting WIPA services to stakeholders, be prepared to answer the audience’s most important question: “What’s in it for me?” If you are unable to articulate how your WIPA project can benefit them on a personal level, you won’t be able to “sell” the service and receive referrals. People don’t buy things they don’t want or think they don’t need — it’s that simple.

An effective marketing presentation answers these four basic questions:

- What are the tangible benefits of WIPA services?
- What problems will WIPA solve?
• How will WIPA services prevent potential future problems?
• What are the unique “features” of WIPA services?

Answers will vary depending on the stakeholder group. Never assume what one group perceives as a benefit of WIPA services will be of equal value to another group. Each group will value different aspects of the program. Evaluate the interests of your stakeholders and customize your sales pitch to match.

When presenting, highlight the benefits of the service and what problems it will solve. Consider making a list of important benefits and features to include in handouts or show during presentations. Customize the list to meet the needs and interests of each stakeholder group. Making a list of benefits and features helps you think about the interests of the audience in advance. The more prepared you are to address their specific interests or concerns, the more effective your presentation will be. Speaking extemporaneously is never recommended — preparation and practice are the keys to success.

Be clear about the purpose of the presentation and stay on-message. Tell the audience what to expect in advance, then continue with the prepared presentation outline. Marketing talks are intended to help the audience understand what WIPA services include, who they serve, and what benefits they offer. They aren’t the appropriate setting to train the audience on the details of the Social Security work incentives or other federal income support programs. Marketing and training are very different, and you must never confuse these functions. This is also not the time to counsel specific individuals, even if members of the audience ask case-specific questions. If questions about specific cases arise, ask to meet with the individual after the presentation for a private discussion. Addressing case-specific issues in front of a group often confuses the audience. Don’t let audience members lead the presentation off-track.

Limit marketing presentations to 45-60 minutes, which should be sufficient to achieve your desired goals, particularly if you arrive prepared and stay on-message. The presentation must be accompanied by written materials, such as program brochures or fact sheets, to reinforce what is presented. Keep printed materials brief and user-friendly. Make sure to provide correct contact information and give instructions about how to access services.
Whenever possible, partner with other players to provide outreach or marketing presentations. If more than one WIPA project exists in the state, seek opportunities for staff members from different agencies to work together on marketing functions. WIPA projects should also collaborate with Social Security Area Work Incentives Coordinators (AWICs) on outreach efforts when possible. Additionally, most large Social Security offices have Public Affairs Specialists, Work Incentives Liaisons (WILs), or other staff who perform community awareness functions. Teaming up is a great way to build relationships and demonstrate the partnership between Social Security and the WIPA project.

“Staying On-Message”

Communicating a clear and consistent message is crucial for a successful marketing campaign. This process is commonly referred to as “staying on-message.” While staying on message may be simple when selling a product like toothpaste, it becomes rather challenging when marketing a complex service such as WIPA. Even more challenging is selling the notion that employment and disability benefits aren’t mutually exclusive when beneficiaries have spent months or years proving to Social Security that they are incapable of working at a substantial level in order to initially qualify for benefits. To avoid misunderstandings, you must clearly state your message. You must convey the following five points whenever conducting outreach or marketing activities:

1. Paid employment and Social Security disability benefits aren’t mutually exclusive — beneficiaries don’t have to choose between work and benefits.
2. It’s possible to work (even full-time) and keep Medicaid and Medicare in almost every case.
3. It’s possible to work and come out ahead financially, even if Social Security and other agencies reduce or cease public benefits.
4. It’s possible to receive disability benefits again if they are stopped due to employment.
5. WIPA services aren’t intended to force people off of benefits or help them maximize use of public benefits.
If you focus on these points and constantly reinforce them, you can correct a great deal of misinformation. Repeat these points at every event and interaction with beneficiaries, family members, and community agency personnel so people can really understand the message and accept it as fact. Communicating this message is a never-ending process and one of the most basic services you will provide to your local community.

**The “Anti-Message” — A Warning!**

There is one message you must be vigilant to avoid communicating. In the world of WIPA we refer to this as the “anti-message.” The intent of WIPA services isn’t to indefinitely keep individuals on disability benefits. You shouldn’t act as if it’s your job to “save” beneficiaries from benefit cessation or termination due to employment at all costs. You should not behave in ways that cause beneficiaries to unnecessarily fear working above SGA, earning wages over the SSI break-even point, or earning more than the 1619(b) threshold amount. Similarly, don’t routinely encourage all beneficiaries to suppress their wages or net earnings from self-employment (NESE) in order to retain benefit eligibility. Finally, it isn’t your duty to find some way, to reduce countable earnings to evade benefits cessation or termination.

While it may not be in the best immediate interest of some beneficiaries to fully terminate from benefits due to work, this is certainly NOT the case for all beneficiaries, or even most beneficiaries. Terminating from benefits isn’t a universally “bad” thing and isn’t harmful in the majority of cases. CWICs must not present this outcome in a negative way when counseling beneficiaries. In fact, those with the capacity to earn wages sufficient to cause termination are frequently better off financially by doing so as long as they consider all costs of employment and they continue to meet health care needs. Work with each beneficiary to determine what his or her goals are, and support him or her to achieve the highest earning potential possible within the framework of those goals. Counseling techniques or messages that discourage beneficiaries from working or frighten them into retaining attachment to public benefits is contrary to everything WIPA services work to achieve.
Managing Beneficiary Expectations during Outreach

An important aspect of successful marketing is managing beneficiary expectations. Many of us have experienced being sold a product after a salesperson has made many grandiose promises only to be disappointed after purchasing the product. That is something WIPA projects must avoid at all costs when marketing and delivering services. It’s better to “undersell” the services and then exceed beneficiary expectations. This is how to create satisfied users of WIPA services.

Underselling = Developing Realistic Expectations

The phrase “underselling” means helping beneficiaries achieve realistic and reasonable expectations of the benefits and outcomes of WIPA services. It’s crucial to not make promises you can’t keep.

An example of this would be telling beneficiaries that WIPA services will ensure that overpayments don’t occur. No matter how diligent you might be in your work with a beneficiary, overpayments may occur.

Another example is to promise beneficiaries or service providers that you’ll personally handle all work incentives issues such as claiming Impairment Related Work Expenses (IRWEs) or writing Plans to Achieve Self-Support (PASS). This is bad practice on several counts. First, you won’t have time to fulfill commitments like this, nor would you want to foster this level of dependency with beneficiaries. Beneficiaries who receive WIPA services must be active participants in the process and need to understand they will have an active role in developing and managing work incentives.

Similarly, you may need to help Social Security personnel understand what they can reasonably expect from WIPA services. You aren’t responsible for reporting wage information for beneficiaries, nor do you function as representative payees in managing benefits. You must have a crystal clear understanding of your role and its limitations. You must clearly and consistently communicate your role, and its limits to all stakeholder groups.
Over-Delivering = Exceeding Beneficiary Expectations

CWICs who successfully manage the expectations of beneficiaries and referral sources are more likely to meet or exceed those expectations when providing WIPA services. For a CWIC, meeting expectations means providing clear, correct, and complete benefits information that helps beneficiaries achieve their employment goal and enhances financial stability. At a minimum, your job is to answer benefits questions, lay out available options, and provide specific information about the pros and cons of various courses of action. The ultimate goal, however, is to “over-deliver” services or go beyond what the beneficiary expects. This doesn’t mean you should do everything for the beneficiary. Exceeding expectations means being creative and going beyond merely answering questions posed by beneficiaries. It means applying your work incentives expertise to maximize the positive outcomes from employment.

Establishing Trust = Delivering Quality WIPA Services

Finally, to be successful over time, you must establish trust by consistently delivering high-quality services. Word of mouth is a powerful marketing tool that can work to your advantage or disadvantage. Beneficiaries and agency personnel will talk to each other about their experiences with WIPA projects. A dis-satisfied beneficiary or community stakeholder can severely damage a program’s reputation for long periods of time. Slick marketing presentations will never make up for shoddy service delivery. Keep in mind that the beneficiary is only one of the “customers” you need to think about. You must also provide great service to referral sources and the other key stakeholder groups in order to protect the reputation of the program. Successful CWICs treat every interaction with a beneficiary or stakeholder as a valuable marketing opportunity.

Evaluating Outreach and Marketing Efforts

WIPA projects must track outreach activities to determine which are most effective in soliciting referrals. Projects that maintain and review good outreach data will learn a great deal about which activities work and which don’t in terms of soliciting appropriate referrals.
Keeping Track of Outreach Activities

You can track outreach by maintaining a chronological list that includes marketing presentations, who presented, and who attended. You can develop a list of attendees by passing around a sign-in sheet for name and contact information. If there are sufficient time and staff resources, developing a database, mailing list, or email list also is helpful. You can use this information to prepare mass mailings or email blasts of brochures, newsletters, or other materials to keep stakeholders updated about services. In addition, you should collect and track data on how beneficiaries hear about the program or who referred them.

Tracking Referral Sources and Checking Penetration of Populations

WIPA Project Managers should track details that determine which stakeholder groups generate the most high-priority referrals. It’s simple — during the initial call ask beneficiaries who referred them, and keep track of this information. Tracking referral sources also helps determine which tend to misunderstand the objective of the WIPA project. Agencies that repeatedly refer ineligible or low-priority individuals need more education. Tracking referral sources helps managers know when agencies need another outreach or education session.

Referral source data will also indicate which population groups you are successfully reaching and which need more outreach attention. WIPA Project Managers should examine beneficiary demographics to make sure outreach efforts are penetrating each subgroup of Social Security beneficiaries with disabilities in your local service area. In some cases, projects might miss certain age groups, such as transition age youth or beneficiaries over age 60. In other cases, outreach efforts might not attract some disability groups or minority populations. All of this information has important implications in terms of outreach design and delivery. WIPA projects can’t evaluate how effective outreach efforts are if they fail to collect data and review it periodically.

NOTE: Social Security expects WIPA projects to target outreach efforts to underserved populations such as transition-aged youth (defined as beneficiaries at least 14-25 years old), veterans, Native Americans, and other racial, ethnic, disability, and socioeconomically disadvantaged or minority populations. You need to track how well your
Refining Strategies to Increase Priority Referrals

When reviewing outreach results, keep in mind that maintaining the same approach often means getting the same results. CWICs need to change their outreach strategies to attract beneficiaries that they haven’t attracted in the past. Take a critical look at the groups you are presenting to and how you contact them. What approaches might work best with underrepresented groups? Talk to your WIPA team, brainstorm techniques, and ask stakeholders for advice on contact methods. Outreach strategies need to constantly evolve to keep targeted audiences engaged and interested.

Accommodating Disability and Cultural or Ethnic Differences when Conducting Outreach

WIPA services are available to all eligible high-priority beneficiaries regardless of disability, ethnicity, gender, race, age, or any other characteristics. Unit 4 of Module 7 covers this important issue. You should read this unit before conducting outreach in the community to ensure all participants benefit from outreach activities. Here are a few tips to keep in mind when designing outreach activities for all potential participants:

- Choose locations that are physically accessible to all beneficiaries, regardless of disability.
- Bring materials or handouts in a variety of formats including large print, Braille, and on CD.
- Arrange for a certified sign language interpreter to attend, if needed. Make sure attendees know how to alert the project if an interpreter is necessary.
- Include foreign language interpreters when conducting outreach activities in areas with high concentrations of persons who speak a foreign language. Offer outreach meetings in a variety of locations and at a variety of times to accommodate transportation needs and work schedules.
- Choose locations accessible by public transportation, because many beneficiaries don’t drive.
• Offer free or low-cost childcare to increase family attendance.

Conclusion

As a CWIC, you are part of a larger team of people dedicated to improving employment outcomes for people with disabilities. You have an important role to play on this team, but can’t play it in isolation. Conducting outreach to disability services organizations and other community stakeholders is the critical first step to joining the “team” for each beneficiary served. When community agencies that support people with disabilities in achieving their employment goals know about and utilize WIPA services, the entire team functions more efficiently and achieves better outcomes. WIPA projects must make an ongoing effort to spread the word about the availability and importance of WIPA services. You must make sure your partner agencies understand the services you provide and whom the program serves. It’s only by mutual understanding, cooperation, and collaboration that Social Security beneficiaries with disabilities will reach the shared goal of employment.

Conducting Independent Research

A variety of approved sample WIPA outreach presentations and materials is available at VCU NTDC’s website here:

(https://vcu-ntdc.org/resources/resourceDetail.cfm?id=7)
Competency Unit 2 – Collaborating with the Ticket Program Manager and Ticket to Work Help Line to Conduct Outreach

Introduction

Social Security conducts significant outreach for its work incentives programs through its Ticket Program Manager (TPM) contractor. Because Social Security limits the amount of time WIPA projects are permitted to conduct direct outreach, it’s critical for CWICs to collaborate with the TPM.

Ticket Program Manager Overview

In September 2015, Social Security awarded MAXIMUS Federal Services a five-year contract to serve as the Ticket Program Manager (TPM). Previously, two separate entities were responsible for different aspects of the Ticket Program. Under the current contract, the TPM is responsible for providing support for beneficiaries to encourage and facilitate participation in the Ticket Program. It also provides a wide variety of employment network (EN) support services to meet the objectives of the Ticket Program.

TPM responsibilities include:

- Conducting outreach to beneficiaries: The TPM is responsible for designing, implementing, and managing an ongoing, nationwide effort targeted at to Ticket-eligible beneficiaries and other program stakeholders to educate them on the benefits of participating in the Ticket program and employment opportunities through Section 503;

- Ensuring timely and accurate communication with beneficiaries: The TPM assists Social Security by operating the Ticket to Work Help Line, which is staffed by Customer Service Representatives
(CSRs) who are specially trained and certified by the VCU National Training and Data Center (NTDC) to answer beneficiaries’ questions. The TPM also manages the Ticket to Work website (www.choosework.ssa.gov) that provides program-related information and a platform for beneficiaries to post and read comments about the Ticket program;

- Facilitating beneficiary access to ENs: The TPM assists Social Security in developing and executing strategies to enable Ticket-eligible beneficiaries to connect with service providers who are capable and willing to serve them;
- Recruiting experienced and highly-qualified ENs;
- Assisting Social Security in facilitating and monitoring active EN participation in the Ticket Program;
- Facilitating Ticket assignment and EN payment processes;
- Assisting Social Security to ensure the quality and integrity of EN Ticket services; and
- Coordinating and merging all beneficiary and EN marketing, outreach, training, support, and performance monitoring.

Beneficiary Support and Outreach Functions of the TPM

Ticket to Work Help Line

For general questions or guidance specific to a beneficiary’s situation, beneficiaries can call the Ticket to Work Help Line at 1-866-968-7842 (V) / 866-833-2967 Text Telephone (TTY), Monday through Friday from 8 a.m. - 8 p.m. Eastern Time (excluding federal holidays).

The Ticket to Work Help Line handles approximately 200,000 calls a year from beneficiaries who hear about the Help Line from Social Security websites and publications, Ticket program marketing materials, webinars, and social media. Customer Service Representatives (CSRs) provide information about the Ticket program, confirm beneficiary eligibility, and respond to specific questions. Help Line CSRs also offer callers a list of service providers in their area that includes ENs, State Vocational Rehabilitation (VR) agencies, WIPA projects, and Protection and Advocacy
for Beneficiaries of Social Security (PABSS) agencies. Representatives offer to send this listing by mail or email, but they also direct callers to the Choose Work website, where callers can create and print their own list. CSRs mail more than 4,000 lists every month. CSRs also assess the beneficiary’s readiness to move forward on the road to employment, introduce the caller to the availability and value of benefits counseling, and, if appropriate, facilitate a referral to a WIPA project.

**WISE Webinar Series and Online Tutorials**

Work Incentive Seminar Events (WISE) webinars are live, free, and accessible online events for those interested in learning about Ticket to Work, work incentives, and other topics related to disability employment. WISE webinars are designed to encourage beneficiaries of Social Security’s disability benefit programs to explore their work options, join the workforce, and achieve greater financial independence while reducing or eliminating their need for SSDI or SSI cash payments.

On these webinars, employment service providers including WIPA projects, State VR agencies, PABSS, and ENs discuss their services. Ticket to Work program participants who gained employment through the Ticket to Work also offer first-hand accounts of their success.

WISE events take place via free Internet-based webinars. Some of the webinars address general program and work incentives information; others are specific to people in select disability categories or age ranges, or with special interests. Past webinar topics have included:

- Ticket to Work and Employment Supports for Veterans;
- Healthcare and the Path to Employment;
- Ticket to Work’s Resume and Interview Tips;
- Reasonable Accommodations and the Path to Employment;
- Ticket to Work and the Path to Employment;
- Working With a Mental Illness;
- How to Help Your Clients and the People You Serve;
- Achieving Financial Independence with the Ticket to Work and an ABLE Account;
• Debunking the Three Biggest Myths About Disability Benefits and Work; and

• Setting Goals with Ticket to Work.

The webinar-based format allows beneficiaries to learn about employment resources without having to travel. In addition, beneficiaries can access the archived webinars online at their convenience. WISE webinars typically occur once per month. Beneficiaries can register for webinars on Ticket to Work’s website (https://choosework.ssa.gov/wise/). The most recent archived webinars are available at Ticket to Work’s website (https://choosework.ssa.gov/webinars-tutorials/webinar-archives/index.html).

To complement WISE webinars, a series of online, self-paced tutorials are also available. No matter where beneficiaries stand on the employment continuum, these six interactive learning modules equip them with the knowledge they need to achieve their work goals. The tutorials are available online at choosework.ssa.gov under training (https://choosework.ssa.gov/training/).

Additional Resources

The TPM provides resources to WIPA projects and other stakeholders, including:

• Choosework.ssa.gov: This beneficiary-focused website includes Ticket information, the Find Help tool, the webinar registration system, a document library, the Choose Work blog, and multimedia including video and print success stories and the Ticket Talk podcasts. The Find Help tool is the most used portion of the website. It allows visitors to search for service providers that serve their zip code. It can filter results by disabilities, languages, services, or distance. In addition, a guided search function asks visitors a series of questions about their goals and work history, then provides a list of recommended service providers.

• Service provider resources: This comprehensive collection of Ticket to Work outreach materials and tools includes success stories, customizable fliers, posters, wallet cards, and website banners (https://yourtickettowork.ssa.gov/resources/service-provider-outreach-toolkit.html).
• **Social media:** The TPM manages several Ticket program social media accounts including Facebook, Twitter, YouTube, and the Choose Work Blog (www.choosework.ssa.gov).

• Through these channels, the team responds to Ticket to Work inquiries, encourages beneficiaries to register for WISE webinars, conducts Facebook Q&A sessions and Twitter chats, and attracts other organizations to promote awareness of the Ticket program.

• **Facebook:** http://www.facebook.com/choosework
• **Twitter:** http://www.twitter.com/chooseworkssa
• **YouTube Channel:**
  http://www.youtube.com/user/choosework
• **Blog:** https://choosework.ssa.gov/blog/index.html

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## Working With the Ticket to Work Help Line

The Ticket to Work Help Line is often the beneficiary’s first point of contact in his or her return to work efforts. The Help Line has the same mission as WIPA projects:

- Promote employment, and
- Help beneficiaries to achieve financial independence.

WIPA projects and the Help Line are partners on the same team and must work together in assisting beneficiaries to achieve their employment and financial independence goals.

## Role of the Help Line

The Help Line is a critical referral source for WIPA projects. Initially, Help Line services focused solely on helping beneficiaries make informed choices about using their Tickets and selecting an EN or state VR agency. Beginning in 2009, Social Security expanded the role of the Help Line by establishing a special cadre of Customer Service Representatives (CSRs) specifically trained and certified to provide basic work incentives information to callers. Today, the Help Line functions as an intermediary service that screens referrals to WIPA projects. To ensure appropriate beneficiary referrals, CSRs:
• Identify callers who are working, have job offers, or are interviewing for jobs;

• Provide basic information to help beneficiaries understand the SSI and SSDI programs, Social Security’s work incentives, and the effects of earnings from work on cash benefits and health care coverage, including Medicare and Medicaid;

• Provide referrals to the appropriate WIPA project via secure encrypted email;

• Encourage the pursuit of work to callers who haven’t yet decided to work or are preparing for a job search; and

• Provide alternative referrals for non-WIPA services, such as PABSS (Protection and Advocacy for Beneficiaries of Social Security) projects and other organizations responsible for local or state benefits programs and resources, as appropriate.

Prior to making a referral to the WIPA projects, Help Line CSRs screen all beneficiaries with inquiries about work incentives to determine whether:

• The beneficiary meets the eligibility criteria for WIPA services;

• The beneficiary is working or is actively conducting a job search; and

• The beneficiary needs or is interested in receiving WIPA services.

As part of the screening and referral process, Help Line CSRs also:

• Collect demographic information; and

• Record information on Ticket status, employment status, the beneficiary’s county of residence, and other expressed concerns.

When it’s determined that a beneficiary is (1) eligible for WIPA services, (2) working, considering a job offer, or interviewing for jobs, and (3) has a desire for more intensive, individualized services, the CSR generates a referral to the WIPA project serving the beneficiary’s place of residence. The Help Line CSR provides information to the beneficiary about the protection and use of personally identifying information (PII) that he or she will share with the WIPA project in the referral process and obtains the beneficiary’s consent prior to sending this information via encrypted email.
Help Line Services to Transition-Aged Youth

Beneficiaries receiving services from the Help Line must be eligible for the Ticket to Work program, which requires an adult determination of disability. Due to this requirement, the Help Line may not serve callers ages 14-17, including parents who call on a child’s behalf. With Social Security’s emphasis on outreach to transition-aged youth, there is concern that youth in transition or SSI youth might contact the Help Line and become discouraged by a lack of assistance. To respond to this need, Social Security allows the Help Line to refer young beneficiaries or their representatives directly to WIPA projects through the encrypted email referral process.

NOTE: Social Security defines transition age youth as those beneficiaries between ages 14 and 25. Although youth between 18 and 25 are Ticket-eligible, they are still considered under the transition youth umbrella and are expedited as referrals to WIPA projects no matter how close they are to work.

These referrals are somewhat different from traditional referrals because the Help Line does not provide the same level of triage or Information and Referral (I&R) services to youth that it provides to adults. Instead, CSRs provide brief information about the WIPA program to those interested in WIPA services, regardless of where the beneficiary is on the employment continuum, and refer callers to the local WIPA project. Referrals contain contact information for the young beneficiaries and their guardian or representative payee. The WIPA staff receiving the referral must review and assign the referral, and then begin attempts to contact the youth, parent, or payee as soon as possible to begin services. During that initial contact, CWICs evaluate the beneficiary’s need for I&R services and the appropriateness of WIPA services. Transition age youth between ages 14 and 25 are a high priority for WIPA services no matter where they are on the employment continuum.

CWIC Interaction with the Help Line

Because of the close working relationship between the Ticket to Work Help Line and WIPA projects, CWICs occasionally interact directly with Help Line CSRs either via email or phone. CWICs must remember to protect a beneficiary’s personally identifiable information (PII) when contacting the Help Line with questions about referrals. You must also
understand that if you call the Help Line directly, although they are our partners in the WIPA initiative, the CSRs can’t disclose any beneficiary information directly to you. Types of interaction will vary by situation, and we will discuss the most common situations and strategies for success below.

Clarification of referral information: The amount of beneficiary information you receive in a referral may be limited by how much the beneficiary shared and provided permission for release. In some cases, you may try to reach out to the Help Line by replying to the referral email. If you need to ask a question about the referral, you must reply to the original referral email within the secure Cisco account. Do not simply reply to the initial referral email you received without logging into the secure system. In most cases, you don’t need to contact the Help Line, because the CSRs provide everything the beneficiary permitted for release.

Beneficiary assistance with information related to Ticket status:
You may encounter instances when a beneficiary needs to contact the Help Line on his or her own, or via a three-way call with you. Some of the information you and the beneficiary might need includes:

- Ticket assignment or “in use” status;
- Name of provider (Employment Network/Vocational Rehabilitation) listed for Ticket assignment;
- The status of the last Timely Progress Review (TPR);
- How to unassign and reassign a Ticket; and
- How to obtain an EN list.

Provide specific information to the beneficiary about exactly what he or she needs to ask the Help Line. Give the beneficiary a list of questions to ask the Help Line. For example: If the beneficiary is unsure of his or her Ticket assignment status, you might suggest the following:

“Contact the Help Line at 866-968-7842 and ask if your ticket is currently assigned, and if so, to what agency. You should also ask them the status of your last Timely Progress Review.”

Remind the beneficiary that you are the source of specific and individualized information about the effect of earnings on benefits. Prepare the beneficiary to let the Help Line CSR know he or she is already
connected with a CWIC if the CSR begins providing general work incentives information. Another alternative is to initiate a three-way call with the beneficiary and the Help Line to assist the beneficiary in gathering necessary information. You shouldn’t be directing the conversation. Your role is to provide support and clarification as needed. The Help Line can’t provide this information to you without the beneficiary being present. The Help Line isn’t able to receive or respond to signed releases of information faxed from CWICs regarding the Ticket status of a beneficiary.

**Conclusion**

The Ticket Program Manager provides invaluable avenues of outreach to beneficiaries in a variety of modalities. Collaborating with the TPM on outreach efforts and working closely with the Ticket to Work Help Line will allow you to focus your energies on providing high quality, individualized services to beneficiaries as they pursue employment and financial independence goals. Remember that the Ticket Program and the WIPA Initiative are partners in Social Security’s efforts to assist individuals with disabilities to return to work and realize their goals and dreams.

**Conducting Independent Research**

A wide variety of resources is available at the following Ticket to Work websites:

- **Ticket to Work Resources** (https://yourtickettowork.ssa.gov/resources/index.html)
- **Ticket to Work website** (https://choosework.ssa.gov/)
Competency Unit 3 – Collaborating with Other Key Stakeholders to Promote Employment of Social Security Beneficiaries with Disabilities

Introduction

WIPA projects are encouraged to develop collaborative working relationships with other community agencies and make direct referrals to community agencies for needed services. CWICs are expected to assume an active role in helping beneficiaries plan for employment and access the services and supports needed to make employment possible. This emphasis on employment outcomes requires understanding the array of employment services and resources in your community and strong working relationships with these agencies to support the work goals of beneficiaries. Taking time to build these partnerships can make your job much more manageable. Collaborating with partner agencies allows you to concentrate on your area of expertise, knowing other partners are assuming responsibility for assisting the beneficiary in other areas related to employment.

At a minimum, the agencies you need to form partnerships with include:

- Social Security Administration (Social Security)
- State Vocational Rehabilitation Agencies (SVRAs)
- Employment Networks (ENs) under the Ticket to Work Program
- State or Regional Workforce Investment Boards (WIBs) and local American Job Centers (AJCs)
- State/local intellectual disability/developmental disability agencies
- State/local mental health/chemical dependency/ substance abuse agencies
• Centers for Independent Living (CILs)
• State Protection and Advocacy Agencies (P&A)
• Public school systems
• Individual Development Account (IDA)/Asset Development Programs
• U.S. Department of Veterans Affairs (VA) and other agencies serving veterans with disabilities

Building and maintaining strong working partnerships with local agencies will provide you with opportunities to work as part of an interdisciplinary team.

This collaboration includes:

• Communicating directly with multiple agencies or organizations to build a more comprehensive understanding of their missions, eligibility rules, policies and procedures, and services and supports.

• Educating the employment service or support community on the role of WIPA services in supporting the employment efforts of beneficiaries.

• Identifying, developing, and implementing formalized strategies and processes for joint employment and work incentive or support planning for beneficiaries.

• Implementing strategies to build general knowledge of how employment affects federal, state, and local benefits and how to incorporate work incentives into existing vocational planning, job development, and employment support efforts.

This unit provides specific recommendations about ways to collaborate with community partners to promote employment and enhance financial independence for Social Security beneficiaries with disabilities. Let’s begin by examining how WIPA projects should work with their primary partner, the Social Security Administration.
Working with the Social Security Administration

Social Security employees are faced with a challenging array of tasks and functions. Most activity centers on processing initial claims so benefits can begin. This makes sense because applicants are often in dire need of the cash payments and medical insurance associated with Social Security benefits. While promoting employment might not be considered the most important function for Social Security employees, there is a growing awareness within local Social Security offices that helping beneficiaries with disabilities understand how work affects benefits is important. Social Security personnel at the national, state, and local levels understand that they need WIPA projects to help with this task.

To collaborate with Social Security, WIPA projects need to understand how the agency functions and what the various players do. The following sections provide an overview for how to work with Social Security employees to help beneficiaries achieve their employment goals.

Organizational Structure of the Social Security Administration

Social Security is a large federal agency with more than 60,000 employees nationwide. The central office is in Baltimore, Maryland and has authority over all other offices in the Social Security system. Ten regional offices report to Baltimore. These regional offices have jurisdiction over a designated multi-state region of the country. The next level down in authority includes the 58 area directors’ offices. For the most part, an area office corresponds to a state. For very populous states like California, New York, or Florida, there is more than one area office. Area, regional and central offices are part of the administrative structure of the Social Security. Personnel in these offices don’t provide services to beneficiaries directly.

For information about the 10 regional offices, go to the websites for each region listed below.

- **Region 1:** Boston office (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont)
  http://www.ssa.gov/boston
• **Region 2:** New York office (New Jersey, New York, the Commonwealth of Puerto Rico, the U.S. Virgin Islands) http://www.ssa.gov/ny

• **Region 3:** Philadelphia office (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia) http://www.ssa.gov/phila

• **Region 4:** Atlanta office (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee) http://www.ssa.gov/atlanta/southeast/index.htm

• **Region 5:** Chicago office (Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin) http://www.ssa.gov/chicago

• **Region 6:** Dallas office (Arkansas, Louisiana, New Mexico, Oklahoma, Texas) http://www.ssa.gov/dallas

• **Region 7:** Kansas City office (Iowa, Nebraska, Kansas, Missouri) http://www.ssa.gov/kc

• **Region 8:** Denver office (Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming) http://www.ssa.gov/denver

• **Region 9:** San Francisco office (Arizona, California, Hawaii, Nevada, American Samoa, Guam, Saipan) http://www.ssa.gov/sf

• **Region 10:** Seattle office (Alaska, Idaho, Oregon, Washington) http://www.ssa.gov/seattle

Area directors’ offices are the level just above the local Social Security offices in communities nationwide. Local Social Security offices are called “district offices” (DO) or “field offices” (FO). These local offices form the “face” of Social Security. This is where the public goes to apply for benefits, report work, or otherwise get help from Social Security in person. There are more than 1,400 field offices across the country. The local office bears the lion’s share of responsibility for interviewing applicants and beneficiaries, processing initial claims, and making individual decisions about benefits and payments.

In addition to decision-makers in the local field offices, the six processing centers and the 130 hearing offices make some decisions. Obviously, there is a complex chain of command within Social Security with many different units performing various functions.
Understanding the Roles of Social Security Field Office Personnel

CWICs encounter many different types of Social Security employees in their day-to-day work. The more you understand the responsibilities of each position, the easier it will be for you to work effectively with these critical partners. As you begin to work with local field offices, you will encounter two additional types of Social Security employees who are on the front line in delivering service to beneficiaries and applicants: Service Representatives (SRs) and Claims Specialists (CSs). Let’s take a look at the duties for each position.

Service Representatives

In most field offices, the first Social Security employee a beneficiary or applicant has contact with is a Service Representative. These positions provide a wide range of general assistance to the public. Service Representatives answer questions about all Social Security benefits, SSI, and Medicare and are responsible for explaining program rules in a way the public can understand. Service Representatives also interview beneficiaries and claimants and assist with gathering the information necessary to adjudicate benefit claims or resolve problems with benefits. This position has the most contact with the public in the agency and requires excellent communication skills. When a claimant or beneficiary presents an issue the Service Representative can’t resolve, a Claims Specialist typically provides assistance.

Claims Specialists

This is the keystone position through which Social Security achieves its major operating objective of bringing direct personal service to the public. Duties performed by Claims Specialists (CSs) are expansive and include (but aren’t limited to) the following:

- Conducting interviews to obtain, clarify, and verify information about individual applicants’ initial and continuing eligibility for retirement, survivors, disability, black lung, health insurance benefits, and eligibility for supplemental security income payments, including state supplements where required;

- Examining evidence to evaluate its validity and acceptability in establishing entitlement to benefits, and, when necessary, taking the required developmental action to ensure all available relevant evidence has been obtained. CSs also assist applicants
in securing evidence, and prepare special determinations of fact to resolve evidentiary discrepancies;

• Authorizing payment claims for benefits and eligibility to all programs administered by Social Security. CSs also have authority to disallow a full range of SSI and Title II benefit claims.

• Conducting interviews, developing, investigating, and resolving post-entitlement actions, including SSI redeterminations, which may involve suspension, resumption, or termination of eligibility or payments;

• Assisting claimants in filing for administrative appeals in matters concerning entitlement to benefits or coverage under the various programs;

• Conducting case reviews, informal and formal conferences to reconsider initial decisions and post-eligibility decisions affecting a claimant’s eligibility, continuing eligibility, or amount of payment under the supplemental security income program, and making final decisions on nonmedical issues in SSI reconsiderations;

• Determining if applicants for or recipients of disability insurance benefits and disability payments under the SSI program are engaging in substantial gainful activity;

• Recognizing the need for and approving the selection of representative payees for individuals unable to handle his or her own benefits;

• Protecting the integrity of Social Security programs through identification, investigation, and resolution of potential program abuse situations;

• Providing referral services to beneficiaries needing the services of other programs or organizations,

• Protecting the rights of beneficiaries by assuring that claimants or their personal representative understand the claimant’s legal rights and obligations under the Act and its relationship to other social welfare and benefit programs;
• Developing, investigating, and resolving discrepancies in earnings and determining amounts to be posted or deleted from individual records; and

• Determining whether income is wages or self-employment income and whether it’s covered income under the Social Security Act.

For more information about positions within the Social Security Administration, go to [ssa.gov Job Position Summary](http://www.socialsecurity.gov/kc/jobs_position.htm).

**Social Security Employees with Specific Work Incentives Duties**

In addition to Service Representatives and Claims Specialists, two types of Social Security employees have very specific duties related to work incentives: Work Incentives Liaisons (WILs) and Area Work Incentives Coordinators (AWICs). CWICs work very closely with these employees and should have a general understanding of their job functions.

**Work Incentives Liaisons (WILs)**

Some Claims Specialists (CSs) act as the designated Work Incentive Liaison (WIL) in addition to their regular CR duties. These aren’t separate positions. The WIL designation represents additional work requirements for Social Security employees selected to serve in this capacity. The WIL is a special designation given to a Social Security employee, most typically a Technical Expert (TE) or Management Staff Support (MSS) with expertise in the disability programs and associated work incentives. The WIL acts as an internal resource for other Social Security personnel on work incentives issues within that local office. The WIL is the go-to person in the local Social Security office for all questions about how earned income from wage employment or self-employment affects benefits. When Claims Specialists and Service Representatives have questions about how to apply the disability program work incentives, their first resource is the WIL. These individuals are also the primary contacts on work incentives issues for WIPA programs.

**NOTE:** Different field offices deploy the WIL in different ways. Communicate with the manager of each field office in your service area to find out what roles the WIL plays and
how the manager expects you to work with the WIL. Never assume you know how to interact with the WIL — ask!

**Area Work Incentive Coordinators (AWICs)**

These employees coordinate with WILs in local field offices to provide improved services and information on Social Security’s employment support programs, which are structured to assist beneficiaries with disabilities who want to start or continue working. AWICs are experienced employment support experts who:

- Coordinate and conduct public outreach on work incentives in their local areas;
- Provide, coordinate, and oversee training on Social Security’s employment support programs for all personnel at local Social Security offices;
- Handle sensitive or high-profile disability work-issue cases, if necessary; and
- Monitor the disability work-issue workloads in their respective areas.

**NOTE:** You can find the **AWIC for each federal region at Social Security’s website** (http://www.socialsecurity.gov/org/dco.htm#sb=2). The websites for the ten (10) Social Security federal regions are organized differently. For example, if you click on the link and go to the Boston, Atlanta, San Francisco, and Seattle regions, the AWIC is listed on the left side of the page. For the New York region, you have to click on “Work Incentive Network,” then “Local WIN coordinators.” For the Philadelphia region, the link is labeled as “Contacts for Disability Employment Support Programs.” For the Chicago region, the link is “Employment Supports,” for the Dallas region it’s “Return to Work,” and finally, for the Kansas and Denver regions, AWICs are listed under the label “Work Incentives.”
Establishing Positive Relationships with Local Social Security Offices — Strategies for Success

You mustn’t assume that local Social Security personnel know what services WIPA projects provide or who is eligible for WIPA services. Like all other partner agencies, local Social Security personnel need to be introduced to CWICs and educated about WIPA services. Take the following steps to start these relationships off on the right foot:

- **Set up an initial meeting with the manager of each of the local offices that your project serves.** This is the time for the WIPA Project Manager to introduce the program to the field office manager and to ask about preferences for contacting the staff. This is also an appropriate time to ask if CWICs can attend the next Field Office staff meeting to introduce themselves and convey the project’s objectives. Another helpful tip at this meeting is to request the name of the WIL, Title II post-entitlement CRs, and a list of SSI CRs by their caseload designation (many offices split the SSI caseload by alphabet or digits in the SSN). In addition, inform the manager that the project is eager to work collaboratively with the local office to help make beneficiaries’ return to work efforts a smoother transition for all involved.

- **Conduct a brief presentation about the WIPA project to the field office staff.** Introduce the CWICs who will interact with the local office and explain how the project is conducting business. Ask the local office staff for their input on collaborative efforts and suggestions. The local Social Security staff can be a valuable referral source. The VCU NTDC website contains a pre-approved PowerPoint presentation WIPA personnel should use when describing the WIPA program to Social security employees and other stakeholders (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=194).

- **Maintain regular contact with the office — know the players!** Your role isn’t only to support beneficiaries in their return to work efforts, but also to help them communicate with Social Security more effectively. Open communication creates a “win-win” situation for everyone.
• **Collaborate on presentations with the AWIC and Public Affairs Specialist.** Collaboration on outreach enhances the WIPA project’s reputation and will increase referrals. It’s important for other community providers to see that CWICs and Social Security present a united front to assist beneficiaries.

• **Get acquainted with the WIL and any assigned backup contact person.** This is the primary point of contact for CWICs. Be clear about the role of the WIL in each field office and know how each WIL wants to communicate with you.

• **Know who the post-entitlement person is in each office.** This is another key relationship for you to cultivate. The post-entitlement person processes work-related Continuing Disability Reviews (CDRs) and is the go-to person for beneficiary issues related to reporting work activity.

**Working Collaboratively with Local Social Security Offices to Promote Employment and Enhance Financial Stability**

WIPA projects and Social Security field offices partner in numerous ways. Relationships with local Social Security personnel should be reciprocal. Cultivating a strong working relationship with the local office benefits the WIPA program, Social Security, and the beneficiaries they both serve. Visualize all these players as cooks in a kitchen, working together to make a pot of soup. Each cook will have a different perspective on the recipe and thus contribute different ingredients to make the soup. All of the inputs and viewpoints of the partners must combine to create the best possible outcome. You must remember that you can’t be everything to all beneficiaries. Social Security must be an active partner in the provision of services.

In any true partnership, there is a give and take. Maintaining a strong alliance with local Social Security offices makes everyone’s job easier. Let’s take a closer look at exactly how that happens.

**How CWICs Assist Social Security Personnel**

• CWICs can teach beneficiaries what information they need to report and how to report information correctly. By helping beneficiaries report wages and work incentives information
correctly, you save Social Security employees time and effort in resolving mistakes and dealing with overpayments.

- You can provide tremendous assistance to Social Security CSs by helping Title II disability beneficiaries develop their work histories and track usage of their own work incentives.

- You can serve as interpreters for beneficiaries when they receive correspondence or attend appointments at the Social Security office. While Social Security employees are trained to work with people who might have disabilities that impede communication or limit understanding of complex information, you can still help facilitate effective communication between the beneficiary and CS. In most cases, you’ll have worked with the beneficiary for some period of time and may have a close, trusting relationship with him or her. Helping with communication is a tangible way you can support Social Security personnel.

- Explaining how various work incentives apply is time-consuming. You can help beneficiaries understand and apply these provisions correctly the first time, which saves the CS a great deal of work. This can be of particular use during a Substantial Gainful Activity (SGA) determination. When you help the beneficiary develop all the work incentives and present them in an organized fashion to the CS, SGA determinations become a much simpler task.

- Many beneficiaries struggle with developing Plans to Achieve Self-Support (PASS). When you help facilitate this process, it aids the PASS Specialist and reduces the amount of time it takes for Social Security to approve the PASS. In addition, having a CWIC to talk to about the PASS helps facilitate changes and makes sure transitions go smoothly.

**How Social Security Personnel Assist CWICs**

- One of the most important ways Social Security employees can help you is to provide prompt access to Benefits Planning Queries (BPQYs) for verification of benefits. This report is essential because it precedes any individual counseling. The faster Social Security can provide this report to the beneficiary or to you, the faster you can begin services!

- The CS can also help by correcting issues in the BPQY such as undeveloped earnings, work incentives usage, etc. In some local
field offices, the WIL is a central point of contact to help resolve problems identified on BPQYs.

- Although you can help identify work incentives and facilitate their development, only the CS can enter this information into the Social Security computer system to adjust SSI payments, or use the information to conduct SGA determinations. When Social Security personnel promptly act on the information you supplied, they can avoid overpayments or underpayments.

- PASS Specialists can be essential to beneficiaries when it comes to explaining the PASS rules and requirements, especially if Social Security rejects a PASS or requests significant changes. PASS Specialists can also alert you to potential problems that you can help resolve. For PASS Cadre contact information can be found online at socialsecurity.gov (http://www.socialsecurity.gov/disabilityresearch/wi/passcadre.htm).

- AWICs can provide valuable support to WIPA programs by working with local Social Security offices on applying various work incentives correctly, and responding to BPQY requests in a timely fashion. You need to let AWICs know about problems so that training and technical assistance can correct them.

Collaboration Example: You receive a call from the WIL at the local Social Security office referring a beneficiary for WIPA services, named Bill Beneficiary. Bill came into the local office asking for assistance with funding for training so that he could learn new job skills and eventually become self-supporting. The WIL felt that he might be a good candidate for a PASS plan. As you gather information and verify benefits, you discover that Bill has worked since becoming entitled to SSDI and hasn’t reported this to Social Security. Based on Bill’s pursuit of employment training and interest in receiving WIPA services, you enroll Bill in the WIPA services and develop a Benefits Summary & Analysis (BS&A) report so that he is able to make an informed choice about pursuing the PASS. After reviewing the BS&A, you assist Bill in developing a Work Incentives Plan (WIP). While you are helping him develop the PASS plan, you are in contact with the regional PASS Cadre to
ensure that the PASS contains all of the information the specialist will need. Meanwhile, you are working with Bill and the Claims Specialist at the local Social Security office to properly report wages and complete a Work Activity Report, as well as completing an SSI application (part of the PASS requirement).

**Common Questions CWICs have about Working with Social Security Field Offices**

Social Security employees have a great many responsibilities and multiple demands on their time and attention. Unless you have introduced yourself to the local FO staff, it’s quite possible that these personnel will be unaware of the WIPA program and unfamiliar with the services it provides. Take the time to conduct formal introductory meetings with each FO in the service area. These meetings shouldn’t just occur once, as Social Security experiences staff turnover just like all employers. There will always be new employees who aren’t aware of the WIPA program.

CWICs sometimes struggle with understanding the strict confidentiality requirements to which Social Security adheres. When you are working with beneficiaries, there is no “automatic” sharing of information between WIPA projects and Social Security. In order for Social Security to release ANY information about a beneficiary to you, the beneficiary must sign the appropriate release forms and send them to the Social Security staff person. WIPA projects are required to use the [approved Social Security release of information form (SSA Form 3288 – Consent for Release of Information)](http://www.ssa.gov/forms/ssa-3288.pdf) when requesting information about a beneficiary.

In summary, you should remember that Social Security personnel are your partners in serving beneficiaries. While the roles of the two organizations are very different, both parties share the goal of helping beneficiaries become successfully employed. To the extent that you provide assistance to the local Social Security office, the employees in that office will be more likely to cooperate and help. This cooperation will save valuable time and energy when assisting beneficiaries with Social Security work incentives.
Collaborating with Agencies Providing Employment Services and Support

Because the focus of WIPA services is promoting employment, you must collaborate with a variety of other agencies involved in providing employment services and supports. You are just one member of the team of professionals who form the individual’s “employment support team.” Each of the partners is working to achieve one common goal — enhancing an individual’s financial stability through successful employment. No single entity can achieve that goal alone; it requires continuous cooperative effort. Each member of the interdisciplinary team has a unique role to play. This is a symbiotic relationship, the advantage being that each team member’s workload becomes lighter by working together as a group.

The Employment Support Team

Every beneficiary will have a different team of people involved in his or her return-to-work effort. Each individual will come to the WIPA project with a unique mix of agency support or assistance. Occasionally, you will encounter individuals who literally have no external support. In these instances, you need to work with the beneficiary to determine if he or she needs employment services and if so, which agency would best meet the presenting need. The most common agencies represented on a beneficiary’s employment support team would include the following:

- American Job Centers (AJCs)
- State Vocational Rehabilitation (VR) Agencies
- Employment Networks (ENs)
- Public Schools
- Centers for Independent Living (CILs)
- Community Rehabilitation Providers
- Private Rehabilitation Companies
- Agencies serving veterans with disabilities including the VA

Each of the above entities provides different types of services to beneficiaries seeking employment. You will find a complete description of each major stakeholder agency in Unit 3 of Module 1. At times, it may
seem that the various partners working with a beneficiary are duplicating or overlapping services, but this is seldom the case. Every member of the employment support team brings his or her unique perspective to the table to reach that one common goal — successful employment. The members of an individual’s employment support team may change as the beneficiary meets his or her goals in the plan. Each beneficiary will have an individualized lineup of players on his or her team.

**How CWICs Assist Other Partners on the Employment Support Team**

- CWICs offer in-depth knowledge about Social Security’s work incentives and employment initiatives to their partners on the employment support team. Not only do you educate beneficiaries on the available work incentives, but you also educate provider agency staff. Community partners have a need for this information for a variety of reasons. The primary one is dispelling fears of employment caused by misinformation about the effect of earnings to benefits.

- You can also educate community partners on program eligibility criteria and scope of services. This will enhance the number of eligible and high priority referrals you receive.

- One of the most important ways that you can assist other partners is by providing thorough analysis of an individual’s benefits situation and identifying critical transition points at which benefits might change. Obtaining the job is only the first hurdle that a beneficiary will encounter. Once the beneficiary gets a job, the tendency is for the beneficiary and other partners to forget about what happens down the road. You can be instrumental in guiding the journey so that bumps in the road are anticipated and planned for in advance.

- There are so many pieces to an individual’s benefit puzzle that it can be difficult for beneficiaries to navigate. They often rely on their employment support team to lead the way. You have access to knowledge and resources to provide information on other federal and state benefit programs that interact and are affected by employment, such as Medicaid, food stamps, housing, etc.
• You can assist in development of previous work that may affect future work and benefits. Many times beneficiaries don’t have a clear recollection of their prior work activity. Access to the information on the BPQY can help trigger the beneficiary’s memory when developing a resume or completing applications.

• You have access to a wide variety of community resources and can act as a link between agencies to provide referrals for additional services that the beneficiary may need.

• You can help other partners meet their agency goals in relation to placements. Every agency that provides some type of employment service has measurable goals that determine the success of the project. You can have a positive effect on those agency goals by providing information to both beneficiaries and providers. Knowledge of the work incentives encourages beneficiaries to work, which increases the number of successful placements the provider agencies achieve.

How Other Partners Assist CWICs

• Other partner agencies can help you by providing eligible, high-priority WIPA referrals. This can help limit the initial screening process to determine eligibility which saves you valuable time.

• The beneficiary, with the assistance of the CWIC, largely directs the Work Incentive Plan (WIP). You can delegate tasks in the WIP to other members of the employment support team. This will lighten your load and allow you more time to work with other eligible beneficiaries.

• Other partners also have access to information and services that may be outside of your area of expertise. Employment support team members are active advisors in the employment process and can help connect beneficiaries to other necessary services.

• Education and information from other partners about their scope of services and eligibility criteria is invaluable for you. Not only can this enhance services they provided to beneficiaries, it also allows them to be better referral sources for the partners themselves.

• Other community agencies that are part of the employment support team can provide other avenues for outreach to
beneficiaries. You are charged with reaching a wide variety of different populations. Collaborating with agencies that serve some of these specific groups can enhance the program’s exposure to beneficiaries.

**Collaboration Example:** Continuing with the example of Bill Beneficiary, who was referred to the WIPA program by the local Social Security office, the PASS Specialist requests that Bill obtain a vocational evaluation to determine whether the job goal that Bill is considering will be feasible, given his aptitude and his medical condition. You discuss the various options available in your community for the vocational evaluation. You, the State VR program, and local ENs help Bill select the most appropriate option. You refer Bill to the State VR agency for an evaluation, and also to see if they can provide services that will assist Bill in his job goal.

With Bill’s permission, you provide the VR counselor with a copy of the Benefits Summary & Analysis and the Work Incentives Plan that you have developed. The three of you sit down and discuss the benefits planning information, as well as the development of the PASS Plan. This information helps Bill and his VR counselor determine the best course of action in developing an Individualized Plan for Employment (IPE) with appropriate goals and supports. In return, the VR counselor provides you with a copy of the vocational evaluation. The information contained in the evaluation leads Bill to decide to change his job goal slightly, to better account for the local job market. You assist Bill in adjusting his PASS accordingly. The VR counselor is impressed with the valuable information provided by you (the CWIC), and she refers another of her consumers for benefits counseling.

**Common Questions CWICs have about Working with Employment Support Team Members**

One of the most common misconceptions employment support team members have is that beneficiaries are only able to work part-time if they want to retain cash benefits and critical medical insurance. While this may be the case for some beneficiaries, it isn’t true for everyone. Fight
this misconception at every opportunity by showing employment support team members how working more than a few hours each week can financially benefit beneficiaries. It’s quite possible to work full-time and not lose full cash payments in the SSI system. Even if work causes the loss of SSI cash payments, 1619(b) extended Medicaid coverage protects the vast majority of people from losing essential Medicaid coverage. In the Title II disability program, some beneficiaries have the potential to earn far more than they receive in monthly cash payments. To hold these individuals back to part-time employment is a shame when full-time work could offer a far superior financial outcome while maintaining Medicare coverage. You should remember that an important part of your role in working with employment support team members is educating them about how work really affects Social Security disability benefits. You must continue to reiterate the “message” as described in Unit 1 of this module with employment support team members.

Another issue that CWICs have when working with employment support team members relates to helping these individuals understand the role and function of WIPA personnel. Employment services providers tend to believe that you can and should assist their clients with every issue or problem related to benefits. WIPA projects can avoid problems of this nature by educating employment support team members about the focus of these counseling services and repeatedly reiterating their limits. You should invest your time in educating employment support team members about how they can provide assistance to beneficiaries in these non-employment related matters.

Finally, CWICs sometimes get frustrated with receiving referrals on beneficiaries only after going to work has created significant problems for them. Rather than referring individuals for WIPA services early on in the process of preparing for employment, some employment services providers use the local CWIC as a damage control mechanism. Again, this is an educational issue. You need to invest time in teaching employment services providers about the importance of early intervention when it comes to benefits counseling and planning. This type of education is an ongoing process that you must repeat over and over again.
Collaborating with Other Community Agencies

Social Security beneficiaries with disabilities receive services and supports from a host of community agencies beyond those that help with vocational or employment issues. In some cases, these agencies have significant influence in the lives of beneficiaries and can seriously affect return to work efforts or even the decision to pursue employment. It’s not enough for you to coordinate their counseling efforts only with members of the employment support team. Many other entities need to be involved if you are to promote work and enhance financial stability. This section will examine these agencies and the various roles they play in the lives of Social Security beneficiaries with disabilities.

Agencies Providing Residential Services and Supports

Beneficiaries come from all walks of life and will present all manner of support needs. While some individuals may live completely independent lives in the community with no agency involvement, others may live in small communal residences such as group homes or halfway houses, be assisted by supported apartment programs, reside in nursing homes or institutions, or even be staying in emergency shelters for individuals who are homeless. You need to work with the agencies providing residential services and supports, because these agencies typically use Social Security disability benefits to pay for some or all of the cost of residential care. If a beneficiary loses cash benefits, residential service agencies may not be able to recover the cost of the care they provide, or the beneficiary may literally have no way to pay for rent or other residential costs. The residential service providers have a significant stake in the financial status of the beneficiaries they serve. Residential agency personnel are often very concerned about the effect of paid employment on benefits and may actively discourage beneficiaries from working due to fear of benefit loss.

Agencies Providing Case Management Services

Many Social Security beneficiaries served by the state/local ID/DD system or the mental health system have a designated case manager. In most cases, individuals receiving case management services will have severe disabilities that affect their decision-making ability. Case management services typically include planning for services and supports that people with disabilities need, arranging services or benefits, and coordinating the
various services or benefit components. In some cases, the case manager may act as the beneficiary’s representative payee with Social Security, or the case management provider may offer professional representative payee services. In many programs, case managers are also available to provide crisis intervention or problem resolution services when difficulties arise. Case managers often work closely with the beneficiary’s family or other legal guardian to plan and coordinate services. When the beneficiary has no family involvement or other support network, case managers may act as the only party responsible for insuring that the individual’s service needs are met.

**How CWICs Assist Residential Providers and Case Managers**

- You can be an excellent source of information about Social Security benefits and how work affects these benefits. You can be of tremendous assistance to residential service agencies and case managers when dealing with individuals who are already working or who want to work. You can answer questions, provide technical assistance, and offer training to help staff understand the Social Security work incentives. By providing supports of this type, you can help these professionals view work in a more positive fashion and ease fears about how paid employment will affect cash benefits, medical insurance, or Medicaid waiver eligibility.

- You can act as an intermediary between residential providers or case managers in handling problems individuals have with their Social Security benefits. Disability professionals who aren’t accustomed to communicating with Social Security often don’t know how to work with the local office. With just a little training and support, residential providers and case managers can learn to communicate effectively with Social Security personnel.

- Residential providers and case managers often don’t know what information beneficiaries need to report to Social Security or how to report this information. You can provide specific instructions in this area to help beneficiaries avoid overpayments, underpayments, or other benefit problems.

- Use your work incentives expertise to show residential service providers and case managers how beneficiaries can increase their total available income by working. It’s unfortunate that well- intentioned disability professionals sometimes discourage
beneficiaries from working out of fear that paid employment at any level will cause ineligibility for cash benefits and medical coverage. In addition, most disability professionals don’t know that SSI recipients can own businesses and homes, or that Title II disability benefits aren’t means-tested at all. It’s unfortunate that so many Social Security beneficiaries have so few assets when they could be building wealth in allowable ways.

**How Residential Providers and Case Managers Assist CWICs**

- Residential agency staff and case managers can help you perform much of the “legwork” surrounding benefits issues or use of work incentives. Once trained, these professionals can accompany beneficiaries to appointments at the local Social Security office as well as handle meetings with the Medicaid eligibility determinations agency, the food stamp office, or the local Housing Authority. You simply don’t have the time to provide personal assistance with all of the important meetings or appointments that arise, but some beneficiaries simply can’t manage these appointments by themselves. Residential providers and case managers may provide tremendous assistance in this area.

- You rely on residential staff and case managers for help with day-to-day reporting of income and managing benefits. These professionals also have regular contact with beneficiaries and are readily available to help interpret correspondence, collect documentation for work incentives, or communicate critical information to the employer or family members. You rely on these professionals to be your “eyes and ears” and to notify you whenever they need help or problems arise.

- Sometimes you will need help communicating with beneficiaries. While the residential provider or case manager may have a long-standing and trusting relationship with the beneficiary, you may have only met with or talked to the beneficiary once or twice. Case managers can help you explain the work incentives in a manner that is understandable to a beneficiary. They can also help you understand the preferences or desires of individuals who may have communication barriers.
Collaboration Example: As you continue to work with Bill Beneficiary and his VR counselor to access the services and supports he needs to become successfully employed, you learn that one of the goals on Bill’s IPE is to work with a case manager from the local Area Mental Health agency. Bill’s VR Counselor recommended case management services as part of the VR assessment process, to assist Bill with coordination of services such as counseling and medication management, as well as helping Bill to manage the array of paperwork and reports that he must complete in order to maintain benefits such as Medicaid and Food Stamps. You and Bill meet with the case manager and VR counselor to discuss how each member of the team can best assist Bill in reaching his employment goal. The Benefits Summary and Analysis you prepared helps the case manager understand how Bill can reach his employment goal while still retaining his Medicaid and his Medicare insurance necessary for him to remain medically stable. The case manager agrees to assist Bill with reporting and record-keeping responsibilities that become part of the Work Incentive Plan. After the meeting, the case manager calls you to refer another consumer that he is working with and referring to VR for assistance with obtaining a job.

Common Questions CWICs Have about Working with Residential Providers and Case Managers

As indicated, residential services providers and case managers may have tremendous influence in the lives of beneficiaries. You must remember that your primary customer is the beneficiary, not the agencies serving the beneficiary. Although the majority of residential service providers work for agencies whose stated missions are to promote independence and autonomy of their clientele, in some cases, the service provider may have preferences that aren’t in alignment with what the beneficiary wants. In other cases, the service provider may not actually be working in the best interests of the beneficiary. When you encounter situations
like this, it’s important to learn more about the reasons behind the actions of the service provider. There may be more to the situation than is immediately apparent. Is he or she merely following company policy or accepted practices? If so, education and networking at the agency level may help to resolve the issue. Is the issue restricted to the appointed staff member, or is the staff member acting on the wishes of involved family members? Building a strong working relationship with the agency as a whole may also help you bring the issue to the attention of appropriate staff at the agency.

You must remain strictly focused on serving the interests of the beneficiary. The counseling WIPA projects provide is intended for the beneficiary first and foremost, not other involved stakeholders. Although agency collaboration is the goal, you are required to carefully guard the confidentiality of each beneficiary. You may not share information with any external party without express written permission to do so. If you suspect that a service provider isn’t working in the best interests of a beneficiary, you should seek assistance from your assigned VCU NTDC Technical Assistance Liaison. A referral to the State Protection & Advocacy Agency or Adult Protective Services Agency may be needed in the most extreme cases.

**Working with Other Community Agencies**

Beneficiaries may be receiving services from a wide array of programs or agencies that you may want to coordinate with for a number of reasons. In many cases, these agencies aren’t providing services specifically designed for individuals with disabilities, or they may be providing disability-related services, which are more peripheral in nature than those described above. Here are a few agencies that beneficiaries will commonly be involved with whom you may want to contact:

- **Agencies providing Individual Development Accounts or IDAs:** As discussed in Unit 3 of Module 1, IDAs are asset development programs designed to help people with low income save money for things like buying a first home, paying for post-secondary education, or capitalizing a small business. Many IDA providers aren’t accustomed to serving individuals with disabilities and often have questions about what participation in an IDA program will do to Social Security disability benefits,
Medicaid, and Medicare. WIPA projects can offer IDA programs training and technical assistance to relieve these fears. Most IDAs offer beneficiaries a wonderful way to save for post-secondary education, vocational training, or a self-employment goal. For beneficiaries who also may have a PASS with a self-employment goal, there are some intricacies about how IDAs and the PASS work incentive interface that you would need to clarify. CWICs and IDA providers need to work in partnership to support individuals with disabilities so they can fully benefit from participation in IDA programs.

• **Advocacy Agencies:** Some beneficiaries may be involved in peer advocacy or counseling programs operated by local Centers for Independent Living (CILs) or the National Alliance for the Mentally Ill (NAMI), or they may be getting advocacy services from the state Protection & Advocacy (P&A) agency. It’s a good idea to ask beneficiaries about this involvement to see if they want you to discuss any issues with the advocate. In some cases, the advocate may be counseling the individual on employment or financial issues and may benefit from information in the Benefits Summary & Analysis (BS&A) report. Conversely, the advocate may share information that would assist you in the work incentives planning process. Consider asking the beneficiary if coordination between the WIPA project and the advocacy agency would be of assistance.

• **Disability Support Groups:** Many community agencies specialize in providing support to individuals who have certain disabilities and their family members. Some beneficiaries may be involved in the local Head Injury Association, the local Down Syndrome Association, or the Spinal Cord Injury Association. You can help these support groups by providing information about the effect of paid employment on disability benefits and disseminating information to the membership about the availability of WIPA services. In return, these groups may become more actively involved in promoting employment among their membership and may refer eligible beneficiaries for WIPA services. To begin a mutually beneficial collaborative relationship of this nature, all it takes is a phone call from you.
• **Public School Systems:** Younger Social Security beneficiaries with disabilities are often involved in special education programs or specialized services provided through the local public school system. Some schools offer community-based work experiences that may involve paid employment or even self-employment. It’s important for you to work closely with special education professionals whenever they are facilitating volunteer work experience or paid work to make sure that they and the beneficiaries fully understand and utilize work incentives. You should also be informing special education teachers about all the benefit changes that may occur around the beneficiary’s 18th birthday and should offer seminars to families about these changes as well as the work incentives. In return, classroom teachers can encourage students and families to consider employment at an early age. They can also be a rich source of high-priority referrals for WIPA services.

• **Collaboration Example:** After working with Bill Beneficiary for several months, he calls to ask if you would make a quick presentation about WIPA services to the local support group for the National Alliance for the Mentally Ill (NAMI). Bill has been attending this support group off and on for a number of years, and occasionally writes articles for the NAMI newsletter. He also asks if you could provide him with some information about the WIPA program for the next newsletter. After the presentation, you receive several phone calls from members of the support group. Some of the calls are requests for general information, but one caller, named Ervin, states that he is already working and needs some help understanding how to report his earnings to Social Security and to the local housing authority. He requests that the advocate he works with at the Center for Independent Living be involved in any meetings so that she will be able to assist him with any issues that may arise. The advocate has helped him to dispute an overpayment of his Social Security benefits in the past. When the three of you meet, the advocate brings the letters from Social Security regarding the past overpayment. These letters contain valuable information about the current status of Ervin’s Social Security benefits. This saves you a great deal of time in developing the Benefits Summary & Analysis report. You are able to offer Ervin and his
advocate specific information on work incentives that he may be able to claim that would reduce the overpayment amount that he still owes.

## Conclusion

WIPA services are an important component of the current national effort to promote employment for Social Security beneficiaries with disabilities, but it certainly isn’t the only component, or even the most essential component in all cases. WIPA services will only be effective in achieving enhanced employment outcomes for Social Security disability beneficiaries if they are integrated with effective employment services and supports and supported by all of the other disability services systems. WIPA projects must work collaboratively as part of an interdisciplinary team that includes other key stakeholders to achieve the greatest impact. The net effect of this team effort is that each team member can concentrate on his or her area of expertise, thus making everyone’s job easier, and providing the beneficiary with the best chance for a successful employment outcome.

## Conducting Independent Research

**Disability.gov:** This is a resource website created by the federal government to information about services available to people with disabilities. It includes a feature to search by state ([https://www.usa.gov/disability-services](https://www.usa.gov/disability-services)).

**ILRU.org:** This is a website that contains a directory of Centers for Independent Living and associations across the United States ([https://www.ilru.org/projects/cil-net/cil-center-and-association-directory](https://www.ilru.org/projects/cil-net/cil-center-and-association-directory)).

**Career One-Stop:** This website provides information about American Job Centers, along with a state directory ([http://www.careeronestop.org/](http://www.careeronestop.org/)).

**SAMHSA’s National Mental Health Information Center:** This website contains a mental health services locator by state: ([https://findtreatment.samhsa.gov/](https://findtreatment.samhsa.gov/)).
Module 3 – Understanding Social Security Disability Benefits and Associated Work Incentives
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Module 3 – Understanding Social Security Disability Benefits and Associated Work Incentives

Introduction

Many Social Security disability beneficiaries hesitate to participate in return-to-work efforts because they fear paid employment will cause them to lose critical cash benefits and health insurance. In most cases, this fear is unjustified, as the Social Security disability programs include many work incentives designed to encourage and facilitate employment. The WIPA services that Community Work Incentive Coordinators (CWIC) provide are the single most effective method for communicating correct information to help beneficiaries overcome these fears. However, to be effective in this counseling, CWICs must completely understand Social Security disability programs, their various eligibility requirements, their operational details, and all associated work incentive rules or provisions.

Content in this area will focus on the Title II and Supplemental Security Income (SSI) disability programs and how wage employment affects eligibility for benefits and cash payment amounts. This module will discuss in detail and provide examples of all work incentives associated with the disability programs. This module will also include a separate unit on how beneficiaries can use Plan to Achieve Self-Support (PASS) as an employment support tool and how Net Earnings from Self-Employment (NESE) affect Title II and SSI benefits. A separate unit on the Ticket to Work program provides CWICs with comprehensive information about how beneficiaries may get help with achieving their career goals. Finally, this module will cover rights and protections provided to beneficiaries under the Social Security disability rules and regulations, including Expedited Reinstatement (EXR), Section 301 payments, and appeals.

CWIC Core Competencies

- Demonstrates knowledge of the Social Security disability evaluation and continuing disability review (CDR) process,
including eligibility criteria for Title II disability and SSI programs and other non-disability programs administered by Social Security.

- Demonstrates the ability to analyze the effects of wage employment on Title II and SSI disability benefits including eligibility and cash payment status.

- Demonstrates the ability to individualize and apply the relevant work incentives using complex, multi-phase case scenarios involving Title II disability benefits, SSI, and concurrent beneficiary examples (e.g., PASS, Student Earned Income Exclusion (SEIE), Blind Work Expenses (BWE), Trial Work Period (TWP)/Extended Period of Eligibility (EPE), Subsidy & Special Conditions, Impairment Related Work Expenses (IRWE), etc.)

- Demonstrates the ability to analyze the effects of self-employment on Title II and SSI disability benefits, including knowledge of Social Security and IRS regulations that define self-employment, the manner in which business structures affect Social Security benefits, methods for determining earnings from self-employment, and the application of work incentives that may assist beneficiaries to achieve or maintain a self-employment goal.

- Demonstrates the ability to advise beneficiaries regarding their rights and protections under the Social Security disability rules and regulations, including Expedited Reinstatement (EXR), Section 301 payments, and appeals.

- Assists beneficiaries to participate in the Ticket to Work program by providing counseling on Ticket eligibility, assignment and unassignment procedures, reporting requirements, timely progress requirements, and making referrals to Employment Networks (ENs) and state Vocational Rehabilitation (VR) Agencies.
Competency Unit 1 – Disability Evaluation and Determination
Understanding Eligibility for Social Security Disability Benefits

Introduction

This unit provides the reader a broad understanding of how Social Security defines disability and gives an overview of the initial application and disability adjudication process. Social Security restricts Work Incentives Planning and Assistance (WIPA) services to beneficiaries already entitled to Social Security disability benefits based on the person’s own disability. It’s important for CWICs to understand the eligibility determination process, as some concepts remain relevant after Social Security establishes entitlement.

Some Social Security disability beneficiaries receiving WIPA services may be eligible for additional benefits. Part of a CWIC’s job is to screen for potential eligibility for additional benefits or services and make referrals to other agencies or programs as needed.

It’s essential to understand that CWICs have a limited role in establishing eligibility for Social Security benefits. While it’s important that CWICs gain a basic understanding of the eligibility determination process, Social Security does not expect CWICs to develop expertise in this area. In fact, Social Security prohibits CWICs from assisting with initial applications for Social Security benefits.

Disability Defined

To meet the definition of disability under the Social Security Act, a number holder (NH) must be unable to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can be expected to result in death, or has lasted or can be expected to last for a continuous period of not less than 12 months. SGA means “the performance of significant physical and/or mental activities in work for pay or profit, or in work of a type generally performed for pay or profit, regardless of the legality of the work”. For
more information about SGA, refer to POMS DI 10105.065 - Disability Requirement (https://secure.ssa.gov/poms.nsf/lnx/0410105065).

NOTE: The definition of disability under the Social Security Act quoted in the section above has three criteria:

1. The person must have a medically determinable impairment;
2. The person must be unable to perform SGA because of that impairment; and
3. The condition must meet the duration requirement.

To receive benefits, the person must meet all three of these criteria.

**Childhood Definition of Disability for the SSI Program**

In the SSI program, the definition of disability for children (anyone under the age of 18) is different from the definition applicable to adults. Social Security considers an SSI claimant under age 18 disabled if he or she has a medically determinable physical or mental impairment or a combination of impairments that causes marked and severe functional limitations. In addition, Social Security must expect the impairment or combination of impairments to result in death or last for a continuous period of not less than 12 months. This childhood definition of disability ONLY applies in the SSI program. The adult standard of disability applies to all claimants in the Title II disability program regardless of age. More information about the definition of disability for children in the SSI program is available in POMS DI 25201.001 Childhood Disability – Introduction found online (https://secure.ssa.gov/apps10/poms.nsf/lnx/0425201001).

**A Word about Social Security’s Program Operations Manual System or “POMS”**: This manual is a valuable resource, but it’s essential that CWICs learn where to find information as close to the original source as possible. Laws and rules change, so learning how to search for and find references will keep the information you have at hand from becoming obsolete. For the remainder of the units in this module that discuss Social Security benefits, references will appear in this manner: DI 13010.060. These refer to the Program Operations Manual Systems (POMS) sections where you can find specific information.
The POMS is an enormous online reference that outlines all of the operational instructions that Social Security personnel use as guidance for all technical activities, and that the state DDS uses when making medical decisions. The POMS is difficult to read because Social Security designed it for agency employees who have gone through extensive training. It’s also full of Social Security-specific acronyms unfamiliar to CWICs. It’s important that CWICs learn to navigate the POMS because it contains Social Security’s rules that affect the beneficiaries with whom CWICs work. Understanding the language and the rules will help CWICs provide accurate information. The glossary at the end of this module may help you understand POMS references more easily.

Social Security maintains a public version of the POMS online, and you can access the table of contents by going to ssa.gov (https://secure.ssa.gov/poms.nsf/home!readform).

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**How Social Security Determines Disability**

When an adult individual initially applies for disability benefits, he or she must have a severe disability that prevents them from performing SGA. Social Security must expect the disability to last at least 12 months, or end in the claimant’s death. To establish that a disability exists, Social Security looks closely at the claimant’s medical records.

During initial disability claims, the burden of proof lies with the person filing the claim, not with Social Security.

**State Disability Determination Services (DDS)**

The State Disability Determination Services (commonly referred to as simply DDS) are state agencies responsible for developing medical evidence and determining whether the claimant is or isn’t disabled or blind under Social Security law. Many people mistakenly believe that Social Security makes all medical determinations of disability. In fact, Social Security contracts with DDS agencies to perform this function.
The DDS tries to obtain evidence from the claimant’s own medical sources first. If that evidence is unavailable or insufficient, the DDS may arrange for a consultative examination (CE) to obtain the additional information needed. The claimant’s own medical source generally is the preferred source for the CE; however, the DDS may also obtain the CE from an independent source.

After completing its initial development, the DDS makes the disability determination using, at minimum, an adjudicative team that includes a medical and/or psychological consultant and a disability examiner. If the adjudicative team finds that it needs additional evidence, the consultant or examiner may re-contact a medical source(s) and request supplemental information.

After the DDS makes the disability determination, the case either returns to the Social Security field office for appropriate action or it’s reviewed by quality review analysts at the state DDS office or at a federal Social Security branch. After quality review, cases will be returned to the Social Security field office for final processing. If the DDS finds the claimant disabled, Social Security will complete any remaining non-disability development, compute the benefit amount, and begin paying benefits. If DDS finds the claimant not disabled, the field office retains the file in case the claimant decides to appeal the determination.

If the claimant files an appeal of a denial, Social Security usually handles the appeal much the same as the initial claim, except that an adjudicative team in the DDS different from the one that handled the original case will make the disability determination.

The Sequential Evaluation Process

Social Security uses a five-step process for initial and reconsideration level decisions known as the sequential evaluation process to make disability determinations.

1. **Is the claimant performing SGA?**

Social Security personnel conduct this first step of the sequential evaluation process. After considering any applicable work incentives,

If the claimant is working and performing SGA, Social Security will decide that the individual doesn’t meet the disability standard. If the claimant isn’t working, or the average countable monthly earnings are less than
the current SGA guideline, Social Security sends the file to the DDS for the medical review.

**NOTE:** SSI claimants who meet Social Security’s definition of blindness are not subject to the first step of the sequential evaluation – the SGA test. Blind SSI claimants are eligible for SSI payments even if they are performing SGA, provided the claimant meets the other requirements for eligibility, such as income and resources.

2. **Are the claimant’s impairments “severe?”**

For the DDS to decide that an applicant is disabled, a medically determinable impairment or combination of medically determinable impairments must significantly limit the claimant’s ability to do basic work activities (such as walking, sitting, carrying, seeing, hearing, remembering simple instructions, and responding appropriately to the public and usual work situations) for at least one year. If the medically determinable impairment(s) has no more than a minimal effect on his/her ability to perform basic work activities, the DDS will determine that the individual doesn’t meet the disability standard. If the impairment(s) is severe, the DDS continues to Step 3.

3. **Is the claimant’s impairment on the Listing of Impairments?**

To make medical disability determinations, the DDS uses the “Listing of Impairments”. This describes impairments that are severe enough to prevent a person from doing any gainful activity. If a claimant has an impairment that is listed, the DDS will find the claimant disabled at Step 3. If the impairment (or combination of medical impairments) isn’t on this list, the DDS looks to see if the condition is as severe as a listed impairment. If the severity of the claimant’s impairment(s) meets or medically equals that of a listed impairment, the DDS will decide that the claimant is disabled. If the medically determinable impairment does not meet, or medically equal a listed impairment, the DDS goes to Step 4.

**The Listing of Impairments**

The Listing of Impairments describes, for each major body system, impairments that are considered severe enough to prevent a person from doing any gainful activity (or in the case of children under age 18 applying for SSI, cause marked and severe functional limitations). Most of the listed impairments are either permanent or
expected to result in death, or a specific statement of duration is made. For all others, the evidence must show that the impairment has lasted or is expected to last for a continuous period of at least 12 months. The criteria in the Listing of Impairments are applicable to the evaluation of claims for disability benefits or payments under both the Social Security disability insurance and SSI programs.

The **Listing of Impairments** is available at Social Security’s website (https://www.ssa.gov/disability/professionals/bluebook/general-info.htm).

The criteria in the Listing of Impairments apply only to one step of the multi-step sequential evaluation process at the initial and reconsideration level. At that step, the presence of an impairment that meets the criteria in the Listing of Impairments (or medically equals the severity) is usually sufficient to establish that an individual who is not performing SGA meets the definition of disability.

If the impairment does not meet a listing, the adjudicator moves on to the next step of the process and applies other rules in order to resolve the issue of disability.

4. **Can the claimant do the work that he or she did before?**

At this step, the DDS decides if the impairment(s) prevents the claimant from doing his or her past work as he or she performed it before, or as generally performed in the national economy. If past work is not precluded, the DDS will decide that the claimant does not meet Social Security’s definition of disability. If past work is precluded, the DDS goes on to Step 5.

5. **Can the claimant make an adjustment to any other type of work?**

If the claimant cannot do the work he or she did in the past, the DDS looks to see if the claimant would be able to make an adjustment to other work. The DDS evaluates the individual’s medical condition, age, education, past work experience, and any skills the claimant may have that he or she could use to do other work. If the claimant can’t do other work, the DDS will decide that the claimant’s impairment meets the Social Security definition of disability. If the claimant can make an
adjustment to other work in the economy, the DDS will decide that the beneficiary is not entitled to benefits based on disability.

To learn more about the sequential evaluation process, refer to POMS DI 22001.001 - Sequential Evaluation of Title II and Title XVI Adult Disability Claims found online (https://secure.ssa.gov/apps10/poms.nsf/lnx/0422001001).

**Continuing Disability Reviews (CDRs)**

Once Social Security entitles individuals to benefits, beneficiaries must periodically prove that their disability continues to be severe to retain eligibility. In some situations, Social Security will simply review the folder and determine that the impairment could not have improved. In other cases, the beneficiary will receive a questionnaire in the mail, and the information he or she provides on the questionnaire will be sufficient for Social Security to determine continued eligibility. Sometimes, however, Social Security will need to gather medical evidence and interview the beneficiary to determine if the disability continues to meet Social Security’s definition. Social Security calls these periodic reviews of a beneficiary’s condition “Medical Continuing Disability Reviews” (CDRs).

As with initial disability determinations, the local Social Security field office gathers the medical information and sends it to the DDS. For medical CDRs, the DDS uses a different standard from the one it uses for initial applications. Once individuals are entitled to benefits, the DDS doesn’t look for medical evidence to re-establish existing and documented impairments, because this was already completed when the beneficiary was first determined to be disabled. Instead, the DDS considers evidence to determine if the medical impairment(s) has improved. If there’s sufficient medical improvement, Social Security terminates the person’s benefits. The Medical Improvement Review Standard (MIRS) is the legal standard used by Social Security for determining if disability continues in a CDR. Under the MIRS standard, DDS considers current signs, symptoms, and laboratory findings related to the impairment(s) documented at the time of the last favorable decision to determine if there has been any changes or improvement as the basis for finding medical improvement (MI).
Medical Improvement Review Standard (MIRS)

Social Security will determine that an adult beneficiary of Social Security disability benefits is no longer disabled if the evidence demonstrates that the person has:

- Medical Improvement (MI) related to the ability to work, and
- The ability to engage in SGA.

Like the initial determination, the MIRS definition has two parts: medical improvement and the ability to perform SGA.

Medical Review Diaries

Once an individual meets the disability requirements or a CDR establishes that a beneficiary continues to have a disability under Social Security’s definition, the DDS sets a date called a “diary” when it will review the individual’s disabling condition again to see if the disability continues. There are three primary diaries: Medical Improvement Expected (MIE), Medical Improvement Possible (MIP), and Medical Improvement Not Expected (MINE).

Medical Improvement Expected (MIE)

MIE reviews apply to individuals with impairments that Social Security expects to improve sufficiently to permit the individuals to engage in SGA. A CDR diary for MIE means that Social Security will review the medical file in less than three years.

Medical Improvement Possible (MIP)

MIP reviews apply to individuals with impairments who either at the time of initial entitlement or after subsequent review, Social Security considers to have the possibility of improving. In these cases, improvement may occur to permit the individuals to perform SGA, but Social Security cannot predict improvement with accuracy based on current experience and the facts of the particular case. An MIP diary means that Social Security should review the medical file within three years.

Medical Improvement Not Expected (MINE)

MINE reviews apply to individuals with impairments that either at initial entitlement or later, after further review, Social Security does not expect to improve. These are extremely severe impairments that have shown, on the basis of administrative experience, to be at least static but more
likely to be progressively disabling. Improvement to permit the individuals to engage in SGA is unlikely. Social Security may consider the interaction of the individual’s age, impairment consequences, and the lack of recent attachment to the labor market in determining whether it expects the impairment to improve. A MINE diary means that Social Security should review the file within seven years but no more frequently than once every five years.

More information about the CDR process is available in the POMS starting with DI 28005.000 - The CDR Evaluation Process. You may access that online (https://secure.ssa.gov/apps10/poms.nsf/lnx/0428005000).

**Protection from Medical CDRs**

The Ticket to Work and Work Incentives Improvement Act of 1999 created two provisions that protect beneficiaries from medical CDRs:

- Social Security will not initiate medical CDRs for beneficiaries who are actively using their Ticket to Work. We discuss the Ticket to Work program in detail in Unit 10 of this module.

- Effective January 1, 2002, if an individual has been receiving disability benefits for at least 24 months, Social Security will not initiate a medical CDR solely because an individual goes to work. This is an essential protection for beneficiaries who decide to pursue employment. Beneficiaries who have received cash benefits for at least two years will only undergo the regularly scheduled medical CDRs based on the MIE, MIP, and MINE diaries set at the last medical determination of their benefits. A report of work activity will no longer solely “trigger” a medical review. A beneficiary does not need to have a Ticket or be using a Ticket to be afforded this second CDR protection.

**Age-18 Redeterminations in the SSI Program**

Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (P.L. 104-193) in 1996. The Act requires that all Social Security review the eligibility of all Supplemental Security Income (SSI) recipients who turn 18 years of age as if they were applying for adult SSI for the first time without consideration of previous disability determinations. Social Security calls this review process the “age-18
redetermination,” and the agency performs it because the childhood definition of disability varies greatly from the more comprehensive adult standard in the SSI program. Because of the more comprehensive definition of disability for adults, when Social Security conducts age-18 redeterminations, the agency may determine an individual ineligible for SSI benefits as an adult. This is true even though there has been no change in medical condition or ability to function since Social Security found the beneficiary eligible for childhood SSI benefits.

**IMPORTANT NOTE:** The age-18 redetermination process only applies to SSI recipients. This is because the SSI program has two different definitions of disability: one for children under age 18 and one for adults aged 18 and above. Title II disability beneficiaries aren’t subject to redeterminations at the age of 18 because there is only one disability standard in the Title II program. This standard is the same as the adult standard for SSI entitlement.

**The Age-18 Redetermination Process**

The age-18 redetermination occurs for all childhood SSI recipients at some point after their 18th birthday. It may occur at a regularly scheduled CDR or at another point as determined by Social Security. In general practice, the age-18 redetermination usually occurs within 12 months after the 18th birthday. Social Security does not initiate the review prior to the month before the month the individual turns age 18. Social Security should never initiate an age-18 disability redetermination if the person was not eligible for SSI based on a childhood disability, in the month before the month of his or her 18th birthday.

To conduct a redetermination at age 18, Social Security gathers information on the young adult and determines eligibility under the adult criteria for SSI. The agency considers age-18 redeterminations to be initial eligibility decisions rather than CDRs. This means that the medical improvement review standard (MIRS), which Social Security uses in conducting CDRs, does not apply to the redetermination. When the agency applies the MIRS, the burden of proof falls on Social Security to document that the beneficiary has medically improved. Without the application of the MIRS, the burden of proof lies with the individual in establishing that he or she meets the adult disability criteria for SSI. Consequently, there is a heightened need for youth, their families, school personnel, and others to provide accurate and up-to-date documentation.
and evidence related to the disabling condition and the person’s ability to function and work when the age-18 redetermination begins.

The general process is as follows:

1. **Written Notification of Redetermination**

   The local Social Security field office begins the process by sending written notification to the individual and parents or guardians that Social Security will review the person’s medical situation to see if he or she has a disability that meets the adult standard.

2. **Interview at Social Security Field Office**

   The young person and his or her family members, guardians, or representatives may go to the local field office to complete an initial eligibility interview. The purpose of the interview is to gather information on the severity of the disability and how it affects the person’s ability to function. During the interview, Social Security personnel will complete initial disability interview forms including Form SSA-3367-F4 (Disability Report Field Office), Form SSA-3368-BK (Disability Report-Adult), and appropriate disability and functional reports. Social Security also requests permission to contact physicians, service providers, and teachers who work with the beneficiary. Social Security will ask the beneficiary to sign Form SSA-827 (Authorization for Source to Release Information to the Social Security Administration) for each source of information.

**IMPORTANT NOTE:** Social Security personnel must ask the claimant if he or she is receiving vocational rehabilitation, employment, training, educational, or other support services from any source during the redetermination interview. The answers provided to these questions are critically important because they indicate the potential for Section 301 continuation of benefits if an adverse determination occurs. We provide more information about Section 301 in unit 9 of this module.

3. **The Disability Determination Service (DDS) Review**

   Social Security forwards all the information gathered at the interview to the DDS. The DDS follows a detailed process (known as the sequential evaluation process) to determine if the youth’s impairment is “severe” by Social Security’s criteria. Keep in mind that the criteria to receive the
label of “severe impairment” are more comprehensive for adults than for children in the SSI program.

**Note:** Social Security bypasses the first step of the sequential evaluation (are you currently engaged in SGA?) during an age-18 redetermination.

The DDS also examines the claimant’s ability to engage in SGA by reviewing information gathered from the young adult’s teachers, medical sources, counselors or therapists regarding his or her abilities. If the claimant is involved in a special work program such as vocational rehabilitation, records are requested from applicable sources to assess the impact of the individual’s medical condition(s) on their functional ability to engage in substantial employment opportunities in the national economy.

4. **Social Security Notifies the Individual of the Determination**  

All individuals for whom Social Security conducts an age-18 redetermination receive a written notice. If the determination is favorable, the individual continues to receive SSI cash payments and Medicaid with no interruption.

An individual whom Social Security finds ineligible for SSI benefits as an adult will receive a written notice stating that he or she is no longer qualified to receive benefits. These individuals are entitled to receive two more months of payments after the date of this notice. Overpayment may occur if an ineligible individual continues to receive payments after the two-month grace period. Social Security will only seek to recover those payments after the agency makes its determination and the two-month grace period is over.

**IMPORTANT NOTE:** When conducting an age-18 disability redetermination involving a concurrent claim, the DDS may not adopt a Title II disability determination made before age 18 to an SSI age-18 disability redetermination. Social Security personnel must advise the individual that an unfavorable determination on the SSI disability redetermination will trigger a medical CDR on the Title II disability claim.
For more information about the age-18 redetermination process, refer to **POMS DI 23570.000 - Title XVI Childhood and Age 18 Disability Redetermination Cases** found online (https://secure.ssa.gov/apps10/poms.nsf/lnx/0423570000).

**Applying for Social Security Disability Benefits**

A network of local Social Security field offices and state Disability Determination Services (DDS) agencies process most initial Social Security disability claims. Social Security accepts applications for disability benefits in person, by telephone, by mail, or by filing online. The application and related forms ask for a description of the claimant’s impairment(s), treatment sources, and other information that relates to the alleged disability. The Social Security field office is responsible for verifying non-disability eligibility requirements that may include age, employment, marital status, or Social Security coverage information. The field office then sends the case to the DDS to evaluate the alleged disability.

Individuals can apply for disability benefits in three ways. They can:

- **Apply online by going to the Social Security website** (http://www.socialsecurity.gov/applyfordisability/#a0=0)
- Apply at the nearest Social Security field office;
- Call Social Security’s toll-free number, 1-800-772-1213, to make an appointment to file a disability claim at the local Social Security office or to set up an appointment for someone to take the disability claim over the telephone. The disability claims interview lasts about one hour. Individuals who are deaf or hard of hearing may call Social Security’s toll-free TTY number, 1-800-325-0778, between 7 a.m. and 7 p.m. on business days; or
- Claimants can use the online application to apply for disability benefits if they:
  - Are age 18 or older;
  - Aren’t currently receiving benefits on their own Social Security record;
• Are unable to work because of a medical condition that is expected to last at least 12 months or result in death; and

• Were not denied disability benefits in the last 60 days. If Social Security denied an application for medical reasons in the last 60 days, the Internet Appeal is a starting point to request a review of the medical determination.

Social Security will request the following information during the initial interview:

• Social Security number;
• Birth or baptismal certificate;
• Names, addresses, and phone numbers of the doctors, caseworkers, hospitals, and clinics that would have information about the disability;
• Names and dosage of all medicines;
• Medical records from doctors, therapists, hospitals, clinics, and caseworkers;
• Laboratory and test results;
• A summary of work history; and
• A copy of the most recent W-2 form (Wage and Tax Statement) or, for self-employed individuals, a copy of his or her federal tax return for the past year.

In addition to the basic application for disability benefits, claimants need to complete other forms. One form collects information about the medical condition and how it affects the claimant’s ability to work. Other forms give doctors, hospitals, and other health care professionals who have treated the claimant permission to send Social Security information about the claimant’s medical condition.

When the DDS has made a determination on a claimant’s case, Social Security notifies the individual by mail. If Social Security approves the application, the letter will show the amount of the monthly benefit and will indicate when the payments will start. If Social Security denies the application, the letter will explain why and provide information about how to appeal the decision. The Social Security appeals process is described in Unit 9 of this module.
IMPORTANT RESOURCE: Social Security has produced a series of videos that provide a clear overview of the disability evaluation and determination process. CWICs can find these videos on YouTube (https://www.youtube.com/watch?v=OvQFbwq4dNA&list=PLGSYaN04xzFCoEqDIY3n7xgWLh55vvDh).

Conclusion

CWICs may not help individuals apply for Social Security disability benefits. However, there will be instances when an individual who already receives a disability benefit from Social Security may become eligible for another type of Social Security benefit. This possibility can have a significant effect on how paid work affects a person’s benefits. CWICs should be alert to the possibility of establishing entitlement to other programs and should be aware of the events that could trigger eligibility. CWICs also need to provide information to beneficiaries about how to apply for additional Social Security benefits or other programs.

Conducting Independent Research

Social Security’s Website: An incredibly valuable reference is the SSA.gov website, where you can find informative and useful forms, pamphlets, and resources (https://www.ssa.gov/).

Social Security Redbook on Work Incentives: One especially valuable resource available on Social Security’s website is the Redbook on Work Incentives. CWICs can find this comprehensive look at the Social Security work incentives online (https://www.ssa.gov/redbook/).

Code of Federal Regulations (CFR): The CFR lists the regulations of the Social Security Act on which the POMS are based. The CFR is a good place to look for information to help understand complex provisions. Keep in mind, though, that Social Security uses the POMS much more than the CFR. CWICs can find the CFR online (http://www.socialsecurity.gov/OP_Home/cfr20/cfrdoc.htm)

NOTE: Future sections in this manual will have references to the POMS in the text, and in the “Conducting Independent Research” sections. CWICs should consider
making these “favorites” as you will need this information at some point in the future.

**Disability Evaluation under Social Security:** Disability Evaluation under Social Security (also known as the Blue Book) provides physicians and other health professionals with an understanding of the Social Security Administration’s programs. It explains how each program works and the kinds of information health professionals can furnish to help ensure Social Security makes sound and prompt decisions on disability claims.

**The Adult and Childhood Listings of Impairments** are included in this online publication. These listings are just part of how Social Security decides if someone is disabled. Social Security also considers past work experience, severity of medical conditions, age, education, and work skills. The current listing of impairments is online (http://www.socialsecurity.gov/disability/professionals/bluebook/general-info.htm)
Competency Unit 2 – Understanding Social Security Title II Benefits

Introduction

Social Security benefits began during the Great Depression as a retirement program to partially replace wages lost when an individual left the workforce because of age. All of the benefits paid under Title II of the Social Security Act have grown from that historical beginning as Congress has added new categories of eligibility. Social Security benefits replace wages for workers and certain dependent family members. Social Security bases payment amounts under the Title II program upon the wages on which the worker paid Social Security taxes.

This unit will provide an overview of the different types of benefits Congress authorized under Title II of the Social Security Act, as well as the specifics of entitlement associated with each benefit type. CWICs should understand the distinguishing characteristics of each type of Title II benefit in order to accurately advise beneficiaries.

Benefits for the Number-Holder (NH) (The person who paid into Social Security)

The two types of benefits that a worker can receive under Title II of the Social Security Act are:

1. Retirement benefits paid as early as age 62, or
2. Disability benefits if the worker has a severe disability that renders the person unable to perform substantial work.

Retirement Insurance Benefits (RIB)

Social Security may pay retirement benefits as early as age 62. An individual isn’t eligible for a full benefit unless he or she becomes entitled at full retirement age or later. Full retirement age (FRA) used to be 65 for everyone, but it’s increasing. For people retiring at the time of this publication, FRA is age 66. The age will continue to increase until people born in 1960 will need to be 67 to attain FRA and retire without a reduction in their Social Security Retirement Insurance Benefits. Individuals can use a retirement age calculator available on Social

Reduced Retirement Insurance Benefits (RIB)

As previously stated, a person entitled to a Social Security retirement insurance benefit payment prior to full retirement age (FRA) will usually have a permanently reduced benefit, unless a situation allows Social Security to later adjust the amount of reduction. Social Security calculates the final amount of payment using a “reduction factor.” The reduction factor is the number of months that the person received a benefit prior to FRA. For example: If a person applies for retirement benefits at exactly age 63, and his or her full retirement age is 66, Social Security would reduce benefits permanently by a factor of 36 months. If that same person waited to retire until the month the person turns age 65, the reduction factor would be 12 months.

Social Security determines these reductions, and the determinations are far outside the scope of the CWIC’s responsibilities. It’s good, however, to understand that these other benefits exist and how the non-disability benefits relate to the disability benefits that are the primary focus of this manual.

Benefits for Dependent Family Members

Dependent family members include spouses (or divorced spouses), widow(er)s, (or surviving divorced spouses), parents, and eligible children. We will discuss several categories briefly in this section. Remember that family relationships can be complicated, and only Social Security personnel make these determinations.

Spouse or Widow(er) Benefits

Social Security pays benefits to the

- Spouse;
- Divorced spouse who has been married to the worker for 10 or more years;
- Widow or Widower; or
- Surviving divorced spouse of a worker who paid into the Social Security system. As with the retirement and disability programs, there are different avenues through which an entitled spouse or
surviving spouse can access a benefit to replace some of the wages lost due to retirement, disability, or death of the Social Security worker.

Marital relationships can be complicated. Many factors can influence the relationship determination including previous marriages, the type of ceremony, or the duration of the marriage if the individuals were divorced. Determining who the spouse, widow, or widower is under state law for the purposes of Social Security benefit entitlement is solely the responsibility of Social Security.

**Determining the Relationship**

Social Security determines relationships when individuals apply for Social Security benefits. These determinations are important because Social Security may provide cash payments to certain eligible family members in addition to the primary claimant or number holder (NH). Family relationship determinations are far more complex than most people realize. Social Security bases them on state and federal laws. Whenever there is a possibility of entitlement, you should refer the individual to the local Social Security field office for a formal determination.

**IMPORTANT NOTE:** Effective June 20, 2014 Social Security published instructions that allow the agency to process claims in which same-sex relationships affect entitlement or eligibility. These instructions come in response to the Supreme Court’s decision in U.S. vs. Windsor that found Section 3 of the Defense of Marriage Act unconstitutional. The policy also addresses **Supplemental Security Income (SSI) claims based on same-sex relationships** ([https://www.ssa.gov/people/same-sexcouples/](https://www.ssa.gov/people/same-sexcouples/)).

Once Social Security establishes the marital relationship, the individual must meet additional eligibility criteria to indicate dependence on the worker. These factors are age and whether or not the spouse or surviving spouse has an entitled child of the worker in his or her care. These definitions are specific. If the person who worked and paid into the Social Security system is receiving either a retirement or disability payment, a spouse can receive benefits on the worker’s record one of three ways:

- The spouse is over age 62; or
• The spouse has an entitled child of the worker who is under age 16 in his or her care; or
• The spouse has the worker’s entitled disabled child in his or her care, and the child is over age 16.
• A Widow(er) may receive benefits at:
  • Age 60 or later, or
  • Any age, if the widow(er) has an entitled child in-care (mother’s/father’s benefits); or
• Age 50 if he or she is disabled, called Disabled Widow(er) Benefits (DWB).

Even if a widow(er) meets the above requirements, Social Security precludes entitlement if the claimant was convicted of the felonious and intentional homicide of the worker.

**Definition of Child in Care**

A child in care is a child who is:

• Under age 16; or
• Age 16 or older and severely disabled (See RS 01310.001E https://secure.ssa.gov/apps10/poms.nsf/lnx/0301310001)

**Independently Entitled Divorced Spouse Benefits**

Independently entitled divorced spouses must be:

• The divorced spouse of a fully insured worker age 62 (worker must be 62 throughout the first month of entitlement but need not have filed a claim for benefits);
• Able to meet other entitlement requirements including having been married to the worker for at least ten years; and
• Finally divorced from the worker for at least two continuous years.

**Child’s Benefits**

Social Security pays child’s benefits to dependent children of certain insured workers. Even if the child has a disability, the child receives regular child’s benefits until the age of 18. This point often confuses inexperienced CWICs. Remember, individuals can’t collect a Title II
benefit based on disability until the age of 18. Only in the SSI program are benefits payable based on disability to individuals under age 18. All children under age 18 who are receiving a Title II benefit from the Social Security Administration will be receiving child’s benefits, not CDB. Social Security may pay child’s benefits to multiple children up to the maximum amount that family may receive, based on the worker’s lifetime earnings. To be entitled to Title II child’s benefits, an individual must’ve filed an application for child’s benefits and must be:

- The child of an insured worker who is deceased, retired, and collecting Social Security retirement benefits, or disabled and collecting SSDI; and
- Dependent upon that insured worker; and
- Unmarried (with some exceptions).
- Social Security assumes dependence if the child is unmarried and:
  - Under age 18; or
  - If age 18 or over, a full-time elementary or secondary school student under age 19; or
  - Over age 18, and disabled prior to age 22, called Childhood Disability Benefits (CDB).

Eligibility for child’s benefits hinges primarily on how Social Security defines the words “child” and “dependent.” The regulations surrounding the Social Security Administration’s definition of a child are complex and cover situations such as adoption, stepchildren, grandchildren, illegitimate children, and many other relationships. Social Security defines dependency precisely and relates it to where and with whom the child lives and how much financial support he or she receives. Only Social Security personnel have the authority to decide when an individual meets all the requirements to be eligible for a Title II child’s benefit. CWICs must refer all questions on these matters to the local field office.

**The Earnings Test (ET)**

People who receive Title II Social Security benefits not based upon disability are subject to an Earnings Test (ET). To understand the
Earnings Test (sometimes referred to as the retirement test) it may be helpful to remember that Social Security benefits are intended to partially replace wages for workers and dependent family members when the worker stops or significantly reduces work. Each year, Social Security establishes an “exempt amount.” Only countable earnings over the exempt amount will affect the beneficiary’s Social Security payments. The ET applies to earnings within a calendar year. The exempt amount of gross earnings (or net earnings from self-employment) is fairly high when compared to earnings limits under the Title II disability programs. The ET never applies to SSI benefits.

To find the current exempt amount, go to RS 02501.025 - Determining Annual and Monthly Exempt Amounts found at Social Security’s website (https://secure.ssa.gov/apps10/poms.nsf/lnx/0302501025#b1).

The Social Security website also has a calculator to help beneficiaries find out the effect of work on benefits not based on disability. You will find this calculator online (https://www.ssa.gov/OACT/COLA/RTeffect.html).

### Understanding Entitlement for Social Security Benefits

#### Types of Benefits Provided under Title II of the Social Security Act

Social Security benefits paid under Title II partially replace income lost when a worker retires, dies, or develops a disabling condition that prevents substantial work. Social Security pays benefits to retired or disabled workers and their dependent family members, as well as the surviving spouses and children of deceased workers. The descriptions of benefit types and entitlement requirements in this unit aren’t exhaustive.

When individuals seek entitlement determinations on any Title II benefit, you should refer them to the local Social Security field office, or to Social Security’s website (www.ssa.gov) to apply. Here is a brief list of the types of benefits paid under Title II of the Social Security Act:

- **Retired worker**: Beneficiary who worked enough in Social Security-covered employment to be due benefits and who is at least 62 years old (Social Security reduces benefits if claimant is
Social Security defines Full Retirement Age (FRA) based on the year of birth of the claimant.

- **Disabled worker**: Beneficiary who had sufficient work in Social Security-covered employment or self-employment and who had recent covered employment or self-employment prior to disability onset.

- **Spouse of retired or disabled worker**: (1) The individual is taking care of a child, entitled on the worker’s record, who is under age 16 or disabled, or (2) is at least 62 years old. Entitlement applies to an unmarried, divorced spouse who is at least 62 if the marriage(s) to the worker lasted at least 10 years. In some situations, he or she may receive benefits even if the worker isn’t receiving them.

- **Child of retired, disabled, or deceased worker**: Individual must be under age 18, or between 18 and 19 and in primary or secondary school.

- **Disabled child of retired, disabled or deceased worker**: Individual must be age 18 or older and experiencing a disability (as defined by Social Security) that began before the adult child turned age 22.

- **Aged widow(er)**: Individual must be at least 60 years old.

- **Young widow(er)**: Individual must have the worker’s entitled child who is under age 16 or disabled in his or her care.

- **Surviving divorced spouse**: Individual who is at least age 60 (50-59 if disabled) if the marriage lasted at least ten years. The former spouse doesn’t have to meet the age or length of marriage rule if he or she is caring for the worker’s entitled child who is under age 16 or disabled.

- **Disabled widow(er)**: Individual must be disabled and be at least 50 years old.

- **The deceased worker’s dependent parents**: Parents can receive benefits if they are age 62 or older. For parents to qualify as dependents, the worker would’ve had to provide at least one-half of their support, and meet other criteria.
NOTE: A living retired or disabled worker must be due a benefit in order for Social Security to entitle the children or spouse of the worker (with some exceptions, including if Social Security suspends the worker’s benefits due to incarceration).

Earning Entitlement to Social Security Benefits

Social Security taxes are somewhat like insurance premium payments. Workers earn benefits by paying Social Security taxes on wages or on the net-profit from a trade or business. All benefits stem from the work of the person who owns the Social Security number on which Social Security pays the benefits. When a worker retires and collects a Social Security benefit, dies, or becomes entitled to Social Security disability benefits, the amount of wages previously taxed determines eligibility for benefits and the amount of payments. Since 1978, Social Security gives 1 credit for payment of Social Security taxes on a minimum amount of wages to determine eligibility on a worker’s history of earnings. Workers originally earned Social Security “credits” based on earnings at or above an amount earned during a certain part of the year. Social Security uses a count of QCs to measure if the claimant had enough work credits for the worker, or for dependent family members, to be due benefits. Credits or QCs only matter at the time of application for benefits.

Quarters of Coverage

Previously, Social Security QCs referred to an actual three-month period, or quarter of the calendar. The quarter was “covered” if the person worked and had earnings at or above the amount Social Security credits as a QC. Since 1978, however, Social Security bases QCs on the amount of earnings credited to a calendar year regardless of when the earnings occur in the calendar year. A beneficiary can earn a maximum of four QCs per year. Social Security also refers to QCs as earning “credits.” Quarters of Coverage and credits mean the same thing.

NOTE: The amount required for a beneficiary to earn a QC changes annually. In 2020, a worker must earn $1,410 in Social Security-covered employment to earn one QC.

Having enough QCs is a “yes” or “no” eligibility question. Social Security determines if a person is eligible or “insured” for benefits by determining
when and how many QCs the person has earned. There are several types of insured statuses, and the amount of required work depends on the type of benefits, the person’s age, and the point at which the person becomes disabled. Social Security will make this determination when the person applies. CWICs aren’t responsible for determining eligibility, and it’s not possible for CWICs to perform this task. Only Social Security personnel have access to the information needed to make entitlement determinations.

**Insured Status**

There are several rules around when and how much a person has to earn for entitlement to benefits under Title II of the Social Security Act. The amount and timing of work the claimant needs to earn benefits depends on the type of benefits he or she requests.

**“Fully Insured” Status**

Social Security considers someone to be “fully insured” if he or she earns one credit for each year between the time the person turned 21 and the date of death, date of disability, or the date the person turns 62. Social Security uses fully insured status to entitle someone for Retirement Insurance Benefits (RIB), for survivor’s benefits, and for disability benefits if the claimant is blind. A person can earn these credits any time during his or her work history. Regardless of the person’s age, the person who paid into Social Security or the “Number Holder” (NH) must have earned at least six credits for anyone to receive benefits on the work record. The number of credits required for insured status will never exceed 40, or the cumulative equivalent of ten years of covered earnings. There is another type of insured status required for people who apply for disability benefits, called “disability insured” status.

**Disability Insured Status**

Disability insured status means that the individual meets the fully insured status test discussed above, and also meets the test for recent work. For disabilities that began when the claimant was over age 31, the claimant must have at least 20 QCs or credits during the ten-year period immediately before the date the medical evidence indicates the disability began. If the claimant is younger than 31, the number of credits for disability benefits is less than 20, and varies depending on the claimant’s age. Note that people who are blind need only meet the fully insured status test. Some claimants earn insured status after the disability
began. Some claimants develop a disability after insured status ends. Because of the 20-out-of-40 rule for insured status, people can be ineligible for SSDI if the disability onset occurs after the last date they were insured. Remember, Social Security makes these decisions. If a CWIC works with someone who may be entitled to a disability payment, such as a working SSI beneficiary, have that person apply.

**Insured status** is a complex concept that can be difficult to understand. Social Security provides a clear explanation of it in the Social Security Handbook, found online here: (https://www.ssa.gov/OP_Home/handbook/handbook.02/handbook-0200.html)

### Calculating Benefit Amounts

Once Social Security determines that a worker has sufficient QCs to permit entitlement, it calculates the Primary Insurance Amount (PIA) and payments based on wages or self-employment income (SEI) on which the worker paid taxes. There are many different calculations, and Social Security chooses the appropriate one based on the worker’s date of birth and the date the disability began, or the date the worker died or became entitled to a retirement benefit. Social Security’s computer system reliably performs the complex benefit calculation when an individual applies for benefits. Re-computations occur periodically when an individual has additional earnings that positively affect the potential benefit. CWICs should never attempt to calculate benefit amounts or even offer estimates of what payment might be. Only Social Security personnel can perform this task.

**Primary Insurance Amount (PIA)**

The PIA is the result of a complex benefit calculation that Social Security performs to determine the amount of payments. Social Security calculates all benefits it pays on this worker’s record from the PIA. For example, children receive a dependent amount equal to a percentage of the worker’s PIA. The child of a living worker receives benefits of up to 50 percent of the worker’s PIA, but a surviving child receives benefits of up to 75 percent of the worker’s PIA.

### Clarification of Terms

Social Security refers to the person who has earned the benefits as the worker, Wage-Earner (W/E), or the Number Holder (NH). Social security
refers to dependent family members as “auxiliaries” if the worker is alive or “survivors” if the worker is deceased. Auxiliary or survivor beneficiaries receive a percentage of the amount of the worker’s benefit. For example, a child of a living disabled worker would receive an amount up to one half of the PIA. The PIA is essentially the worker’s highest possible benefit based on his or her work history. When the worker dies, the worker’s dependent child would be due a benefit of up to 75 percent of the worker’s PIA.

If the worker is alive and loses entitlement to cash benefits because Social Security decides he or she no longer has a disability under Social Security rules, dependent family members also lose their entitlement to benefits.

**Family Maximum (FMAX)**

The FMAX caps the amount of benefits paid to dependent or surviving family members based on a worker’s earnings. If the worker is living, the worker receives his or her full benefit, and the rest of the dependent family members share what is left. If the former worker is deceased, the entitled family members each receive their full benefit, unless the total exceeds the family maximum. If it does, then family members each split a portion of the remainder of the FMAX after deducting the worker’s benefit. Social Security calculates the FMAX by subjecting the PIA to a complex formula.

**Example of Family Maximum:**

Alexander became disabled last year and receives $1,200 per month in SSDI beginning in January. Alexander has three children who are all under age 18. Alexander is a single parent, and no one other than Alexander and his children receives benefits based on Alexander’s work.

Because Alexander is living, each child could be eligible for an amount equal to up to half of his SSDI of $1,200, no more than $600 per child. Alexander’s FMAX, however, is $1,800. Because there are three children, the FMAX will reduce the children’s benefits. Alexander receives his full benefit of $1,200, leaving $600 of the FMAX for the three children to share. Each child would receive a benefit of $200.
**NOTE:** We simplified these figures for this example. The FMAX depends on the amount of wages paid. It may simply be the PIA (the worker’s highest possible benefit) or it may be significantly higher than the PIA.

Beneficiaries and CWICs often misunderstand the complex family maximum concept. To find a detailed explanation of this concept, refer to Social Security’s resource document titled “Understanding the Social Security Family Maximum” (https://www.ssa.gov/policy/docs/ssb/v75n3/v75n3p1.html).

**Understanding Title II Disability Benefits**

The previous section described the entitlement requirements for the various types of Title II benefits. An individual may establish entitlement to a Social Security benefit numerous ways, the majority of which have nothing to do with disability. It’s important to remember that the terms of the agreement projects hold with Social Security restrict WIPA projects to working with individuals who receive benefits from Social Security that are based on the beneficiary’s disability. In the following section, we focus specifically on the different types of Title II disability benefits individuals may receive.

**Disability Benefits**

Unit 1 of this module explained the definition of disability and the process that Social Security uses to determine whether or not a claimant for benefits meets Social Security’s stringent definition of disability. The definition of disability and the disability determination process are the same for both Title II and SSI benefits. The only exception to this is that Social Security evaluates SSI claimants under age 18 using a different definition of disability. Once SSI recipients turn 18, Social Security reexamines their disabilities to see if they meet the adult disability standard for entitlement. Unlike SSI, the adult definition for disability is the only one Social Security applies in the Title II disability program.

**Types of Disability Benefits**

Title II of the Social Security Act authorizes three types of disability benefits. For all of these benefits, the claimant must meet the disability
standards discussed in Unit 1 of this module as well as other non-disability criteria including submitting an application, proving age, relationship to the insured worker, etc. Remember, only Social Security makes these entitlement decisions. Whenever there is a possibility of entitlement, refer the individual to the local Social Security field office, to the 1-800-772-1213 call center, or to the “My Social Security” portal on the www.socialsecurity.gov website to apply.

- **Disability Insurance Benefits (DIB)**, also called Social Security Disability Insurance (SSDI), are payable to workers insured under the Act. To be insured, the worker must meet fully insured, and disability insured status, and must meet the other disability and non-disability requirements for entitlement.

- **Childhood Disability Benefits (CDB)**, previously called Disabled Adult Child’s benefits (DAC), are payable to a disabled adult child of an insured worker who has retired or become disabled and is collecting Social Security benefits, or who has died. The child must have a disabling condition that began prior to the time the child attained age 22. Although the disability had to begin prior to the age of 22, individuals cannot become entitled to CDB until they have turned 18. Those under age 18 may be eligible for child’s benefits not based on disability.

- **Disabled Widow(er)’s Benefits (DWB)** are payable to the widow, widower, or surviving divorced spouse of an insured worker. The widow, widower, or surviving divorced spouse must be at least age 50, be disabled before the end of a specified period of time called the “prescribed period,” and meet other requirements regarding relationship to the worker and the length of time between the worker’s death and the application.

The definition of disability is the same for all three groups, but entitlement requirements and the events that terminate cash payments differ. Because Social Security bases eligibility for DWB and CDB on the claimant’s dependency on, and relationship to the former worker, marriage may terminate a Childhood Disability benefit, or make an claimant ineligible as a Disabled Widow(er). Marriage never affects entitlement to SSDI.
Effect of Marriage on CDB and DWB

A Childhood Disability Beneficiary’s benefits will terminate when he or she marries unless the marriage is to someone entitled to a Social Security benefit authorized under Title II of the Act. The law has one exception. If the CDB beneficiary marries someone receiving a minor child’s benefit, the CDB benefits cease effective with the date of the marriage. Keep in mind, Supplemental Security Income (SSI) is not a Social Security benefit paid under Title II of the Act. Effective January 1984, re-marriage won’t terminate benefits for a Disabled Widow(er) or a disabled surviving divorced spouse if the individual was already entitled as a DWB at the time of the marriage (See POMS RS 00207.003 online at: https://secure.ssa.gov/apps10/poms.nsf/lnx/0300207003)

You must verify the type of disability benefits the individual receives before you advise the beneficiary about the potential effect of marriage on benefits.

Waiting Period for Title II Disability Benefits

Before entitlement to SSDI or DWB can begin, a person must wait five full calendar months. The waiting period begins the first full month the person is disabled and meets requirements for entitlement, such as having worked enough under the Social Security system. Unlike SSDI and DWB beneficiaries, CDB beneficiaries never serve a waiting period.

Example of waiting period for Title II Disability Benefits:

Renee filed for SSDI and Social Security found her to be disabled on July 17, 2016. The first month of her waiting period is August, because she wasn’t disabled the entire month of July. August, September, October, November, and December are her waiting period months. The first month she is eligible for a payment is January 2017. Because Social Security pays benefits for the month that has just passed, her first check will arrive in February.

Renee isn’t due SSDI payments at all for the waiting period, so the check that comes in February will be for one month’s benefits.
Important Concepts Affecting Entitlement to Title II Disability Benefits

• **The “Date of Onset”** is the date that evidence demonstrates the disability is severe and prevents SGA. This is a date the DDS establishes when the individual first applies and it finds him or her eligible. The waiting period follows the Date of Onset.

• **The Filing Date, or Date of Application**, is the earlier of either the date Social Security receives a valid application or the protective filing date. Essentially, the protective filing date is when Social Security first officially knew an individual wished to file for benefits.

• **The Date of Entitlement** is the first month for which benefits are payable. Social Security may pay Title II disability benefits retroactively, which means that Social Security can pay benefits for months prior to the date of the application. The amount of retroactivity depends on numerous factors including the type of benefit, whether the worker is living, when the date the disability began to meet Social Security requirements, as well as other factors.

• **Open application**: If a beneficiary is entitled to Supplemental Security Income (SSI), and that person is working and earning QC’s, he or she may earn enough QCs to become entitled to SSDI. SSI requires beneficiaries to apply for any other possible benefit, and the SSI application is considered an “open application” for all other benefits. This means that the SSI beneficiary’s SSDI entitlement is retroactive to the date of entitlement to SSI, or the date the person first had enough quarters to be insured, whichever is later.

Comparison of Title II Benefits

It’s important that you understand which type of Title II disability benefit a person receives in order to advise him or her properly about the effect of work, as well as other events. This chart explains some of the differences between the three disability benefits:
<table>
<thead>
<tr>
<th>Issue</th>
<th>Childhood Disability Benefits (CDB) DI 10115.000</th>
<th>Disabled Widow(er)s Benefits (DWB) DI 10110.000</th>
<th>Disability Insurance Benefits (DIB) AKA: Social Security Disability Insurance (SSDI) DI 10105.000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Waiting Period</strong></td>
<td>Never</td>
<td>Five full calendar months after onset at initial entitlement</td>
<td>Five full calendar months after onset at initial entitlement</td>
</tr>
<tr>
<td><strong>Relationship to Worker</strong></td>
<td>Disabled child 18 or older</td>
<td>Widow(er) or surviving divorced spouse age 50 or older</td>
<td>Self</td>
</tr>
<tr>
<td><strong>Disability</strong></td>
<td>Disability must be established to have occurred before age 22</td>
<td>Disability must be established before the end of the “prescribed period”</td>
<td>Disability may begin at any time</td>
</tr>
<tr>
<td><strong>Effect of Marriage on Entitlement</strong></td>
<td>Benefit terminates unless marrying someone entitled to Title II benefits other than minor child’s benefits</td>
<td>Benefit continues as long as individual was already entitled as DWB</td>
<td>Marriage has no effect on DIB/SSDI</td>
</tr>
</tbody>
</table>
Confusing Situations

Social Security authorizes many different types of benefits under Title II of the Social Security Act. Sometimes it’s difficult for CWICs to determine exactly which type of benefit a person is receiving. To further complicate matters, some beneficiaries receive more than one type of Title II benefit simultaneously. This section will describe and clarify some common situations that may confuse CWICs as they try to determine who is eligible for WIPA services and which benefits would be most advantageous for an individual.

Child’s Benefits vs. Childhood Disability Benefits

Social Security child’s benefits and Childhood Disability Benefits (CDB) have different requirements. Social Security pays Child’s benefits up to the age of 18 (19 if in secondary school). Social Security only pays CDB benefits once the beneficiary reaches age 18. Work affects these programs differently. For youth with disabilities under the age of 18, the Earnings Test (ET) would apply if the youth received child’s benefits. (We
explain the ET later in this unit.) If the child becomes entitled to SSDI, the Substantial Gainful Activity (SGA) rules outlined later in this module would apply.

As the youth nears age 18, he or she should apply for CDB if he or she has a severe disability that prevents SGA. If the child becomes entitled to CDB, then the SGA rules apply. The ET would no longer apply because the benefit would be CDB, a benefit based on disability. Keep in mind that Title II child’s benefits may continue up to the age of 19 years and two months if the beneficiary fails to meet the disability criteria at 18 and is attending elementary or secondary school on a full-time basis.

**Interaction between SSDI and Retirement Insurance Benefits**

Social Security disability benefits and Retirement Insurance Benefits (RIB) relate to each other intimately. Essentially, disability payments a former worker receives are the retirement benefit taken early. We tend to think of these two benefits as distinctly different because the entitlement factors differ, as do the age requirements. Also, the effect of work on disability benefits is vastly different from the effect of work on retirement benefits.

One way to reconcile this relationship is to consider both benefits as two different doors through which a person who worked and paid into the Social Security system can access the payments he or she is due because of his or her work history. Workers are eligible for payments when they leave the workforce, either because of age or disability. The effect of paid employment differs, and the amounts of benefit payments may differ, but the essential fact is that both benefits are intended to partially replace wages lost because an individual leaves the workforce.

When most Title II disability beneficiaries reach full retirement age (FRA), their disability benefits automatically convert to Retirement Insurance Benefits (RIB). In these cases, a disability beneficiary’s last month of entitlement to disability benefits is the month before his or her FRA. This conversion to RIB status only applies to SSDI and DWB beneficiaries, not to individuals receiving CDB. Individuals who receive CDB don’t automatically convert to the retirement system when they reach full retirement age because most of these beneficiaries don’t have sufficient work credits on their own Social Security Number (SSN) to establish eligibility for retirement. It’s not possible to collect Social Security
retirement benefits based on a parental work record. Many beneficiaries on CDB continue to receive this benefit into old age and until death.

When the beneficiary reaches FRA, Social Security converts him or her automatically. The beneficiary doesn’t need to apply or notify Social Security. Many beneficiaries aren’t even aware that they have converted to RIB, as their monthly payment remains the same and Medicare coverage continues uninterrupted.

**Determining a Beneficiary’s FRA**

Many people think that FRA is always age 65. This was the case for many years, but starting in 2003, the FRA began to rise based on a person’s year of birth. The FRA is gradually increasing for people born on or after January 2, 1938. The age at which a disabled beneficiary will attain full retirement age will depend on his or her date of birth.

Once an individual attains FRA and converts from disability benefits to retirement benefits, income from work no longer affects benefits. There is no annual earnings limit for persons of full retirement age receiving Social Security retirement benefits. Individuals can use a [retirement age calculator to determine full retirement age](https://www.ssa.gov/benefits/retirement/estimator.html), found online.

**Disability Benefits and Early Retirement**

When a Title II disability beneficiary turns 62, it’s possible to switch over to the retirement system. Unfortunately, making this change will reduce the beneficiary’s monthly payment, although the beneficiary will continue to have Medicare coverage as long as he or she still has a disability under Social Security regulations. It’s even possible to convert back to the disability program from early retirement in some instances. There are specific circumstances under which conversion from disability to retirement at age 62 (or back again) would be advantageous.

Beneficiaries who are approaching retirement age may ask CWICs about changes that can or will affect their benefits. CWICs aren’t trained to be experts on retirement benefits, but they can provide beneficiaries with general information and explain how Social Security can help explore options in more detail. For more information on the interaction between retirement and disability benefits, refer to the VCU NTDC resource document titled “**Transition to Retirement**” found online (http://vcu-ntdc.org/resources/viewContent.cfm?contentID=43).
Dual Entitlement to Title II Benefits

There is a common misconception that Social Security only allows individuals to draw a Social Security benefit off of one SSN at a time. In fact, this isn’t the case. Many people are “dually entitled” to Social Security benefits in which they collect a Title II benefit based on their own work record, and another payment from the work record of either a parent or spouse. Here are some important definitions of terms:

- **Dual Entitlement** exists when an individual is entitled to different types of Social Security Title II benefits on two or more earnings records. For example, a beneficiary could be entitled to SSDI on his or her own work record, but also be receiving CDB on a parent’s earnings record.

- **Simultaneous Entitlement** exists when a person is entitled to the same type of Title II benefit on two or more earnings records. An example of this would be an individual who is eligible for widow(er)s benefits on more than one deceased spouse’s work history. Another example would be someone who is eligible for CDB on the earnings records of both parents.

Individuals with multiple entitlements don’t receive the full benefit from each work record. Social Security must pay an individual the full benefit due to him or her on his or her own work record first. Social Security will then pay additional benefits from another number holder (if the beneficiary is entitled to such payment), with the total payment being the higher of the two payment amounts. The following examples clarify this:

**Example of a beneficiary with multiple entitlements:**

Georgette applied for CDB payments on her deceased father’s work record when she turned 18 and was awarded a monthly payment of $800. She subsequently went to work part-time and eventually established insured status on her own work record. Social Security determined that she was entitled to SSDI payments of $400 each month from her past work, so the agency awarded her this payment. Because Georgette was already eligible for a payment of $800 on her father’s work record, Social Security reduced this payment to $400. Georgette still receives the same amount each month, $800, that she received before. However, now Georgette is dually entitled
because $400 of that payment comes from her own work record and the remaining $400 comes from her father’s work record. The two payments combined are the same as the higher of the two benefits available to her.

**Example of a beneficiary with multiple entitlements:**

Cletus worked as a roofer until an accident disabled him. He filed for SSDI, and Social Security awarded him $880 per month. Cletus’ wife worked as a bookkeeper for many years until her death. Cletus was 52 when his wife died, at which time he applied for benefits as a disabled widower. Social Security determined he was entitled to a monthly payment of $1,000 per month on his wife’s work record. Social Security continued to pay Cletus the $880 on his own work record, but added a DWB payment of $120 to bring the total benefit up to the higher of the two payment amounts or $1,000.

CWICs need to know when an individual is dually entitled because there can be some implications if the beneficiary is using work incentives. While Social Security often gives people who are dually entitled two separate payments each month, this isn’t always the case. Contact Social Security to verify benefits when dual or simultaneous entitlement is possible.

For more detailed information on this subject, refer to the resource document titled **“Work Incentives Counseling for Dually Entitled Beneficiaries”** found on the VCU NTDC website (http://vcu-ntdc.org/resources/viewContent.cfm?contentID=164)

**Title II Disability Payments**

**How Social Security Pays Regular Monthly Benefits**

Social Security pays benefits each month. Generally, the day on which an individual receives benefit payments depends on the birth date of the person on whose work record Social Security is paying the benefits. For example, Social Security uses the birth date of individuals who receive benefits as retired or disabled workers to determine their benefit payment date. Individuals who receive benefits on a spouse’s or parent’s work record will have a payment date based on that person’s birth date.
Social Security now requires beneficiaries to sign up for payments by direct deposit whenever possible. Beneficiaries who don’t have a bank account may sign up for a Direct Express debit card. The Direct Express card is a prepaid debit card option for federal benefit recipients to receive their benefits electronically. With the Direct Express card, federal benefit payments are automatically deposited directly into the card account each month on the designated payment day. Cardholders can make purchases at stores that accept Debit MasterCard, pay bills, purchase money orders from the U.S. Post Office and get cash from ATMs or financial institutions that display the MasterCard acceptance mark. No bank account or credit check is required to enroll. There are no sign-up fees or monthly account fees. Many card services are free. Additional information about the Direct Express® card is available at www.usdirectexpress.com.

**Immediate Payment (IP)**

Social Security established IPs in 1985 to allow Social Security to make expedited payments to beneficiaries in dire need of funds faster than the five-to seven-day period required to deliver Treasury-prepared payments. Immediate payments apply to both SSI and Title II payments as well as concurrent cases. For Social Security to even consider making an immediate payment, the case must meet the following criteria:

- **SSI Cases:** There is a delayed payment of an initial claim, delayed or interrupted payments, or non-receipt of an issued payment.

- **Title II Cases:** A payment is due because of a stop payment action taken, nonpayment, or a newly processed claim.

To receive an IP, the beneficiary must have an immediate financial need for payment (i.e., a need for food, shelter, medical treatment, etc.) that he or she can’t reasonably meet through other resources available in the community. In Title II cases, each beneficiary who meets the requirements may receive an IP, but Social Security must make a payment to that person (or the person’s representative payee) directly (e.g., a father may not receive an IP for his entitled children unless he is their payee). Each child’s payment requires a separate IP. IPs are considered advances against future SSI or Title II disability payments, so Social Security must recover them at a later date.
Returning Payments

Sometimes beneficiaries receive Social Security payments they aren’t due. Individuals who have direct deposit and receive a payment they shouldn’t have should call or visit the local Social Security field office to find out how to return the payment. Beneficiaries who spend Social Security benefits they aren’t entitled to will have to repay the funds at a future date.

Conclusion

Individuals receive Social Security benefits because someone worked and paid into the Social Security system. The benefits partially replace wages or self-employment income lost because that person died, or stopped working due to disability or age. Social Security bases benefits eligibility on the number of years a person worked and paid Social Security taxes, and the amount of earnings that the person has. Social Security bases entitlement for dependent family members on their relationship to and dependence on the person who worked and paid Social Security taxes. If a dependent family member is entitled on the work history of a living worker, the family member will usually not receive benefits if the worker isn’t due benefits.

It’s critical that CWICs understand that there are three types of disability benefits paid under Title II of the Social Security Act. They are:

- Social Security Disability Insurance (SSDI)
- Childhood Disability Benefits (CDB)
- Disabled Widow(er)s Benefits (DWB)

The work incentives are the same for all of these benefits, and we will describe these work incentives in great detail in the next unit of this module. Other factors such as marriage may affect entitlement. CWICs need to verify the type of benefits customers receive, and need to be aware of life events that may impact entitlement.
Conducting Independent Research

POMS Sections dealing with various types of Social Security Title II benefits unrelated to disability:

- **RS 00201: Retirement Insurance Benefits**  
  (https://secure.ssa.gov/apps10/poms.nsf/lnx/0300201000)

- **RS 00202: Spouse’s Benefits**  
  (https://secure.ssa.gov/apps10/poms.nsf/lnx/0300202000)

- **RS 00203: Child’s Benefits**  
  (https://secure.ssa.gov/apps10/poms.nsf/lnx/0300203000)

- **RS 00207: Widow(er)’s Benefits**  
  (https://secure.ssa.gov/apps10/poms.nsf/lnx/0300207000)

- **RS 00209: Parent’s Benefits**  
  (https://secure.ssa.gov/apps10/poms.nsf/lnx/0300209000)

- **RS 00208: Mother’s and Father’s Benefits**  
  (https://secure.ssa.gov/apps10/poms.nsf/lnx/0300208000)

POMS Sections dealing with the three types of Title II disability benefits with links to Table of Contents:

- **DI 10110.000: Disabled Widow(er)’s Benefits (DWB) - Table of Contents**  
  (https://secure.ssa.gov/apps10/poms.nsf/lnx/0410110000)

- **DI 10115.000: Childhood Disability Benefits (CDB) - Table of Contents**  
  (https://secure.ssa.gov/apps10/poms.nsf/lnx/0410115000)

- **DI 10105.000: Disability Insurance Benefits (DIB) and Freeze - Table of Contents**  
  (https://secure.ssa.gov/apps10/poms.nsf/lnx/0410105000)
Competency Unit 3 – Understanding Substantial Gainful Activity

Introduction

Unit 1 of this module described the definition of disability and the process Social Security uses to decide if someone has a disability that meets the definition under the Social Security Act. The definition of disability has two primary requirements: Applicants must be unable to engage in any Substantial Gainful Activity AND must be disabled based on a medically determinable impairment. Unit 1 of this module discussed the medical determination of disability. This unit describes the non-medical determination about whether or not an individual’s work represents Substantial Gainful Activity (SGA).

Social Security defines SGA in the following manner:

“Substantial gainful activity” means the performance of significant physical and/or mental activities in work for pay or profit, or in work of a type generally performed for pay or profit, regardless of the legality of the work. “Significant activities” are useful in the accomplishment of a job or the operation of a business, and have economic value. Work may be substantial even if it is performed on a part-time basis, or even if the individual does less, is paid less, or has less responsibility than in previous work. Work activity is gainful if it is the kind of work usually done for pay, whether in cash or in kind, or for profit, whether or not a profit is realized. Activities involving self-care, household tasks, unpaid training, hobbies, therapy, school attendance, clubs, social programs, etc., are not generally considered to be SGA.”

(From DI 10501.001- Meaning of SGA and Scope of Subchapter)

Determining Substantial Gainful Activity

Social Security employees make SGA determinations about work performed by beneficiaries - both at the initial application (for Title II disability benefits and SSI) and during work CDRs (Title II disability benefits ONLY). Social Security must decide if the “unable to perform
Substantial Gainful Activity” half of the disability requirement applies to an individual.

During an SGA determination, Social Security determines the value of work activity as compared to a specific dollar figure known as the SGA guideline. Once Social Security applies all applicable work incentives, the agency compares the “countable” income to the applicable SGA level for the year — different years have different SGA guideline amounts. If countable income averages above the applicable SGA guideline, the work activity generally represents SGA. If the countable income averages below the applicable SGA guideline, Social Security is unlikely to consider the work activity SGA.

**Recent SGA Guidelines**

Under current regulations, the SGA guidelines can change annually — this is referred to as being “annually indexed.” In addition, one SGA guideline applies to individuals who receive benefits due to statutory blindness and another SGA guideline applies to all other individuals with disabilities. The SGA guideline for Blind Individuals has been annually indexed since 1978. The SGA guidelines for non-blind disabled individuals have been indexed since 1999.

SGA guideline levels for 2004 to the present are below. For a comprehensive listing of all SGA guidelines for both Blind Individuals and Disabled Individuals, go to DI 10501.015 - SGA Guidelines:

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</table>

**SGA for Blind Individuals**

The Social Security Act has several special work incentives that apply to people who meet the definition of blindness called “statutory blindness.” The Social Security Act defines statutory blindness in a specific way:

“Statutory blindness is defined in the law as central visual acuity of 20/200 or less in the better eye with the use of correcting lens. An eye which has a limitation in the field of vision so that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less.”

(From 20 CFR 404.1581 - Meaning of blindness as defined in the law)

**Statutory blindness isn’t total blindness.** Individuals who meet Social Security’s definition of blindness may walk without a cane or dog, may be able to read print, and, in rare circumstances that depend on special equipment and state law, may even be able to drive. Some
people who don’t see well, but don’t consider themselves as blind, may actually meet Social Security’s test for statutory blindness.

The most important work incentives affected by statutory blindness are the amount Social Security considers to be SGA under the disability programs authorized under Title II of the Act, and a more lenient deduction for work expenses under the SSI program. This manual discusses both of these later in this module.

SGA is a Decision

Many people think that SGA is simply a number — an objective concrete dollar figure that Social Security establishes each year as the upper limit that a beneficiary can earn before benefits end. In fact, SGA is far more than just a number. SGA determinations require that Social Security personnel gather the applicable facts, apply the appropriate rules and procedures, and use their best judgment to render a decision about the “value” of an individual’s work. SGA determinations involve the interpretation of complex regulations as they apply to an individual beneficiary given that person’s unique situation. Whenever Social Security personnel make SGA decisions, some subjectivity will be in evidence. This flexibility is necessary and positive, but can be difficult for beneficiaries and CWICs to understand.

REMEMBER: SGA isn’t just a number — it’s a DECISION!

Overview of SGA Determinations

Social Security makes SGA determinations at the initial application for Social Security or SSI disability benefits and during work Continuing Disability Reviews (CDR) performed on Title II disability beneficiaries. Social Security Claims Specialists within the local Social Security field office typically make SGA decisions, but other Social Security personnel may make these determinations under certain circumstances. A work CDR is a specific type of review they perform when a beneficiary reports having earnings from employment or self-employment or when Social Security discovers that a beneficiary has earned income.

The first step in any work determination is the information beneficiaries report. Beneficiaries must report a change in work activity such as beginning, decreasing, or increasing work or earnings. Social Security
has several avenues working beneficiaries may use to make these reports. Beneficiaries may report wages by contacting a Teleservice Contact Representative by calling 1-800-772-1314, by sending paystubs to the local office by mail, or they may make the report in person at the local office. If the beneficiary’s earnings are above the Substantial Gainful Activity guideline that applies in the year the beneficiary performed the work, the beneficiary should expect to have Social Security make contact to request the SSA-821 or 820 (Work Activity Report) along with paystubs and information about any applicable work incentives the person is using.

One of the most efficient options for reporting wages is the “My Wage Report” option via the My Social Security portal on the SocialSecurity.gov website. To report wages online, the beneficiary must have a mySSA account, be receiving Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI), and be employed. Representative payees of someone who is working and receiving SSDI or SSI or the spouse, parent, or sponsor of someone receiving SSI who is employed may also use the system. The beneficiary or the representative payee must have already reported the employment to SSA at least once, so that the agency has the name and Employer Identification Number in the My Wage Report system.

At the moment, My Wage Report has some limitations. For example, it is not possible to report self-employment earnings via the system. Although SSDI beneficiaries and representative payees may report wages up to two years prior to the current date, SSI recipients and concurrent beneficiaries may only report wages for the month prior to the current month. Finally, beneficiaries may not report the use of work incentives, or any special wage payments such as sick or vacation pay, via My Wage Report.

SSDI beneficiaries using work incentives who report wages using the My Wage Report system will not experience immediate changes to their payments, since Social Security must perform a work Continuing Disability Review (CDR) before making adjustments to payments. When SSDI beneficiaries report the wages online, they should save receipts and other evidence to provide Social Security when Social Security conducts the work CDR. During the CDR, Social Security needs the information and evidence about using work incentives in order to make an accurate determination.
Social Security uses a system to process reports of earnings for the SSDI program. When gathering information to evaluate if an individual is performing SGA, Social Security may use the SSA-821 for wage employment and the SSA-820 for self-employment to collect information about work incentives, special pay etc. These are forms that a beneficiary may complete to provide information that technicians use to make the SGA decision.

Simply reporting earnings and getting a receipt from Social Security may not initiate the work CDR. Making the report, however, causes information to be entered into SSA’s systems, so that it is available later when Social Security reviews the information to decide if work activity should cause a change in benefit eligibility. When Social Security asks SSDI beneficiaries to provide information for the work activity report, beneficiaries should include any information such as receipts, pay stubs, and other evidence that help establish the use of work incentives. Module 6 discusses the CWIC’s role in this process in detail.

SSI beneficiaries using work incentives should make sure they report any work incentives, and provide proof at the time the beneficiary reports earnings.

**Earnings Evaluation during SGA Determinations – Important Concepts**

Anything beneficiaries receive in exchange for work they perform may count as earned income during an SGA determination. In addition to cash payments, Social Security may consider “in-kind” payments. Payments in-kind would include items such as room and board in exchange for performing work. In-kind pay can be either in lieu of or in addition to cash.

**Pay for Work Activity**

Social Security only counts wages or self-employment income that represents the beneficiary’s work effort. Because of this policy, reimbursements for travel expense and pay for vacation or sick leave generally do not count during an SGA determination. For certain types of income, it may not be immediately obvious whether or not income represent pay for work the beneficiary performed. Examples might include training stipends, royalties, and rental income. The Social Security regulations governing earned income can be complex and confusing. For specific guidance on how Social Security treats various types of income,

When in doubt, CWICs should contact their VCU technical assistance liaison for guidance.

If an individual receives sick or vacation pay for non-work days in a particular month, Social Security will not consider that pay as countable income for that month. Rather, the question is what work activity the individual actually performed in the given month and what earnings the individual received for that work activity. Social Security looks only at a beneficiary’s earnings resulting from work activity in determining if the individual has engaged in SGA in a particular month.

**Example of SGA determination:**

George works one week in a month but is paid sick pay for the rest of the month due to time off from work. During the SGA determination, Social Security only considers the earnings derived from George’s actual work activity. If the earnings for that one week of work represent SGA, then George has engaged in substantial gainful activity for that month.

If an individual takes sick or vacation pay in lieu of time off, Social Security should only use the earnings directly attributed to his or her work activity in that month in determining if the individual has engaged in substantial gainful activity in that month.

**Countable Earnings**

For an employee, or for someone who has been self-employed for more than 24-months, Social Security begins the SGA determination process by looking at gross wages earned in the month. This means that Social Security does NOT subtract the standard payroll deductions such as federal and state withholding taxes, insurance premiums, Federal Insurance Contributions Act (FICA) taxes, or other deductions such as pension payments, union dues, garnishments, etc. These deductions represent part of the person’s earnings from work activity.

Next, Social Security deducts the amount of any subsidized earnings provided by the employer, and any approved Impairment Related Work Expenses (IRWEs). These are special work incentives that allow Social Security to ignore some earnings for Title II disability beneficiaries. This
means that beneficiaries who have gross earnings above the SGA threshold may be entitled to receive ongoing payments. We provide detailed information about these work incentives later in the unit.

The remaining earned income is what Social Security considers “countable” and it’s this income that Social Security considers when making SGA determinations.

**Earned Income Counts when Earned not When Paid**

In the Title II disability program, Social Security generally counts earned income when it was EARNED, not when it was PAID. This may seem like an obscure distinction, but it matters and it can have an effect upon SGA determinations. For example, teachers may elect to be paid on a 12-month basis, even though they only teach for 9-10 months out of the year. The teacher would earn the pay over the school year, not the calendar year. In these cases, Social Security would take the annual salary of the teacher and divide it over the number of months the teacher actually worked to determine the monthly earnings during an SGA determination.

**Important note:** The Bipartisan Budget Act of 2015 simplified post entitlement SGA determinations by allowing Social Security to presume earnings were earned in the month they were paid. However, prior to applying this paid versus earned assumption, program policy requires Social Security personnel to evaluate any readily available earnings verification sources and determine when the beneficiary earned the wages or self-employment income. If Social Security personnel have no other readily available evidence to determine when the beneficiary performed the work activity, they will use other sources of earnings verification even if the earnings source only documents when the employer paid the beneficiary. This new policy applies to all post entitlement determinations made after September 23, 2016.

**Timing of Work Reviews**

Work CDRs, may happen at various points in time, depending on the beneficiary’s circumstances. For example, Social Security regulations state that the agency should conduct work CDRs immediately after the conclusion of the Trial Work Period (TWP). In some cases this does
happen. In other cases, for a variety of reasons, the work CDR is delayed. Usually, this is a result of the beneficiary’s failure to report earnings in a timely fashion, or difficulty acquiring evidence of the earnings.

When beneficiaries don’t report work or Social Security isn’t able to complete CDRs in a timely fashion, there is a risk that Social Security will overpay the beneficiary. Overpayments will be discussed briefly later in this module.

**Conducting the Work Continuing Disability Review**

The first step of a work Continuing Disability Review (CDR) is to determine the gross wages earned in each month of the period under review. Once they determine the amount, Claims Specialists review the pattern of work over a period of time. In many cases, the Claims Specialist can quickly review the evidence of earnings to see that the individual’s earnings clearly average UNDER the applicable SGA guideline. If that is the case, further development may not be necessary — the work is clearly not SGA.

If the gross earnings in the month are over the applicable SGA guideline, the Claims Specialist must evaluate the earnings to see if they actually represent SGA. That means Social Security may ignore earnings due to extra help a person receives, called subsidy, or expenses related both to the disability and work, called Impairment Related Work Expenses (IRWE). Social Security may disregard short periods of work that do not demonstrate the ability to sustain substantial work, called Unsuccessful Work Attempts (UWA). This process is how Social Security determines countable earnings. The following sections will discuss the rules Social Security uses— the “tools” Social Security personnel have in the SGA decision-making “toolbox.”

**SGA Determination “Tools”**

When determining if someone’s work represents SGA, Social Security personnel have four basic tools at their disposal. The tools are:

- Subsidy and Special Conditions
• Impairment Related Work Expenses (IRWEs)
• Income Averaging
• Unsuccessful Work Attempt (UWA)

Remember that only Social Security personnel decide whether or not these provisions apply in any given case. However, it’s essential that CWICs recognize these tools and how they work to assist Social Security in making proper SGA determinations. The CWIC can also help make sure that the beneficiary reports appropriately and saves necessary proof to help Social Security understand whether a deduction exists.

**Subsidy and Special Conditions in Wage Employment**

Social Security defines a “subsidy” as support a beneficiary receives on the job that could result in that beneficiary receiving more pay than the actual value of work performed. Social Security recognizes that sometimes a person’s disability results in the need for extra assistance, a reduced production rate, frequent breaks, or fewer job duties than co-workers in a similar job. When that happens, the individual’s wages represent not only pay for their work product or effort, but also direct help from someone else, like a supervisor, a co-worker, or job coach, or full pay for lower productivity or lower quality work than other employees. In simplest terms, this means that in some cases, a beneficiary may receive more pay than the reasonable value of their work when compared to other employees performing the same tasks.

When performing SGA determinations, Social Security is only interested in assessing earnings that they can attribute to the beneficiary. Social Security uses the process to value earnings potential if supports weren’t in place. Social Security adjusts the value of the income by deducting the cost assigned to the extra help or special situation that a beneficiary experiences. Applying “subsidy” during SGA determinations is the process of performing this adjustment.

**Employer Subsidy**

A subsidy can occur in various ways. Employer subsidies happen when the beneficiary’s employer provides extra accommodations, supervision, or other special assistance because of the beneficiary’s disability. Specific subsidies are those in which employers can designate a specific dollar amount of subsidy after calculating the reasonable value of the worker’s services. Employers establish non-specific subsidies when determining
the value of the subsidy by comparing the individual’s work in terms of time, skills, and job responsibilities at the workplace with that of co-workers without disabilities who are performing similar work. They must then estimate the proportional value of the work according to the prevailing wage for such work.

**Special Conditions**

Another type of subsidy is called “special conditions.” Special conditions exist when a worker receives supports or services from someone other than the employer, potentially subsidizing the worker’s ability to perform SGA. Any third party may provide special conditions. Most often a State VR agency, a community rehabilitation agency, or another service provider provides them. Strong indicators of subsidized work include employment in a sheltered workshop or job coach services provided to workers.

**Job Coaching:** A job coach is a person hired by an employer, a state VR agency, or an individual with a disability to provide an array of supports to assist a person with a disability in gaining and maintaining competitive employment. A job coach provides all vocational interventions, including training, counseling, and support at the job site while the individual is already competitively employed. This allows the individual to learn and retain skills and helps identify other social, behavioral, and physical problems at the worksite. Job coaches continue to monitor work performance and social adjustment after the individual reaches competence, and they make modifications if necessary. The job coach can also assist employers in identifying positions that a person with a disability could fill within the company that may enhance the company’s productivity, as well as identify accommodations that may be necessary.

Social Security determines the value of a special condition subsidy by comparing the time, energies, skills, and responsibilities of the beneficiary to workers without disabilities performing similar work and then estimating the proportionate value of such services according to the beneficiary’s pay scale for his or her work. Calculating the value of such a subsidy can be tricky.
Calculating the Subsidy for Job Coach Services:

When a beneficiary has a job coach, and he or she isn’t paying out of pocket for the services, Social Security determines the dollar amount of the subsidy by the total number of job coaching hours per month multiplied by the disabled worker’s hourly wage. This figure is subtracted from the monthly gross earnings to determine the countable earnings for the month.

Danny worked in a restaurant. He made $11 per hour and worked 120 hours last month. Danny wasn’t blind. Danny’s gross earnings for the month were $1,320 which was over the non-blind SGA guideline for 2020 ($1,260). Did Danny’s work represent SGA?

Danny has a job coach. The job coach works with him 15 hours per month. While the job coach is working with Danny, he is showing Danny his job, and Danny is observing, rather than doing the work himself. When Social Security determines the value of Danny’s job coach subsidy, Social Security multiplies the number of hours Danny worked with his job coach by Danny’s hourly wage.

$11 × 15 = $165

Danny performed this work in 2020, when the SGA level for someone who isn’t blind is $1,260.

$1,320 wages – $165 in job coach subsidy = $1,150 in countable wages

$1,150 in countable wages is less than the $1,260 SGA guideline for 2020.

Although Danny’s gross wages were over the applicable SGA guideline, the deduction of the subsidy means that the “countable” earnings are less than $1,260. Danny’s work doesn’t represent SGA in 2020.

Identifying Subsidy

When Social Security personnel conduct a work CDR, the Work Activity Report (form SSA-821/820) asks questions that should help identify when
a subsidy exists. Social Security will investigate the possibility of subsidy if the beneficiary reports getting extra help, having lower productivity, missing more work, or being hired under a special program or by a friend or relative. To make the decision that a subsidy exists, Social Security gathers information from the beneficiary, from his or her employer, and possibly from any disability services agencies involved in providing job supports.

POMS DI10505.010 contains a series of questions that Social Security can ask beneficiaries if there isn’t sufficient information on the Work Activity Report to determine the time, energy, skills, and responsibility involved in the employment effort. They are as follows:

- Is there a need for extra assistance or services on the job?
- Why was the individual hired?
- What are the individual’s job duties?
- How much time does the individual spend on those duties?
- Who performed the duties before the individual was hired; and how much time did that person spend on those duties?
- If the individual were separated from the job, would he or she be replaced; if so, how much time would the replacement spend on the individual’s duties?
- How often is the individual absent from work?
- Does someone else do the individual’s work when he or she is absent?
- How much time does the temporary replacement take to do the individual’s job?
- What is the relationship of pay to services performed?
- How does the employer compute the individual’s total earnings?
- Does the employer reduce proportionately the individual’s pay when he or she is absent from work? (Compare the employer’s practice concerning an individual with an impairment to that of an unimpaired individual, explaining any difference.)
- Does the individual receive any unusual assistance or supervision? (Describe.)
- If the individual’s pay isn’t set according to normal business practices, what consideration does the employer give to the size of the individual’s family, number of years of past service with the employer, previous earnings, friendship or relationship to the employer, or other factors unrelated to the performance of the work?

- Does the employer consider the individual’s work to be worth substantially less than the amount the employer pays, if so, what are the employer’s reasons for this view? (Give the employer’s estimate of the value of the services and explain how he or she reached this estimate.)

- If the individual is still on the payroll, despite unsatisfactory work, what is the employer’s reason for retaining him or her?

- If the individual is no longer employed, what led to the termination of employment?

If Social Security finds a subsidy, they will then determine the value of the subsidy and apply this to determine the actual value of the employment income — the “countable earned income.” During the SGA determination Social Security only considers the countable earned income rather than the actual dollar amount the individual received in wages.

You can find detailed information about subsidy in Social Security’s POMS (https://secure.ssa.gov/apps10/poms.nsf/lnx/0410505010).

**Impairment Related Work Expenses (IRWE)**

Another tool Social Security uses when determining countable income is called Impairment Related Work Expenses or IRWEs. Under this provision, Social Security subtracts from earnings the cost of certain items and services required by individuals in order to work when determining how much of the person’s income is “countable.” The purpose of the IRWE is to take the costs associated with the disability into account when assessing the value of the earnings.

For an IRWE deduction to be allowable, the expense must meet five criteria:

1. First, the expense must directly relate to enabling the beneficiary to work. This means that items the person needs simply to live more independently would generally
not qualify as IRWEs. However, some items like out-of-pocket costs for prescription medications do qualify as IRWEs even though the individual would be taking the medication whether or not he or she worked. The person may deduct the non-reimbursed cost of the prescription because the medication helps the individual manage his or her impairment, and such management is necessary for the person to work.

2. Second, the expense has to relate to a medically determinable impairment being treated by a health care provider rather than being a cost that anybody would incur by working. This means that things like FICA deductions or health insurance premiums aren’t permissible as IRWEs.

3. Third, the individual must pay the expense out of pocket and not be reimbursed from another source.

4. Fourth, in most cases, the individual must pay for the expense in a month during which the individual was working. Social Security may allow the cost of durable goods to be deducted over a 12-month period. Under some circumstances, Social Security may deduct as an IRWE any costly durable goods purchased during the 11-month period preceding the month work started. Beneficiaries may also consider expenses they incur in a month of work but pay for after work stopped.

5. Finally, the expense must be “reasonable.” The amount is within reasonable limits if it’s no more than the prevailing charge for the same item or service. Prevailing charges are those which fall within the range of charges that are most frequently and widely used in a community for a particular item or service. The top of this range establishes the standard or normal cost that can be accepted as within reasonable limits for a given item or service.

The range of allowable expenditures under IRWE is extensive and includes costs of adaptive equipment or specialized devices, attendant care, counseling services, special transportation costs, costs for the care of service animals, the cost of job coach services if paid by the
beneficiary, and anything else Social Security thinks is reasonable, considering the person’s impairment(s) and circumstances.

**Example of IRWE deduction:**

Nora is working and had $1,892 in gross wages last month. Nora is blind. She had the following expenses for the month:

- Adapted note-taker costing $1,800
- Designer sunglasses costing $200

Evaluating the costs: For each of these expenses, Social Security would look at each of the conditions necessary for an IRWE to be deductible during an SGA determination:

1. **Are the items or services related to the disability or to an impairment for which the person is receiving treatment from a health care provider?**

   **Yes**, Nora needs the note-taker because she is blind and the sunglasses because her eye condition makes her very sensitive to light.

2. **Are the items or services necessary for work?**

   **Yes**, Nora uses the note-taker to keep track of her calendar, to access email for work, to read electronic documents, and to take notes in meetings. Nora needs the sunglasses because the fluorescent lights in the building where she works bother her, and her eye doctor told her to wear regular sunglasses when at work.

3. **Are the costs paid out of the beneficiary’s pocket and not reimbursed?**

   **Yes**, Nora paid for both of these items, and she wasn’t reimbursed for these expenses by any source.

4. **Are the costs reasonable?**

   The cost of the note-taker is reasonable, because it’s actually one of the less expensive note-taker models on the market. Although the doctor said Nora should wear
sunglasses, they aren’t reasonable. In the town where Nora works and lives, she can purchase a reasonably professional-looking pair of sunglasses for only $25.

5. Did the beneficiary pay the costs in the month he or she performed the work?

Nora purchased the sunglasses in October 2020, and Nora’s earnings for October 2020 are part of the SGA determination in process. She purchased the note-taker, however, in August, the month before she started her job.

**Decision:** Social Security can pro-rate the cost of Nora’s note-taker over a 12-month period because it was durable equipment. That means that Nora could’ve had an IRWE deduction of $150 per month from August, when she purchased the device, through July of the following year. Social Security also might approve sunglasses as an IRWE, but might limit the deduction for the sunglasses to the reasonable amount of $25.

Because Nora meets the definition of statutory blindness, the SGA level that applied to her in 2020 was $2,110. If Social Security were to deduct the $150 (1/12 of the note-taker’s cost) IRWE from Nora’s gross earnings of $1,892, the result would’ve been $1,742. The countable earnings would fall below the current SGA guideline. Social Security did not need to use sunglasses as a deduction in the SGA determination, regardless of their value. Nora isn’t performing SGA.

There is no definitive all-inclusive list of acceptable IRWEs. What Social Security will allow as an IRWE deduction during an SGA determination depends on the beneficiary’s unique situation, the impairment, and the reasonableness of the cost. If possible, the beneficiary should submit the receipt for any possible IRWE expense when he or she reports earnings. In some circumstances, a note from the treating doctor or health care provider stating that the items enable the person to work can assist Social Security in making the determination. Social Security can then decide if the beneficiary may deduct the expense.

There are no time limits on how long individuals can use IRWEs to pay for particular services or items. This is beneficial for individuals who have ongoing impairment-related work expenses such as transportation assistance or job coach follow-along services. It’s not necessary that an
IRWE be a monthly recurring expense. In some instances, individuals may have a one-time expense, such as the purchase of a piece of medical equipment. In this case, Social Security may choose to deduct the expense as an IRWE all in one month or to have the expense pro-rated over a period of 12 months, depending on which is better for the beneficiary. Pro-rating the expense is particularly helpful if the services or items are costly, as in the Nora example above.

Definitions Social Security Uses to Determine IRWE Deductions

- **Necessary for Work and Related to an Impairment:** An IRWE means an expense for an item or service which is directly related to enabling a person to work and which a person incurs because of a physical or mental impairment. The person must need the IRWE due to an impairment that the DDS established as the medical basis of disability or another impairment that a physician or health care provider is treating.

- **Health Care Provider:** A health care provider must be a licensed or registered professional. Health care providers may include, but aren’t limited to: osteopaths; naturopaths; psychologists; chiropractors; audiologists; nurse practitioners; dentists; physical, occupational, and speech therapists; registered dietitians; clinical nutritionists; and licensed counselors.

Attendant care or transportation services provided by family members

If a person with a disability pays a member of his or her family to perform attendant care services, the person generally can’t deduct such payment as an IRWE unless:

- The family member has been otherwise employed and suffers economic loss by reducing the number of work hours or terminating his or her other employment in order to perform such service; and

- The beneficiary can document services rendered and that the family member is receiving payment in cash (including checks or other forms of money, but not payment in-kind) from the person with a disability.
CWICs can read more detailed information about IRWEs in Social Security’s Program Operations Manual System (POMS) (https://secure.ssa.gov/apps10/poms.nsf/lnx/0410520000).

CWICs should become familiar with these references and mark these references as favorites in the online version of the POMS for use in the future. Recognizing potential IRWE deductions is critical to assisting beneficiaries to use work incentives appropriately.

**Income Averaging**

Social Security’s regulations require the agency to determine countable earnings from work activity as SGA if they **average** more than the SGA threshold amounts. The regulations further state that Social Security will average earnings if:

- An employee or self-employed beneficiary’s work was continuous; without significant change in work patterns or earnings; and
- There has not been a change in the SGA level.

Therefore, when a beneficiary:

- Has continuous work, and
- Doesn’t have a significant change in work patterns, and
- Has monthly earnings fluctuating from above to below the SGA threshold,

Social Security **must** average the monthly countable earnings and compare the average monthly amount to the appropriate SGA level.

Fluctuations in wages often occur for beneficiaries who earn an hourly wage and whose work hours vary each month. Individuals employed in the service industry (restaurants, hotels, or retail stores) often experience this type of earnings variance. Averaging helps Social Security personnel identify a pattern of SGA-level work in a more accurate way than looking at month-by-month wage data. Averaging is unnecessary and Social Security doesn’t apply it when work is consistently above or below SGA, or when Social Security determines work meets Unsuccessful Work Attempt (UWA) criteria, which is covered a bit later in this unit.
Social Security doesn’t average earnings over the entire period worked if there is a significant change in work patterns or earnings. Although there isn’t an established monetary earnings amount that represents a significant change in earnings or work activity, Social Security personnel are instructed to consider the following work issues:

- Was there a change in job duties or hours (i.e., changing from part-time to full-time work)?
- Did the person have to change his or her position, or leave the job?
- Did the person have any months of zero earnings?

**IMPORTANT:** Regulations require Social Security to average fluctuating earnings if the period of work was continuous. Consequently, the agency isn’t permitted to include any months with zero earnings in any period it averages. Months without earnings would represent a break in continuity, and Social Security never uses them as part of a period to be averaged.

When a beneficiary worked for a continuous period but is no longer working, Social Security personnel are instructed to average earnings over the actual period of time that he or she actively engaged in work activity if there were no significant changes in work patterns or earnings. The instructions further require that they consider all of the work activity facts, especially in the first and last months of work activity. Completed periods of work may contain partial months of work activity. When Social Security determines whether to include partial months in the averaging period, they must evaluate whether there was a significant change in either:

- The earnings; or
- The pattern of work activity in comparison to the rest of the period of employment.

If the Social Security determines that any partial months **do** represent a significant change in the work pattern or earnings, they won’t include these months in the average. If the partial months **do not** represent a significant change, they will be included in the average. By not averaging partial work months with significantly lower earnings, Social Security avoids artificially lowering the figure they determine to be the average.
monthly earnings. Including those months may not be representative of the rest of employment period.

Another important point to keep in mind is that Social Security is required to average “countable” earnings, not gross earnings. If vacation or sick leave or the value of IRWEs or Subsidy reduces gross wages, Social Security averages the earnings after it applies these deductions.

**REMEMBER:** Social Security performs averaging on “countable” earnings, not gross earnings. Countable earnings is the amount left after the agency applies all allowable deductions.

If the average amount of countable earnings exceeds the applicable SGA guideline, the entire period of months that Social Security used in the averaging period the agency would typically consider SGA. If the average countable earnings figure for the period is below the applicable SGA guideline amount, Social Security would typically determine that SGA wasn’t in evidence for any month in the averaging period.

Finally, Social Security doesn’t average income across time periods when the SGA levels changed. Social Security adjusts SGA levels each calendar year in January, but there have been years in which the SGA guideline remained the same for two years. Because of this rule, averaging periods are generally limited to no more than 12 months because the SGA guideline usually changes each year. Social Security doesn’t perform averaging on a full calendar year basis, but rather from the point at which a work effort begins to where it ends or changes. That could be a full calendar year of 12 months (or more if the SGA guideline remained the same), but it might be less than that if the work wasn’t continuous for 12 months, or substantially changed within that year.

**Example of averaging:**

Heather started working part-time in January 2019 and she completed the Trial Work Period (TWP) in September 2019. Her countable earned income was clearly under the SGA guideline when Social Security examined it immediately after the end of the TWP. In 2020, Heather had some health problems that forced her to reduce her hours at work. She was hospitalized in April of 2020 and had no earnings at all that month. Beginning in June 2020 and continuing, Heather’s earnings and work activities rose to
full-time work levels, with some earnings over the 2020 SGA guideline. Social Security hadn’t ceased benefits, so averaging earnings is appropriate:

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>Work Activity</th>
<th>Earnings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 2020</td>
<td>Part-time</td>
<td>$575</td>
</tr>
<tr>
<td>Feb 2020</td>
<td>Part-time</td>
<td>$350</td>
</tr>
<tr>
<td>March 2020</td>
<td>Part-time</td>
<td>$210</td>
</tr>
<tr>
<td>April 2020</td>
<td>None</td>
<td>$0</td>
</tr>
<tr>
<td>May 2020</td>
<td>Part-time</td>
<td>$300</td>
</tr>
<tr>
<td>June 2020</td>
<td>Full-time</td>
<td>$1,130</td>
</tr>
<tr>
<td>July 2020</td>
<td>Full-time</td>
<td>$1,290</td>
</tr>
<tr>
<td>Aug. 2020</td>
<td>Full-time</td>
<td>$1,180</td>
</tr>
<tr>
<td>Sept. 2020</td>
<td>Full-time</td>
<td>$1,190</td>
</tr>
<tr>
<td>Oct. 2020</td>
<td>Full-time</td>
<td>$1,300</td>
</tr>
<tr>
<td>Nov. 2020</td>
<td>Full-time</td>
<td>$1,180</td>
</tr>
<tr>
<td>Dec. 2020</td>
<td>Full-time</td>
<td>$1,230</td>
</tr>
</tbody>
</table>

**Evaluation:** When reviewing the year 2020, you can clearly see a significant change in work patterns and earnings for the months of March through May. A month of zero earnings indicates that the work wasn’t continuous for this period of work activity. In contrast, the work effort from June through December was continuous. Consequently, averaging only applies in the months June 2020 through December 2020.

Averaging doesn’t apply during the following situations:

- Averaging doesn’t determine Trial Work Period (TWP) months. However, Social Security may average work performed in the
Trial Work Period with work after the TWP if it’s all part of the same work effort.

- Social Security doesn’t use averaging during the Extended Period of Eligibility (EPE) after the agency has established the cessation month in order to determine whether a payment is due or not. The sole purpose of averaging is to determine if work effort represents SGA.

- Social Security doesn’t average income when determining payment months during the initial reinstatement period (IRP) in expedited reinstatement cases (EXR).

This discussion represents a summary of averaging policies and doesn’t cover every possible contingency. Determining the period over which to apply averaging can be complex and can only be performed by Social Security personnel. For more information, see **DI 10505.015 Averaging Countable Earnings** (https://secure.ssa.gov/apps10/poms.nsf/lnx/0410505015).

**Unsuccessful Work Attempts (UWA)**

Social Security recognizes that in some cases a beneficiary may try to return to work but may only be successful for a short period of time. Social Security doesn’t want to needlessly stop payments to a beneficiary who tries to perform substantial work, only to find that he or she can’t sustain that effort over time because of the disability. Because SGA is really a pattern of work behavior, it makes sense that Social Security may excuse a work effort of short duration under certain circumstances.

Like many of the disability program work incentives, the UWA provision is complex and can be difficult to understand and apply. First, there must be a significant break in the continuity of a person’s work before Social Security can consider the beneficiary to have begun a work attempt that later proved unsuccessful. A significant break in the continuity of a person’s work could occur if the person:

- Discontinued or reduced work activity to the non-SGA level because of the impairment, or the removal of special conditions related to the impairment that are essential to the further performance of the work;
• Discontinued or reduced work activity to the non-SGA level prior to the alleged onset date of the impairment for reasons unrelated to the impairment (e.g., retirement, or layoff); or
• Has never previously engaged in work activity.

Social Security considers work to be “discontinued” if the person:
• Was out of work for at least 30 consecutive days, or
• Was forced to change to another type of work or another employer.

**NOTE:** On rare occasions, a break lasting a few days fewer than 30 days may satisfy this requirement if the subsequent work episode was brief and clearly not successful because of the impairment.

After the first significant break in continuity of a person’s work, Social Security considers the ensuing period of work as continuous until another such change occurs — that is, until the impairment, or the removal of special conditions related to the impairment essential to the further performance of work, causes the beneficiary to “discontinue” the work, as defined above. Each continuous period, separated by significant breaks as described, may be UWA provided the work activity meets the criteria as to duration and conditions of work.

**Duration and Conditions of Work**

Social Security will consider work of 6 months or less to be an unsuccessful work attempt (UWA) if the beneficiary stopped working or reduced work and earnings below the SGA earnings level because of the impairment or because of the removal of special conditions that took into account the beneficiary’s impairment and permitted the beneficiary to work.

SGA-level work lasting more than six months can’t be a UWA regardless of why it ended or why Social Security reduced it to the non-SGA level.

Detailed information about UWA provisions are available in Social Security’s POMS at [DI 24005.001 Unsuccessful Work Attempts (UWA) for Initial Claims and Reconsiderations](https://secure.ssa.gov/apps10/poms.nsf/lnx/0424005001).
Methods for Making SGA Determinations for Self-Employment

Social Security uses two different methods when making SGA determinations for self-employed beneficiaries. They apply one approach to beneficiaries who have been entitled to Social Security disability benefits for 24 months or more and a different approach to beneficiaries who have been entitled to benefits for fewer than 24 months. The following sections explain the differences between these two approaches.

Countable Income Test for SGA for Self-Employed Beneficiaries

If a Social Security disability beneficiary has received cash benefits for at least 24 months, the Social Security Administration will use the “countable income test” to determine if the individual’s disability has ceased due to SGA.

For the purposes of the countable income test, Social Security considers a beneficiary to have received Title II disability cash benefits for 24 months beginning with the first day of the first month following the 24th month for which he or she received Title II disability benefits that he or she was due. The 24 months don’t have to be consecutive. For Expedited Reinstatement (EXR) cases, the individual meets the 24-month requirement when he or she has completed the 24-month initial reinstatement period (IRP). (For more information on EXR, refer to unit 9 of this module.) Any months for which the beneficiary was entitled to Title II disability benefits but didn’t actually receive a Title II disability cash benefit will not count for the 24-month requirement.

When the countable income test applies, Social Security will compare the beneficiary’s countable income (gross earnings minus allowable work incentives) to the earnings guidelines to determine if the beneficiary has engaged in SGA. If the monthly countable income averages more than the applicable SGA guideline for the month(s) in which the individual worked, Social Security will determine that the individual has engaged in SGA unless evidence shows the individual didn’t render significant services in the month(s). If the average monthly countable income is equal to or less than the applicable SGA guideline for the month(s) in which the individual operated his or her business, or if evidence shows the individual didn’t render significant services in the month(s), Social
Security will generally determine that the individual hasn’t engaged in SGA.

Under some circumstances, Social Security will look beyond the beneficiary’s countable income to determine if he or she is performing SGA. Social Security uses these tests when:

- Determining initial eligibility for disability benefits;
- Determining whether work performed by a self-employed Title II disability beneficiary before he or she has received Title II disability benefits for at least 24 months is SGA;
- Determining whether work performed in or after the EPE or re-entitlement period is SGA after Social Security has determined an SGA cessation;
- Determining SGA during the initial reinstatement period (IRP) for expedited reinstatement (EXR) cases.

You can find the guidance for Social Security personnel on when to apply these tests in POMS DI 10505.020 - “Evaluation Guides.” Social Security instructs their employees that when a beneficiary’s “countable earnings” don’t average more than the amount shown in the Earnings Guidelines, but evidence indicates the individual may be engaging in SGA or that the individual is in a position to control when he or she receives earnings or the amount of compensation paid, Social Security personnel should evaluate the individual’s work activity under the tests of comparability and worth of work to determine if the work is SGA. If the beneficiary qualifies for the exemption of work activity provision, then Social Security would use the countable income test. Consider both of the following tests before making a finding that the individual’s work isn’t SGA.

The additional two tests are:

1. Comparability of Work Activity: The individual’s work activity is SGA if, in terms of all relevant factors such as hours, skills, energy output, efficiency, duties, and responsibilities, it’s comparable to that of unimpaired individuals in the same community engaged in the same or similar work activity as their means of livelihood; or

2. Worth of Work Activity: The individual’s work activity is SGA if, although not comparable to that of unimpaired individuals, it’s,
nevertheless, clearly worth more than the applicable SGA Earnings Guideline when one considers the prevailing wage scale for that job in the community.

**NOTE:** The comparability of work and worth of work tests never apply to beneficiaries who meet the definition of statutory blindness.

An important part of the comparison: The group of unimpaired persons and the type of work activity must be the same. In addition, the unimpaired persons must maintain, on the basis of their activity, a standard of living regarded as adequate for a particular community. Well-established businesses are generally the most reasonable choice for comparison.

The comparability of work must be specific. Social Security must describe in detail each factor cited above, showing its contribution to the business operation. Social Security considers general descriptions inconclusive evidence for the point-by-point comparison the evaluator must make. Social Security instructions clearly state that if only a general description is possible or available, Social Security personnel must resolve any doubt as to the comparability of the factors in favor of the beneficiary.

Evidence of the beneficiary’s activities accompanied by a statement that the work is comparable to the work of unimpaired persons is insufficient for a sound SGA decision. If necessary, Social Security personnel should obtain a description through a personal interview with an unimpaired individual from the selected group. It may be necessary to have a more comprehensive description of the impaired individual’s activity than the impaired person can provide. Social Security personnel must make contact with people having first-hand knowledge of the beneficiary’s work situation obtained through actual participation or observation.

The degree to which evidence of comparability or worth of services should contain data supplied by outside authorities will depend on the individual situation. In many instances, the local Social Security field office’s familiarity with local conditions will make it unnecessary to document the file in great detail. For example, in a poor farming area Social Security personnel might find that management services on a small farm yielding a less-than-subsistence income aren’t comparable to the full range of physical and mental activities performed by an able-bodied farm operator, nor would the services be clearly worth more than the
applicable SGA guideline. On the other hand, where there’s any doubt as to the comparability or worth of services, Social Security personnel should obtain evidence in appropriate detail and supplement it with opinions from authoritative sources in the community.

**Example of evidence used to determine SGA:**

Ann works part-time in her mother’s flower shop. She works 15 hours a week and earns $8.00 an hour, the amount usually paid for this type of work in her community. Her gross monthly earnings total $519. In this example, Ann only works 15 hours per week, which explains her low earnings. There is no evidence to suggest that her work could be the same in quality and quantity as that done by unimpaired people as their means of livelihood; and, because all workers in her community earn $8.00 an hour working at a flower shop, nothing suggests you can value her work any higher. Therefore, this work isn’t SGA without any further development under the comparability and worth of work tests.

**Example of evidence used to determine SGA:**

Bill has been receiving Title II disability benefits since November 2017. In January 2020, Bill reports he has been working full-time since December 2018 as a desk clerk in a local motel owned by his family. Bill currently earns $1,000 a month. Bill completed his TWP in August 2019. His low earnings don’t appear to be consistent with the full-time work he is doing. Development under the comparability and worth of work tests may be required. Because Bill has not received cash benefits for 24 months in September 2019 (the first month after the TWP ended), Social Security can use the comparability and worth of work tests to determine if Bill has performed SGA.

**Example of an SGA Decision:**

Al became entitled to SSDI benefits in 2008. He finished his Trial Work Period in 2010. Since then, Al has been earning around $800 a month. Al has not been performing SGA because his earnings clearly average below the SGA guidelines for 2010 through 2019).
It’s now March 2020 and Al has come to the local CWIC for WIPA services. In February 2020, Al got both a raise and an increase in his hours. Al is now earning $1,300 per month from his job.

Because Al is now earning over the 2020 SGA guideline ($1,260), the CWIC asks Al about out-of-pocket expenses, and whether or not Al gets extra support on the job. Al pays $50 per month in medicine co-pay amounts, and his employer pays his job coach for 20 hours a month. Al earns $10 per hour, so his job coach increases the value of Al’s work by $10 for 20 hours, or $200.

Because Al has an IRWE of $50.00 and subsidy of $200, the CWIC estimates that Al’s countable earned income is actually $1,050.00, which is below the 2020 SGA guideline of $1,260. The CWIC helps Al document these deductions so Social Security has the information necessary to make an appropriate SGA determination when Al reports a wage increase. Because Al has received benefits for more than 24 months, he qualifies for the Exemption of Work Activity provision, and so the Countable Income test applies.

Conclusion

This unit reviewed the factors that Social Security uses to determine whether work activity performed by a Social Security disability beneficiary represents Substantial Gainful Activity (SGA). This is one of the two primary requirements that beneficiaries must meet for Social Security to consider them disabled under the Social Security Act.

SGA is a decision Social Security makes by using work incentives to trim the amount of a beneficiary’s monthly earnings down to a value representing what he or she would earn if Social Security removed supports. Once Social Security determines this “countable” amount, the agency uses one of two methods to determine if work is substantial: the countable income test, or the comparability or worth of work tests. If work is substantial, Social Security either suspends or terminates benefits — concepts that we will discussed in detail in the next unit.
Conducting Independent Research

A resource document entitled “Understanding Unsuccessful Work Attempts (UWA)” is also available on the VCU NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=31)

Additional Resources

Two SGA Decision Tree charts are included on the following pages. One represents the Countable Income Test, and one the Comparability/Worth of Work tests.
SGA DETERMINATION DECISION TREE
(Countable Income Test)

Gross Wages under SGA

Title II cash payment continues

Gross wages over SGA

Has there been a significant break in work? Has work lasted less than 6 months? Consider Unsuccessful Work Attempt if cessation decision has NOT occurred.

UWA yes UWA no

Consider all applicable deductions

• Leave time pay
• Impairment Related Work Expenses (IRWE)
• Subsidy / Special Conditions

Is there a consistent pattern of earnings? Apply Averaging if appropriate (only applicable prior to cessation decision)

Countable wages over SGA

Cessation and grace period occur, cash payment continues for 3 months

• Cash payment suspended if in EPE
• Benefits Terminated if after EPE

Countable wages below SGA level

Title II cash payment continues
SGA DETERMINATION DECISION TREE
(Comparability/Worth of Work Test)

Gross wages over SGA

Consider Unsuccessful Work Attempt if cessation decision has NOT occurred.

UWA yes  UWA no

Consider all applicable deductions

No work incentives applicable

- Leave time pay
- Impairment Related Work Expenses (IRWE)
- Subsidy / Special Conditions

Is there a consistent pattern of earnings? Apply Averaging if appropriate (only applicable prior to cessation decision)

Countable wages over SGA

Cessation and grace period occur, cash payment continues for 3 months

- Cash payment suspended if in EPE
- Benefits Terminated if after EPE

Countable wages below SGA level

Title II cash payment continues
Competency Unit 4 – Understanding the Trial Work Period (TWP) and Extended Period of Eligibility (EPE)

Introduction

Unit 1 of this module discussed the medical part of the disability definition under the Social Security Act, and Unit 3 explained how Social Security determines whether work represents Substantial Gainful Activity (SGA). This unit will cover the work incentive provisions that help Title II disability beneficiaries retain cash benefits and health insurance once work begins in order to smooth the transition from dependence on Social Security benefits to greater self-sufficiency through employment. In addition, this unit will discuss protections that make it easier for people to return to benefit payment status if necessary after leaving the benefit rolls because of work activity.

The Trial Work Period

1. The first time after entitlement that Social Security disability beneficiaries (SSDI/CDB/DWB) go to work, they may access a work incentive called the Trial Work Period (TWP). The TWP effectively suspends the “able to perform Substantial Gainful Activity” part of the disability definition regardless of how high earnings might be as long as the beneficiary reports work activity and has a disabling impairment. That means beneficiaries may attempt to work without immediately losing their cash benefits during the TWP.

The TWP provides beneficiaries an opportunity to test work skills while maintaining full benefit checks, no matter how much the beneficiary earns. Each year, Social Security sets a monthly amount to use as a guideline for determining use of TWP months.

Only months that Social Security would count as TWP months (or “Trial Work Service Months”) are those in which:
• An individual earns pre-tax wages of more than the guideline; or,
• Works over 80 hours in self-employment.

The TWP ends only when a beneficiary performs nine months of work over the TWP guideline within a rolling period of 60 consecutive months. The TWP months don’t have to be consecutive for Social Security to count them.

**TWP and Disability:** To receive a TWP, a beneficiary must continue to have a disability. The TWP only protects beneficiaries from losing benefits due to work. It does NOT prevent Social Security from considering evidence of medical recovery.

**Income Social Security Considers when Making TWP Service Month Determinations**

When determining if work activity is “services” for TWP purposes, Social Security is only concerned with income paid for work usually performed for remuneration or profit that exceeds the applicable TWP amount. This may include sheltered workshop earnings, vocational rehabilitation (VR) program earnings, and income generated by paid internship programs or work therapy programs.

Work activity performed without remuneration, (e.g., therapy, training, or self-care) does not constitute services if the activity, although resembling services in employment for remuneration or gain, is part of a prescribed program of medical therapy or carried out in a hospital under the supervision of medical and administrative staff. Social Security determines what does and doesn’t count as “services” and these determinations can get complicated. When in doubt, seek assistance from your assigned VCU NTDC Technical Assistance Liaison

**Determining Wages in a Month**

In the Title II disability program, Social Security is interested in work ability or effort performed in a month, and thus generally counts wages when the beneficiary EARNED them, not when the beneficiary received them.
**IMPORTANT NOTE:** The Bipartisan Budget Act of 2015 simplifies post entitlement SGA determinations by allowing Social Security to presume earnings were earned in the month they were paid. However, prior to applying this paid versus earned assumption, Social Security personnel will evaluate any readily available earnings verification sources and determine when the beneficiary earned the wages or self-employment income. If Social Security has no other readily available evidence to determine when the beneficiary performed the work activity, the agency will use other sources of earnings verification even if the earnings source only documents when the employer paid the beneficiary.

When Social Security personnel gather wage information to determine TWP service months, they follow certain procedures. The first step is to evaluate the beneficiary’s monthly breakdown of gross earnings, and then to determine whether those earnings exceed the amount that constitutes a TWP month for that year. Social Security may send the beneficiary a Work Activity Report (SSA-820/821) in order to gather wage information, but the agency must also verify wages.

Social Security uses a variety of methods to verify gross wages or self-employment income, including participation in several internet based wage verification systems such as “The Work Number” and “Verify Advantage”. If wage data isn’t available through these systems, Social Security personnel will move through a series of wage verification methods using a standard hierarchy. This includes wage information the beneficiary provides, earnings data available in other Social Security systems, and earnings information the IRS shares with Social Security. For more information about how Social Security verifies earnings, refer to [DI 10505.005 Determining and Verifying Gross Earnings from Employment](https://secure.ssa.gov/apps10/poms.nsf/lnx/0410505005) found online.

**Counting TWP Months**

For beneficiaries in wage employment, Social Security credits TWP months when gross earnings exceed the monthly TWP amount applicable for that year. For individuals who are self-employed, Social Security will count any month in which net earnings from self-employment (NESE)
exceed the applicable TWP amount, or any month that the beneficiary spends more than 80 hours engaged in work for profit in a business.

Since January 2001, the TWP amount is indexed annually. That means that it will go up (or at least not go down) in January of each new calendar year. Past TWP amounts still apply to work in past years. For example, Social Security evaluates work performed in the 2001 calendar using the TWP standard for 2001, which was $530, not the current TWP amount.

Previous TWP amounts for each calendar year are listed below:

- Years before 1979 — $50 or 15 hours of work in self-employment
- Years 1979-1989 — $75 or 15 hours of work in self-employment
- Calendar years 1990-2000 — $200 or 40 hours in self-employment
- 2001 — $530 or 80 hours in self-employment
- 2002 — $560 or 80 hours in self-employment
- 2003 — $570 or 80 hours in self-employment
- 2004 — $580 or 80 hours in self-employment
- 2005 — $590 or 80 hours in self-employment
- 2006 — $620 or 80 hours in self-employment
- 2007 — $640 or 80 hours in self-employment
- 2008 — $670 or 80 hours in self-employment
- 2009 — $700 or 80 hours in self-employment
- 2010 — $720 or 80 hours in self-employment
- 2011 — $720 or 80 hours in self-employment
- 2012 — $720 or 80 hours in self-employment
- 2013 — $750 or 80 hours in self-employment
- 2014 — $770 or 80 hours in self-employment
- 2015 — $780 or 80 hours in self-employment
- 2016 — $810 or 80 hours in self-employment
• 2017 — $840 or 80 hours in self-employment
• 2018 — $850 or 80 hours in self-employment
• 2019 — $880 or 80 hours in self-employment
• 2020 — $910 or 80 hours in self-employment

Determining the Beginning of the TWP

The TWP is a work incentive. The first possible TWP month usually occurs the first time after entitlement to Title II disability benefits that a beneficiary begins to work and has earnings over the applicable TWP guideline. Here are some limitations:

• The beneficiary must have a TWP available. Later in this unit, we will discuss situations where one may not be available.
• The TWP may not begin before the application date.
• The TWP may not occur before the first month a beneficiary becomes entitled, or reentitled, to benefit payments.

An applicant must be eighteen in order to become entitled to CDB benefits. That means the earliest possible month for the TWP to begin is the month a CDB turns 18.

Completing the TWP

The TWP ends when an individual has completed nine service months within a rolling five-year period. To track this, Social Security marks all of the possible months that could be TWP months. It counts forward to nine, then counts back 60 consecutive months to see if the beneficiary completed all nine service months within that period. If not:

• Social Security disregards the service months that fall before the 60-month period;
• Social Security counts the service months that fall within the 60-month period; and
• The TWP continues.

Each time thereafter that a beneficiary uses a service month, Social Security uses the same procedure, counting forward until they count nine service months, and then counting back 60 months to see if the nine TWP service months all fall within five years. If at any point in time nine
service months fall within a 60-month period, Social Security determines the TWP is complete. Once the TWP ends, the protections afforded by this work incentive end. Beneficiaries have only one TWP during a period of entitlement.

**A Note about the 60-month Period**

Social Security determines the TWP is complete only if an individual has nine TWP service months that fall within a five-year period. The five-year (60-month) timeframe doesn’t mean that a person receives a new TWP every five years. Instead, it means that Social Security may ignore months that happened a long time before the current work effort. Once the beneficiary has used nine TWP months within a 60-month period, the beneficiary has used the TWP — it’s gone. The person doesn’t get another TWP based on the same Social Security record unless Social Security terminates the person’s benefits, and the person becomes entitled again.

**Examples of TWP:**

**Fred:** Fred became entitled to Social Security Childhood Disability Benefits in 2006. For the first time since his entitlement, Fred began to work in March 2013, and has worked steadily since then. Fred makes around $800.00 per month.

<table>
<thead>
<tr>
<th>2013</th>
<th>Jan</th>
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<th>Mar</th>
<th>April</th>
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<th>June</th>
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<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
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<tr>
<td>Earnings</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>775</td>
<td>805</td>
<td>799</td>
<td>810</td>
<td>904</td>
<td>780</td>
<td>860</td>
<td>803</td>
<td>942</td>
</tr>
<tr>
<td>TWP service month?</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>9</td>
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</tr>
</tbody>
</table>

Fred completed his TWP in December 2013, the ninth month in which he earned over the 2013 TWP amount of $750.00.

**Sandy:** Fred’s friend Sandy has been entitled to SSDI for six years. She started to work for the first time around the
same time Fred began to work. She had a couple of breaks in her earnings, though. Sandy’s earnings look like this:

<table>
<thead>
<tr>
<th>2013</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
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<th>Sept</th>
<th>Oct</th>
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<td>0</td>
<td>400</td>
<td>619</td>
<td>0</td>
<td>0</td>
<td>800</td>
<td>42</td>
<td>905</td>
<td>801</td>
<td>1200</td>
</tr>
<tr>
<td>TWP service month?</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</tr>
</tbody>
</table>

Sandy has five TWP months left at the end of the year. She has not used her TWP.

**Melissa:** Fred and Sandy have a friend named Melissa. Melissa is a little older than Fred and Sandy. She was entitled to SSDI benefits in 2001 and has had sporadic work since 2008

<table>
<thead>
<tr>
<th>2008</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
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<td>Earnings</td>
<td>693</td>
<td>729</td>
<td>29</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>50</td>
<td>515</td>
<td>745</td>
<td>142</td>
</tr>
<tr>
<td>$670 = TWP month</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<th>Sep</th>
<th>Oct</th>
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<tr>
<td>Earnings</td>
<td>450</td>
<td>724</td>
<td>1042</td>
<td>569</td>
<td>442</td>
<td>164</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>$700 = TWP month</td>
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<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<td>2010</td>
<td>Jan</td>
<td>Feb</td>
<td>Mar</td>
<td>Apr</td>
<td>May</td>
<td>Jun</td>
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<tr>
<td>Earnings</td>
<td>450</td>
<td>755</td>
<td>215</td>
<td>0</td>
<td>16</td>
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<td>347</td>
<td>201</td>
<td>0</td>
<td>561</td>
<td>1200</td>
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<tr>
<td>$720 = TWP month</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<th>Jul</th>
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<th>Sep</th>
<th>Oct</th>
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<th>Dec</th>
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<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<td>42</td>
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<td>No</td>
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<th>Jun</th>
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<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
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<td>0</td>
<td>49</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>104</td>
<td>0</td>
<td>27</td>
<td>42</td>
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<tr>
<td>$720 = TWP month</td>
<td>No</td>
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<table>
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<th>2013</th>
<th>Jan</th>
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<th>Mar</th>
<th>Apr</th>
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<th>Jun</th>
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<tbody>
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<td>6</td>
<td>115</td>
<td>590</td>
<td>782</td>
<td>800</td>
<td>941</td>
<td>45</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>$750 = TWP month</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Count</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
<td>8</td>
<td>9 TWP ends this mth</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>
Melissa completed her TWP in September 2013. Social Security dropped the first months of work over the TWP limit in 2008 because Melissa wouldn’t have used all nine months within a 60-month period if they included those months.

**The Trial Work Period and Self-Employment**

Social Security counts net earnings from self-employment (NESE) rather than gross earnings. NESE is all the money the business takes in, minus the business expenses, including the extra Social Security taxes self-employed individuals pay. During the TWP, Social Security can use monthly profit-and-loss statements to determine TWP service months. If the statements are unavailable, Social Security determines if the beneficiary used TWP months by averaging the NESE for the period the business was active during the calendar year.

In general, Social Security applies the IRS rules for what constitutes approved business expenses. Work activity in self-employment will constitute “services” only when: (1) net earnings in a calendar month are more than the TWP amount; or (2) the person spends more than a specified number of hours in that month performing the work activity she or he would normally undertake for the business’ profit. Under the current rules, it’s possible to have NESE under the current TWP guideline and still use a service month.

Social Security determines service months on a month-by-month basis in both wage employment and self-employment situations. If the individual is both employed and self-employed, Social Security will add the wages earned to the NESE to determine if the total is over the applicable TWP amount. If the total is under the TWP amount, Social Security will examine the number of hours the beneficiary spent in the business to determine if he or she uses a TWP month.

**Hours in a Business**

A self-employed individual uses a TWP month if the NESE is over the TWP amount, OR if the individual works more than 80 hours in the business. Either factor will cause Social Security to count that month towards the nine months of the TWP. Beneficiaries should keep track of the hours they work in the business. Hours that they should count are hours they spent on the ongoing business duties for pay or profit. Beneficiaries shouldn’t count hours they spent planning the business. You can find
more detailed information about the TWP as it applies to beneficiaries engaged in self-employment in Unit 8, “Self-Employment and Social Security Disability Benefits.”

**When the TWP is Available**

Beneficiaries are entitled to one TWP per period of disability. Social Security grants a new TWP whenever a new period of disability begins. A new period of disability begins after Social Security terminates an individual from benefits, who then re-applies and Social Security finds eligible. As of January 1992, the TWP may begin immediately upon re-entitlement, whether or not the beneficiary serves a five-month waiting period.

In addition, a new TWP is available to individuals who re-establish eligibility for benefits under Expedited Reinstatement (EXR) provisions. A new TWP is available only after Social Security has made 24 EXR payments. For more information on the EXR provision, refer to Unit 9 of this module.

**Limitations to Who May Access a Trial Work Period**

Social Security rules provide most beneficiaries of the Title II disability program the protections of the TWP. There are some situations, however, when beneficiaries aren’t allowed to access this work incentive. Some of these are discussed below.

1. **Medical Improvement:** If Social Security decides that a beneficiary has medically improved, that person may not access the TWP.

2. **Substantial Gainful Activity Shortly After Application:** As discussed in Unit 1, the disability definition for entitlement requires that a person be disabled for at least 12 months. Because of this provision, SGA-level work within 12 months of the date of disability onset could cause beneficiaries to become ineligible for a TWP. Remember, it’s the Disability Determination Service that decides what onset date Social Security will use. SGA-level work within 12 months of that date may mean that the initial disability decision was incorrect because the individual wouldn’t have met the “duration requirement.” In these circumstances, Social Security may “reopen” the individual’s benefits application and decide that all benefits paid to that point
are an overpayment. Some protections under the law assist individuals who return to work within one year of the date the disability officially began:

- If the individual is working, but not performing SGA, the benefits shouldn’t be affected.
- If the person performs SGA shortly after the date DDS determined the disability started, but has to stop, Social Security could continue the entitlement. Social Security may either consider the work to be an Unsuccessful Work Attempt (UWA) or they may be able to establish a later date of onset.
- If the person doesn’t perform SGA until 12 months after the official disability onset date, the TWP applies.
- If the person performs SGA after the waiting period, and after the final determination date, Social Security will afford the person a TWP. The final determination date is officially five days after the date that Social Security sent the beneficiary the award notice.

3. **Trial Work Period and Blindness:** Beneficiaries who meet the requirements for statutory blindness are in a unique situation if they are age 55 or older. If the work they are doing differs greatly than the work they did before losing vision, or reaching age 55, Social Security rules allow them to receive benefits for any months their earnings are not Substantial Gainful Activity. People in this situation do not have a Trial Work Period.

Later sections in this module discuss some differences in work incentives for individuals who meet the standard for statutory blindness. People who receive Title II disability benefits due to blindness and who are under age 55 are entitled to a TWP like non-blind beneficiaries. Blind individuals over age 55, however, may or may not be due a TWP, depending on the situation.

If someone meets the statutory definition of blindness and receives CDB, DWB, or SSDI, access to a TWP may change when the person reaches 55. If the person is performing work that isn’t comparable to work he or she did before being both age 55 and blind, Social Security will simply suspend payments if the individual performs SGA. The individual won’t have a TWP, and won’t risk termination of benefits. If the work is
“comparable” to work the blind person did before being both age 55 and blind, then the TWP provisions apply. Comparability is a determination that Social Security, and sometimes DDS, will make.

Essentially, people who meet the statutory definition of blindness at age 55 may or may not have a TWP, depending on the nature of their work. Non-comparable SGA level work simply suspends the benefits. The blind beneficiary may become entitled to payments again whenever earnings drop. The beneficiary must simply report the change and provide evidence. The beneficiary won’t need to file a new application or request Expedited Reinstatement (EXR), a work incentive we describe later in this module.

Examples of TWP:

**Sam:** Sam is blind and 56 years old. He is working as a receptionist in an independent living center. Sam has only met the standard for blindness for about five years. In fact, Sam’s last work was as a truck driver. Sam is working full-time and, in 2020, has $2,500 in countable earned income per month. The SGA level for blindness in 2020 is $2,110, so Sam is performing SGA. The skills Sam used as a truck driver aren’t comparable to those he is using as a receptionist. Social Security suspends Sam’s benefits when he reaches countable SGA. They remain suspended until Sam’s work again falls below the SGA level. Unlike entitlement prior to age 55, if Sam’s work ceases to be SGA, Sam doesn’t need to reapply for benefits. He simply informs Social Security of his changed work situation.

If Sam had started his receptionist job prior to age 55, the Trial Work rules would apply. However, because he started the job after age 55, Sam doesn’t have a TWP unless he engages in work comparable to that which he performed prior to age 55. Instead, as soon as Sam reports Social Security determines that Sam’s work is SGA, Social Security suspends Sam’s benefits. Social Security should continue his entitlement until he reaches full retirement age and earnings no longer affect his benefits. Sam would be due cash payments for any months during the period that his countable earnings were under the SGA level.
**Lloyd:** Sam’s brother Lloyd was an attorney throughout his work life. Lloyd also lost his vision when he was in his early 50s. Lloyd received SSDI for several years, until he was 57. Lloyd returned to private practice as an attorney and used all of the skills he used prior to attaining age 55. He also made a significant net profit from his business, even after considering all work incentives for self-employed individuals such as unpaid help and unincurred business expenses. When Lloyd returned to work, Social Security determined that he was engaging in comparable SGA. Lloyd’s work was substantial and used the skills he had used prior to attaining age 55 and blindness.

Lloyd was eligible for a TWP because this was his first comparable work attempt after entitlement and attaining age 55. Lloyd hadn’t previously used his TWP. Because Lloyd continued to work above the blind SGA level using the skills he used prior to attainment of age 55, Social Security eventually terminated his benefits. If Lloyd again stops working, or reduces his work to below the SGA level prior to the time he attains full retirement age, he’ll have to reapply for benefits or request Expedited Reinstatement (EXR). Expedited Reinstatement is discussed in Unit 9 of this module.

**Tracking TWP Months**

The local Social Security field office or the Office of Disability Operations (ODO) Payment Service Center (PSC) as requested by the field office may track TWP months once a beneficiary reports work activity. Because many factors may hinder successful TWP tracking, beneficiaries and CWICs should never assume Social Security will know when the TWP ends. Social Security recommends a proactive approach in which the beneficiary assumes primary responsibility for keeping up with service months. The CWIC may assist in this process by working closely with Social Security personnel to research past work history and ensure that the beneficiary reports all work activity that could result in using TWP months.
Important Reminders about the TWP

Social Security is sometimes unaware of work efforts after entitlement. When CWICs give information about the TWP to beneficiaries, CWICs must verify and ensure that the beneficiary has reported and Social Security has developed all prior work activity. If it hasn’t, the CWIC can’t give specific information about TWP availability until the past work has been developed by Social Security. It’s critical that the CWIC and the beneficiary work together to provide wage information to Social Security so that prior work can be developed and TWP months recorded if used. This topic will be discussed in detail in Module 6.

Another critical issue to remember is that during the TWP, NO other work incentives apply. Beneficiaries don’t need to use deductions during the TWP because they can have unlimited earnings without risking loss of cash payments. Work incentives can’t be applied to reduce earnings below the TWP guideline amount. The TWP is a stand-alone work incentive that doesn’t permit deductions from gross earnings and doesn’t interface with any other work incentive.

Benefit payments are protected if the beneficiary is working above the SGA guidelines during the TWP. However, Social Security may use work activity performed during the TWP to establish a pattern of work indicating the person can perform SGA once the TWP ends. If the person continues working after completing the TWP, Social Security will evaluate the individual’s work activity using the SGA criteria. Any services rendered (including the services during the TWP) they will then consider to determine whether the individual has demonstrated the ability to engage in SGA. Social Security can use averaging throughout the TWP and beyond to determine whether there is a pattern of work at the SGA level.

Cessation Month and Grace Period

As long as the beneficiary continues to have a disability, the first time that SGA-level work could affect payment of benefits is after the TWP ends. When a beneficiary performs sustained SGA-level work for the first time after the TWP, this first month where this pattern begins is called the “cessation month.” Social Security allows beneficiaries to receive a payment in this month and the two succeeding months, called the “Grace Period,” for a total of three months. Even though the months have
different names, they are really one work incentive and Social Security always applies them together as one three-month block. These are sometimes referred to collectively as simply the “Grace Period.”

“Cessation” may seem like a confusing name to give this month because benefits don’t actually cease (stop) until the entire three-month grace period has ended. It may help to think back to the two parts of the disability definition (inability to perform SGA due to disability). Essentially, “cessation” means that the individual ceases to meet the second part of the disability definition.

Social Security letters that indicate benefits are going to stop because the person is no longer disabled can confuse beneficiaries. However, the medical impairment must’ve continued in order to access the TWP and the other work incentives. Those Social Security notices mean that the person no longer meets Social Security’s disability definition, which requires both a medical impairment and the person’s inability to perform SGA.

Cessation is a different concept from benefit termination. When Social Security ceases benefits, it means that they merely suspend them, and that they can reinstate cash payments without a new application. Termination, on the other hand, means that the person must formally re-apply or request Expedited Reinstatement to start cash payments again.

For benefit termination to occur due to SGA-level work, the beneficiary must’ve completed the TWP and the Extended Period of Eligibility (EPE) discussed later in this module. The Grace Period must’ve occurred as well. Benefit termination doesn’t always immediately follow the Grace Period, but could happen much later, depending on the work activity of the beneficiary.

The cessation and grace months, like the TWP, are only available once during a period of disability. Social Security affords the beneficiary another Grace Period only if he or she becomes re-entitled to benefits.

**NOTE:** The Cessation and Grace Period months occur the first time Social Security determines that the beneficiary has performed SGA. This can occur at any time after the beneficiary completes the TWP. The Grace Period may occur during the 36-month re-entitlement protection of the Extended Period of Entitlement (EPE), or not until years
after. If the beneficiary never performs SGA, it may not occur at all.

Example of the cessation and grace period:

Sara became entitled to SSDI benefits in May 2008. She began working at the library in July 2008, earning $800 a month. Nine months later, in March 2009, her Trial Work Period (TWP) ended. In April 2009, her three-year Extended Period of Eligibility (EPE) began. She continued to work at the library. Her re-entitlement period ended three years after the TWP, in April 2012. Sara remained in cash payment status even though her TWP and EPE were both used since her earnings were not SGA.

In August 2020, Sara received a promotion to supervisor and increased her monthly earnings to $2,000. She reported her change in income to Social Security, and Social Security determined Sara was performing SGA.

Sara’s Cessation month was August 2020 and her three Grace Period months were August, September, and October 2020. Her termination month was November 2020.

Extended Period of Eligibility (EPE)

Section 303 of the 1980 amendments to the Social Security Act provided a reinstatement period under Title II to an individual who completes nine months of trial work and continues to have a disabling impairment. This provision, referred to as the Extended Period of Eligibility (EPE), provides that an individual can be re-entitled to benefits any time during the 36-month EPE re-entitlement period if his or her work activity falls below the SGA level. The EPE reinstatement period begins with the month immediately following completion of the trial work period and ends 36 months later. The POMS describes the EPE to include any months of entitlement after the 36-month re-entitlement period and before termination. Though it’s correct that eligibility continues, the protection for re-entitlement only lasts 36 consecutive months.

Things to remember about the EPE:
• The EPE is a work incentive protection. A beneficiary must continue to have a disabling impairment to access the EPE.

• If a beneficiary isn’t performing SGA at the time the 36-month re-entitlement period ends, benefits may continue indefinitely.

• The EPE re-entitlement period is a safety net for beneficiaries who engage in SGA. Some beneficiaries may never know they have used it if their earnings are consistently below SGA.

• Cessation and Grace Months may, or may not, occur during the 36-month re-entitlement period of the EPE. Cessation happens the first time after the TWP that a person performs SGA. That could be the month after the TWP, it could be years later, or it might never happen. Cessation isn’t dependent on the re-entitlement period of the EPE, and the Grace Period is a separate and distinct work incentive. The EPE re-entitlement period is a safety net to help beneficiaries return to cash payment status quickly if their benefits cease, and they are again unable to perform SGA.

• The EPE always begins the month after the TWP ends, regardless of whether or not the beneficiary continues to work beyond the TWP. If the TWP ends, the EPE begins the very next month whether the beneficiary continues working or not.

• If Social Security ceases a beneficiary’s payments after the TWP, and the person needs to receive benefits again during the 36-month reinstatement period of the EPE, he or she doesn’t have to file a new application. Instead, the individual must simply establish with Social Security that their work activity is below SGA.

• If Social Security reinstates a benefit during the EPE, the benefit will continue indefinitely until the person again performs SGA, or Social Security determines that the disabling impairment has medically improved.

• If the beneficiary performs SGA during the EPE, Social Security suspends rather than terminates benefits. The termination month is the first month of SGA after the 36-month EPE re-entitlement period ends. If the beneficiary didn’t perform SGA during the 36-month EPE re-entitlement period, and later
performs SGA, the individual is due benefits for the cessation and grace months, and then Social Security terminates benefits. Suspension means that Social Security easily can reactivate the payments without a new application. Termination means that the person must formally re-apply or request Expedited Reinstatement (EXR) to start payments again.

- The EPE doesn’t change the definition of disability. A beneficiary is eligible for payments as long as he or she continues to meet both the medical part of the definition of disability and the “unable to perform SGA” requirement.

The main effect of the EPE provision is that it permits benefit reinstatement during the re-entitlement period. To be reinstated after a work-related suspension of benefits, the beneficiary simply needs to report to Social Security that work is no longer substantial by making a work activity report and supplying evidence of the drop in earnings.

Although SGA isn’t material until after the beneficiary has completed the TWP, Social Security may consider work during the TWP to establish a pattern of ability to perform SGA. This can occur if a period of work extends from TWP months into the EPE. However, if an individual is entitled to a TWP, the benefits Social Security paid during that period are due them, regardless of whether or not the individual performs SGA during the TWP.

**Example of benefits due throughout TWP:**

Angelina became entitled to benefits in October 2008. In March 2013, she began to work for the first time since she became entitled. Below are Angelina’s countable earnings:

<table>
<thead>
<tr>
<th>2013</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earnings</td>
<td>0</td>
<td>0</td>
<td>540</td>
<td>1060</td>
<td>1105</td>
<td>1120</td>
<td>910</td>
<td>1045</td>
<td>1080</td>
<td>1160</td>
<td>1060</td>
<td>1042</td>
</tr>
<tr>
<td>Payment?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>TWP Status</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Angelina was due benefits throughout her TWP, even though her earnings were over the SGA guideline. After her TWP, when Angelina goes to Social Security to report her earnings, Social Security is likely to determine that Angelina demonstrated the ability to perform SGA. Even though Angelina only performed SGA-level work for two months after the TWP, Social Security can consider work she performed during the TWP to ascertain a pattern. It’s not an Unsuccessful Work Attempt (UWA) because Angelina actually had earnings at the SGA level for more than six months. Angelina’s disability would “cease” in January 2014, but she would still be entitled to a benefit payment. After Angelina received the 2 additional Grace Period payments in February and March, Social Security would suspend her benefits. Because Angelina currently isn’t performing SGA, and because she is still within the 36-month reinstatement period of the EPE, Angelina’s benefits would be due for April. However, she would’ve used her Cessation Month and Grace Period and would no longer have access to the Unsuccessful Work Attempt or income averaging provisions in subsequent SGA determinations.
If Angelina had stopped working in November 2013, Social Security wouldn’t have ceased her benefits because the work effort was totally within the protection of the TWP. However, if she didn’t start working at SGA level until after the EPE, cessation wouldn’t occur until the time Social Security made an SGA determination. Remember that the Cessation and Grace Period is a stand-alone work incentive, and isn’t tied to the EPE.

**The Definition of Termination**

Termination for Social Security purposes doesn’t just mean that the cash payments have stopped. Social Security may stop payments under certain circumstances even though a beneficiary remains eligible for disability benefits. Termination means Social Security has terminated or closed the computer record that maintains payments. Once Social Security has terminated benefits, a formal re-entitlement or re-instatement decision is required for payments to begin again. This is important to understand because termination is more than just stopping payments. Termination is more than cessation, suspension, non-payment, or any other term Social Security uses to denote merely the loss of cash payment. It also means that no more benefits are payable based on that application, and that the “period of disability” has closed.

Prior to January 1, 2001, once Social Security terminated a disability benefit, the only way someone could receive payments again was to submit an entirely new application for benefits. The Ticket to Work and Work Incentives Improvement Act of 1999 created an important work incentive called Expedited Reinstatement (EXR). EXR is a way to return more quickly to Social Security disability benefits when the former the beneficiary significantly reduces or stops work, and he or she is unable to perform SGA because of his or her original disabling condition. EXR also permits individuals to receive provisional payments while Social Security is processing the reinstatement request. This work incentive is discussed in detail in Unit 9 of this module.
Extended Medicare

When Title II disability beneficiaries have been entitled to cash payments for 24 months, Title XVIII of the Social Security Act entitles them to Medicare benefits. Medicare is a federal health insurance program that is covered in detail in Module 4 of this manual.

The most important thing for CWICs to know is that after cash benefits have stopped due to work activity, Social Security still allows for the continuation of Medicare benefits through a provision known as the Extended Period of Medicare Coverage (EPMC). This means that beneficiaries may continue, for at least 93 months after the Trial Work Period ends, to receive premium free hospitalization coverage. For the same period, working beneficiaries may continue to purchase Part B coverage even if they aren’t receiving cash benefits. This is a powerful work incentive because many individuals with disabilities fear they will lose their health insurance if they return to work. Module 4 discusses Medicare enrollment and the EPMC in detail.

Conclusion

Unit 3 of this module discussed the SGA determination process. This unit discussed additional protections, called work incentives.

- The TWP offers nine months of protection during which a beneficiary may have no limit on earnings and still be eligible for payments.
- The EPE 36-month re-entitlement period allows Social Security, after suspending beneficiaries’ cash benefits due to work activity, to reinstate the benefits if earnings again fall below the SGA level during the 36-month re-entitlement period.
- The Grace Period offers three consecutive months of payments as a protection the first time a beneficiary performs SGA (cessation occurs) after the TWP.
- Expedited Reinstatement (EXR) offers 60 months after termination when a beneficiary may qualify for reinstatement of his or her entitlement if earnings fall below SGA, the individual
has the same or a related disability, and the benefits terminated less than five years before the drop in earnings.

It’s critical that CWICs understand these concepts. It’s even more important that CWICs are able to explain these concepts clearly to beneficiaries. The concepts are complex and challenging to understand. Beneficiaries, however, need to know that these protections are there to help them if the return-to-work effort falters.

**Conducting Independent Research**

Pamphlets that are good resources:


Programs Operations Manual Systems references:

**DI 13010.035 The Trial Work Period (TWP)**
[https://secure.ssa.gov/apps10/poms.nsf/lnx/0413010035](https://secure.ssa.gov/apps10/poms.nsf/lnx/0413010035)

**DI 13010.060 Determining Trial Work Period (TWP) Service Months and Evaluating Subsequent Work Activity**
[https://secure.ssa.gov/apps10/poms.nsf/lnx/0413010060](https://secure.ssa.gov/apps10/poms.nsf/lnx/0413010060)

**DI 13010.066 Developing and Verifying Monthly Earnings in the Trial Work Period (TWP)**
[https://secure.ssa.gov/apps10/poms.nsf/lnx/0413010066](https://secure.ssa.gov/apps10/poms.nsf/lnx/0413010066)

**DI 13010.210 Extended Period of Eligibility (EPE) – Overview**
[https://secure.ssa.gov/apps10/poms.nsf/lnx/0413010210](https://secure.ssa.gov/apps10/poms.nsf/lnx/0413010210)

**DI 13010.215 Procedure for Extended Period of Eligibility (EPE)**
[https://secure.ssa.gov/apps10/poms.nsf/lnx/0413010215](https://secure.ssa.gov/apps10/poms.nsf/lnx/0413010215)

**DI 28055.005 How the EPE Works**
[https://secure.ssa.gov/apps10/poms.nsf/lnx/0428055005](https://secure.ssa.gov/apps10/poms.nsf/lnx/0428055005)
Competency Unit 5 – Understanding the SSI Program

Introduction

Supplemental Security Income (SSI) is another disability benefit program administered by the Social Security Administration. SSI is very different from the benefits Social Security pays under Title II of the Social Security Act discussed in the previous units of this module. Social Security pays SSI to people who are disabled, blind, or age 65 or older who have few resources and low income, and who meet certain citizenship or residency requirements. SSI benefits don’t come from the Social Security Trust Fund; instead, Social Security pays SSI out of general federal tax dollars.

Prior to 1974, individual states provided varying degrees of public assistance to people with disabilities who didn’t qualify for disability benefits under the Social Security system. Congress created the SSI program to provide a uniform minimum income level for elderly or disabled. SSI is intended to supplement a beneficiary’s other income and help them meet their basic food and shelter needs. Because SSI is a “means-tested” program, Social Security will determine eligibility and payment amount based on the individual’s available income and resources.

Once Social Security has established initial eligibility for SSI, the agency continues to assess the countable income and resources of all SSI recipients on a monthly basis. Beneficiaries with countable income (other than SSI) or resources in excess of the allowable limits aren’t eligible for an SSI cash payment or (in most cases) associated Medicaid coverage.

Eligibility for People who are Blind or Disabled

In the SSI program, an adult applying for benefits must meet the same definition of disability or blindness as individuals applying for Title II disability benefits. Like Title II, disabled applicants performing SGA at the time of application are not eligible for SSI benefits. Social Security waives the SGA test for people who are blind per Social Security’s definition. So, individuals who meet the definition of statutory blindness
may be approved for SSI benefits, even if they are performing SGA-level work.

Once Social Security finds an individual initially eligible for SSI, the SGA test of the disability definition no longer applies. This is due to Section 1619 of the Social Security Act. For disabled individuals, the time of application is the only time SGA affects entitlement under the SSI program. For blind SSI applicants or recipients, the SGA test never applies. As a result, the SGA-related work incentives discussed in Unit 3 of this module do not apply to individuals who already receive SSI. That means, Social Security doesn’t use work incentives such as Subsidy, Unpaid Help, Unsuccessful Work Attempts, or Income Averaging in determinations of continued payment under SSI. The concept of Impairment Related Work Expenses (IRWE) does exist in the SSI program, but as a deduction from countable income in benefit calculations, rather than a means to assess if the person is engaging in SGA-level work.

**Basic SSI Eligibility Requirements**

The following are the basic eligibility requirements for the SSI program:

- Age 65 or older, blind, or disabled;
- Reside in one of the 50 states, the District of Columbia, or the Northern Mariana Islands, except for a child of military parent(s) assigned to permanent duty anywhere outside the United States, or certain students temporarily abroad;
- Citizen or national of the U.S. or an alien who meets the applicable requirements as follows:
  a. For benefits payable beginning August 22, 1996, the alien must meet the alien status requirements in POMS SI 00502.100; or
  b. For benefits payable before August 22, 1996, the alien must be lawfully admitted for permanent residence in the U.S. (see POMS GN 00303.440) or permanently residing in the U.S. under color of law (see POMS SI 00501.420).
- Have income and resources within specified limits;
• Not be absent from the U.S. for a calendar month unless he or she is a child who is a U.S. citizen and lives outside the U.S. with a parent in the U.S. Armed Forces, or is a student who is temporarily abroad for the purpose of conducting studies;
• File for any other benefits for which he or she is potentially eligible;
• Not be a fugitive felon;
• Not be violating a condition of parole or probation;
• Give Social Security permission to contact any financial institution at any time and request any financial records that financial institution may have about the individual. Other people who are responsible for the individual’s support must also give Social Security their permission to contact any financial institution at any time and request financial records that financial institution may have about them; and
• File an application.

For more information, refer to POMS SI 00501.001 - Eligibility under the Supplemental Security Income Provisions found online (https://secure.ssa.gov/poms.nsf/lnx/0500501001).

**Retroactivity and SSI**

Unlike the Title II disability programs, there’s no waiting period and no retroactivity under the SSI program. In the SSI program, Social Security can’t make payments until the first full month following the application. For example, if a person applies for SSI on the 16th day of November and Social Security finds him or her eligible for SSI, Social Security will pay the first SSI benefit on the first day of the NEXT month, which would be December. It’s important that potentially eligible individuals apply for SSI soon as possible, so as not to lose potential SSI payments.

**Federal Benefit Rate (FBR)**

SSI is a program intended to augment any other income a person may already have to meet minimum needs for food or shelter. Social Security
counts an individual’s or SSI-eligible couple’s income on a monthly basis. The Federal Benefit Rate (FBR) is a monthly amount that changes in January of each year, and is the highest federal payment an individual or eligible couple (two SSI beneficiaries married, or holding out to the community as if married) may receive. Unlike the Title II disability benefits, Social Security reduces SSI payments if an individual or eligible couple has countable income. The more countable income an individual or SSI-eligible couple has, the lower the cash payment will be. If an individual or SSI-eligible couple has too much countable income, they won’t be eligible for a cash payment at all. To determine the SSI payment amount, Social Security subtracts countable income from the FBR.

Social Security sets several Federal Benefit Rates (FBRs) each year. There are additional FBR amounts for individuals living in another person’s household, or living in a Medicaid facility. Which FBR applies to an SSI payment determination depends on the person’s living situation and marital status. The chart below shows the most recent FBR amounts:

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Individual FBR</th>
<th>Couple FBR</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>$710</td>
<td>$1,066</td>
</tr>
<tr>
<td>2014</td>
<td>$721</td>
<td>$1,082</td>
</tr>
<tr>
<td>2015 &amp; 2016</td>
<td>$733</td>
<td>$1,100</td>
</tr>
<tr>
<td>2017</td>
<td>$735</td>
<td>$1,103</td>
</tr>
<tr>
<td>2018</td>
<td>$750</td>
<td>$1,125</td>
</tr>
<tr>
<td>2019</td>
<td>$771</td>
<td>$1,157</td>
</tr>
<tr>
<td>2020</td>
<td>$783</td>
<td>$1,175</td>
</tr>
</tbody>
</table>

**Optional State Supplements**

When Congress created the SSI program, states were required to maintain the income levels of individuals whom Social Security transferred from the former state programs. The federal government mandated states to assure that their residents wouldn’t receive lower
benefits under the federal program than they had under the former state program. Some states choose to pay optional state supplements to help individuals meet needs the federal SSI payments don’t fully cover. Some of the states that provide mandatory or optional supplements have elected to administer the payments themselves. In these states, the state agency that administers Temporary Aid to Needy Families (TANF) and Medicaid makes decisions about eligibility. Other states contract with Social Security to administer the state supplements. When Social Security calculates SSI payments for beneficiaries who live in states with federally administered state supplementation, Social Security treats the supplement like an extension of the federal SSI payment. Social Security deducts countable income from the applicable FBR plus the supplement to determine the monthly amount due.

CWICs must remember to take any applicable state supplement into consideration when counseling beneficiaries on the effect of work on benefits. Also keep in mind that for some states, blindness is a criterion that permits payment of the state supplement, so blind beneficiaries might receive a higher amount of SSI, or a different supplement than other beneficiaries. CWICs should seek information on their own state supplement programs and the criteria under which they are paid.

How the SSI Program Defines Income

The SSI program considers income to be anything an individual receives in cash or in-kind that he or she can use to meet the basic needs for food or shelter. In-kind income isn’t cash but food or shelter provided to an eligible individual or SSI-eligible couple by someone else. Under this definition, income also includes the receipt of anything that a person can use, either directly or by sale or conversion, to meet his or her basic needs of food or shelter. This means that some gifts that can be easily converted to cash may count as income when Social Security determines eligibility and payment. Some types of cash or in-kind items do meet Social Security’s definition of income, but a federal statute specifically excludes them.

Any cash or in-kind item that meets the SSI definition of income Social Security must classify as either earned income or unearned income. Social Security treats earned income and unearned income very differently in the SSI program, so it’s important that you take care when
distinguishing between these two categories. Descriptions of both types of income are provided later in this unit.

Social Security determines an individual’s total countable income after applying all allowable deductions or exclusions. Social Security allows many exclusions for each of the two types of income (earned and unearned), some of which will be explained in subsequent sections. To determine how much SSI a person is due for a month, Social Security subtracts the countable income from the SSI FBR for either an individual or an eligible couple. The more countable income an individual or couple has in a month, the less the SSI cash payment will be for that month. If an individual or eligible couple has too much countable income, they won’t be eligible for an SSI payment.

What Isn’t Income?

As stated earlier, Social Security does NOT count items as income for SSI purposes if they are not food or shelter and a person can’t use them to obtain food or shelter. Examples of some of the more common items that don’t meet the definition of income for SSI purposes are listed below. The items listed here aren’t income exclusions. Income exclusions apply to items that DO meet the definition of income, but Social Security simply excludes them when determining countable income. We will discuss income exclusions later in this module. The most common items that don’t meet the SSI definition of income include:

- **Medical and social services:** Medical and social services aren’t income for purposes of the SSI program. Under the complex circumstances specified in POMS SI 00815.050: Medical and Social Services, Related Cash, and In-Kind Items, cash and in-kind items received in conjunction with medical and social services are also not income for SSI purposes. The rules spelled out in this POMS citation are intricate. When in doubt about how to apply the provisions contained in this reference, contact the local Social Security field office for a formal determination.

- **Food and shelter received during a medical confinement:** Food and shelter a beneficiary receives during a medical confinement aren’t income. A medical confinement exists when an individual receives inpatient medical services in a medical
treatment facility. (See POMS SI 00815.100: Food and Shelter Received during a Medical Confinement.)

- **Personal services performed for an individual:** Personal services a person or persons perform for an eligible individual aren’t income. Examples of personal services would include mowing the lawn, doing housecleaning, going to the grocery store, and babysitting. (See POMS SI 00815.150: Personal Services.)

- **Receipts from the sale, exchange, or replacement of a resource:** Receipts from the sale, exchange, or replacement of a resource aren’t income, but are simply resources that have changed their form. This includes any cash or in-kind item that replaces or repairs a resource that has been lost, damaged, or stolen. (See POMS SI 00815.200: Conversion or Sale of a Resource for more information on this issue.)

- **Rebates, refunds, or other returns of money:** Generally, when an individual receives a rebate, refund, or other return of money, it’s not income but a return of an individual’s own money. Some rebates don’t fit that category, so when questions arise, seek assistance from the local Social Security field office. (See POMS SI 00815.250: Rebates and Refunds.)

- **Income tax refunds:** Any refund on income taxes an individual already paid isn’t income. This rule applies even if the beneficiary received income from which the tax was withheld or paid was received in a period prior to application for SSI benefits. Income tax refunds aren’t income, even if Social Security already excluded the income taxes as work expenses of the blind. (See POMS SI 00815.270: Income Tax Refunds.)

- **Proceeds of a loan:** Proceeds of a loan aren’t income to the borrower because of the borrower’s obligation to repay. Likewise, money that a person borrows under a bona fide loan agreement isn’t income. Money a person receives as repayment of the principal of a bona fide loan is also not income. A bona fide agreement is an agreement that is legally valid and made in good faith. If a loan isn’t bona fide, the cash provided by the lender is the borrower’s unearned income in the month received. If a loan isn’t bona fide, payments towards the principal and
interest are unearned income to the lender. Effective July 1, 2004, interest received on money loaned is excluded from income if the loan is bona fide. (See POMS SI 00815.350: Proceeds of a Loan and SI00830.500 Dividends and Interest.)

- **Payment of an individual’s bills**: Payment of an individual’s bills (including supplementary medical insurance or other medical insurance premiums) by a third party directly to the supplier isn’t income. However, anything a beneficiary received in-kind as a result of the payment is income if it’s food or shelter. (See POMS SI 00815.400: Bills Paid by a Third Party.)

- **Replacement income after a loss, theft, or destruction**: If an individual’s income is lost, stolen, or destroyed and the individual receives a replacement, the replacement isn’t income per POMS SI 00815.450: Replacement of Income Already Received. Similarly, a payment isn’t income when the individual is aware that he or she isn’t due the money and returns the check un-cashed or otherwise refunds all of the erroneously received money. (See POMS SI 00815.460: Return of Erroneous Payments.)

- **Weatherization assistance**: Weatherization assistance such as insulation, storm doors, and windows, etc. isn’t income for SSI purposes per POMS SI 00815.500: Weatherization Assistance.

- **Miscellaneous fringe benefits**: Employers make various payments on behalf of their employees that aren’t earnings and aren’t available to meet food or shelter needs. Social Security doesn’t consider these types of payments to be income and include funds the employer uses to purchase qualified benefits under a cafeteria plan, employer contributions to health insurance or retirement fund, and the employer’s share of FICA taxes or unemployment compensation taxes. (See POMS SI 00815.600 Wage-Related Payments.)

- **Clothing**: As a result of a change in regulations, effective March 9, 2005, Social Security eliminated clothing from the definition of unearned income. As a result, Social Security generally won’t count gifts of clothing as income when deciding whether a person can receive SSI benefits or when computing the amount
of the benefits. There is one situation where Social Security considers clothing as income. This situation could occur when an individual receives clothing from an employer that would count as a form of wages.

Complete information about what Social Security doesn’t count as income in the SSI program can be found in the POMS starting with SI 00815.000 - What Is Not Income, this is found online (https://secure.ssa.gov/apps10/poms.nsf/lnx/0500815000).

**How SSI Treats Earned Income**

Earned income is any cash or in-kind item that a beneficiary receives in exchange for work performed or as remuneration for work effort. Earned income includes the following types of payments:

- **Wages:** An individual receives these payments (before deductions like taxes) for working as someone else’s employee. Wages may include salaries, commissions, bonuses, severance pay, military basic pay, sheltered workshop earnings, and any other special payments a person receives because of their employment. Social Security counts GROSS earnings from wage employment, which means before it takes out any taxes or other deductions. Social Security counts earned income at the earliest of three points; when the person receives it, or when it’s credited to his or her account, or set aside for his or her use. Social Security determines earned income for each calendar month.

- **In-kind Earned Income:** This would include the value of food or shelter, or other items an individual receives instead of cash in exchange for work performed. The most common type of in-kind earned income is when an employer provides room and board as part of the remuneration an individual receives for live-in employment. Social Security assesses in-kind earned income by applying current market value. If an individual receives an item (instead of cash) that isn’t fully paid for and he or she is responsible for an unpaid balance, Social Security only counts the amount previously paid as income.

- **Net Earnings from Self-Employment (NESE):** This is gross receipts from a trade or business that an individual operates, less allowable deductions. Social Security counts net earnings
from self-employment (NESE) on a taxable year basis. Social Security multiplies the result by .9235 to deduct half of the Social Security taxes paid by self-employed individuals. Generally, Social Security allows the same deductions as the IRS when determining NESE.

**Earned Income Exclusions**

Social Security doesn’t count all earned income when it determines SSI eligibility and payment amount. Social Security first excludes income as authorized by specific federal laws or statutes. Social Security then applies other earned income exclusions to determine the monthly countable income, in the following order:

1. **Earned income tax credit payments** (effective January 1, 1991) and child tax credit payments;

2. **Beginning September 8, 2006, infrequent income.** Infrequent income is defined as income that an individual receives only once during a calendar quarter from a single source, and which the individual didn’t receive in the month immediately preceding that month or in the month immediately subsequent to that month, regardless of whether or not those payments occur in different calendar quarters.

   Social Security excludes the following amount of income received either infrequently or irregularly:
   - The first $30 per calendar quarter of earned income; and
   - The first $60 per calendar quarter of unearned income.

   Refer to POMS SI 00810.410: Infrequent or Irregular Income Exclusion for additional details;

3. **Earned income of a blind or disabled student regularly attending school, who is under the age of 22, up to the student earned income exclusion (SEIE) monthly limit, but not more than the SEIE yearly limit.** For a detailed explanation of the SEIE and how it’s applied, refer to Unit 6 of this module, or refer to POMS SI 00820.510 Student Earned Income Exclusion;
4. Any portion of the $20 monthly General Income Exclusion (GIE), which has not been excluded from unearned income in the same month;

5. $65 of the Earned Income Exclusion (EIE) in the month;

6. Earned income of disabled individuals that they use to pay Impairment Related Work Expenses (IRWE). These are reasonable out-of-pocket costs that are related to the individual’s disability and which are necessary for work. For more information, refer to Unit 6 of this module or see POMS SI 00820.540 Impairment-Related Work Expenses (IRWE);

7. One half of remaining earned income in a month;

8. Earned income of individuals with blindness that is used to meet any expenses the person has related to working, whether or not it’s related to blindness, called Blind Work Expenses (BWE). BWEs include items that would be excluded under the Impairment Related Work Expense (IRWE) rules. In addition, these deductions are any out-of-pocket expenses that are necessary for work. For more information refer to Unit 6 of this module, or see POMS SI 00820.535 Blind Work Expenses (BWE); and

9. Any earned income a beneficiary uses to fulfill an approved Plan to Achieve Self-Support (PASS). PASS is a highly valuable, yet complex work incentive. For a detailed description of the PASS work incentives, refer to Unit 7 of this module or see POMS SI 00870.000 - Plans to Achieve Self-Support for Blind or Disabled People.

The unit provides a partial listing of the most common forms of earned income and earned income exclusions. For more detailed information, refer to POMS 00820.000 - Earned Income Subchapter Table of Contents found online (https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820000).

**How SSI Treats Self-Employment Income**

Social Security counts net earnings instead of gross earnings when determining the SSI payments for an individual who is self-employed. To determine the Net Earnings from Self-Employment (NESE), Social
Security reviews the individual’s Federal income tax returns for the “Net Profit or Loss” amount on Schedule SE, C, C-EZ or F. Social Security may also look at business records and can accept the individual’s allegation of NESE, if no other evidence can be obtained. Social Security divides the NESE amount equally among all 12 months in the taxable year (i.e., the calendar year), even if the business is seasonal, didn’t operate for the entire year, or ceased operation prior to applying for SSI. Social Security adjusts benefit payments retroactively for the entire calendar year based on the NESE amount.

After the initial year of self-employment, Social Security generally uses the person’s completed tax returns from that first year to estimate the total net profit for the coming year and will adjust the SSI payments prospectively over the entire year based upon this estimate. From that point forward, at the end of each year, SSI recipients submit their tax returns to Social Security so that it can compare the actual NESE to what the person estimated. Social Security will adjust the SSI payments retroactively to account for any variance between what the person estimated and what the person actually reported to the IRS as taxable profit. It’s essential that SSI recipients who are self-employed make their estimates as early and accurately as possible to avoid large under or overpayments. As the year progresses, individuals may revise their estimates if Social Security finds earlier estimates too low or too high. The more accurate the estimate, the less self-employed SSI recipients will owe back to or be owed by Social Security when the tax year closes.

**NESE and SSI Calculations:** Social Security counts net earnings from self-employment (NESE) on a taxable year basis. It normally averages NESE over the calendar year in which the business operated, regardless of how long the business was in operation.

**Example of NESE and SSI calculations:** Elizabeth started her business in October 2018. Her NESE for the year was $6,000. Even though Elizabeth didn’t start the business until late in the year, Social Security would average her NESE over the calendar year: $6,000 divided by 12 = $500. Elizabeth would have $500 per month in NESE for the purposes of SSI benefit calculations for every month in 2018.
Earned Income Limits

For an SSI recipient whom Social Security has already found eligible for benefits, Social Security treats his or her earnings in the manner described above and gradually reduces the SSI check as countable earnings increase. Even when countable earnings are high enough to cause complete loss of the SSI cash benefit, individuals may retain SSI eligibility and Medicaid coverage under a special work incentive known as “1619(b) Medicaid While Working.” To qualify for extended Medicaid under the 1619(b) provision, individuals must continue to meet Social Security disability standard, must have earned income below a special annual threshold amount (which varies by state), must demonstrate a need for Medicaid coverage and must continue to meet all other SSI eligibility requirements such as the unearned income limits and the resource limits. For more information on 1619(b) Medicaid While Working, see Unit 1 of Module 4, “Understanding Medicaid.”

How SSI Treats Unearned Income

The definition of unearned income is very simple. Social Security describes unearned income as any cash or in-kind item a person receives that isn’t earned income. Common forms of unearned income would include the following:

- **Periodic public payments or private annuities or pensions:** These payments are usually related to prior work or service (Social Security benefits, veteran’s benefits, Railroad Retirement benefits, Worker’s Compensation, Unemployment Compensation, etc.).

- **Income of a spouse or parent (for SSI recipients under the age of 18):** Social Security “deems” a portion of spousal income or parental income for SSI recipients under 18 to be available to the SSI recipient. Deeming is a very complex SSI issue and recipients who are married or who are under age 18 need to have deemed income determined by Social Security personnel.

- **Alimony and child support payments:** For SSI purposes, alimony and support payments are cash or in-kind contributions to meet some or all of a person’s needs for food and shelter. These periodic payments may be court ordered or voluntary. Alimony or spousal maintenance is the unearned income of the
adult named in the court order. Generally, Social Security counts child support payments (including arrearage payments) a parent makes on behalf of an SSI-eligible child as unearned income to the child. For SSI recipients under age 18, Social Security excludes one-third of the amount of a child support payment made to or for an eligible child by an absent parent. This one-third exclusion does NOT apply to adults who receive child support payments. Social Security credits child support, or child support arrearages, differently once the child reaches adulthood. (See POMS SI 00830.420.)

- **Rental payments:** Social Security considers rental payments for things such as housing and the use of land or machinery to be unearned income in most cases. Social Security will only count the value of rental payments after the beneficiary deducts expenses related to the rental properties. Social Security makes these determinations on a taxable year basis. In some cases, Social Security determines rental income to be earned income if the SSI recipient is in the business of renting property or equipment. When in doubt about whether Social Security would consider rental income earned or unearned, seek a determination from the local Social Security field office. (See POMS SI 00830.505 Rental Income)

Although Social Security may exclude some types of unearned income completely, the SSI program has only one standard deduction allowed for unearned income — the $20 General Income Exclusion (GIE). Social Security subtracts the $20 GIE from the monthly income attributable to the individual. For individuals whose only income is unearned income, the remaining amount — after the $20 GIE — is subtracted from the FBR. This means that most unearned income results in almost a dollar-for-dollar reduction in the SSI cash payment.

**The Most Common Form of Unearned Income – Title II Disability Payments**

When an SSI recipient is also eligible for a Social Security benefit authorized under Title II, the individual will receive two separate payments each month. These individuals are known as “concurrent beneficiaries” because they receive SSI benefits and Title II benefits concurrently. Here are some examples of how concurrent status occurs:
• Beneficiaries who receive monthly SSDI/CDB/DWB payments that are less than the current FBR may be eligible for an SSI benefit that augments their Title II cash payments, provided they meet all other SSI eligibility criteria.

• SSI beneficiaries who work can establish “insured status” and eventually become entitled to Title II disability benefits. This can happen very quickly for young beneficiaries and beneficiaries who meet the definition of statutory blindness. If the countable SSDI benefit is more than the current applicable FBR, the person’s SSI will stop, but if the benefit is below the SSI FBR plus the $20.00 GIE, the person will get reduced SSI benefits and become a concurrent beneficiary.

• An SSI recipient may become a concurrent beneficiary when a parent retires and collects Social Security, dies, or becomes entitled to Social Security disability benefits. These events could cause the SSI-eligible individual to establish entitlement for Childhood Disability Benefits (CDB). If that occurs, Social Security first makes the CDB payment and provides a reduced SSI if the countable CDB payment is less than the applicable FBR and the beneficiary meets all other SSI eligibility criteria.

• If an individual receives a Title II disability benefit, and then becomes entitled to SSI through use of a PASS, that individual also becomes a concurrent beneficiary.

The SSI program views the Title II payment as a form of unearned income. The $20 GIE reduces the gross unearned income (Title II payment), and the remaining balance is subtracted from the individuals’ applicable FBR to determine the adjusted SSI cash payment.

It’s important to remember that Social Security considers SSI to be the payer of last resort. If an individual is eligible for any other Social Security benefit, Social Security must access that benefit first, before considering SSI. If the amount of the Title II payment is low enough, a beneficiary may receive a reduced SSI payment as long as the individual meets all other SSI eligibility criteria. SSI recipients or applicants cannot refuse a Title II benefit for which they are eligible in order to receive increased SSI payments. By federal law, Social Security must provide the Title II payment first and then will determine if the individual is still eligible for a reduced SSI benefit.
When Unearned Income Affects SSI Benefits

Social Security counts unearned income when the individual receives it, when the bank credits his or her account, or when the individual sets it aside for use. Social Security determines an individual’s unearned income for each calendar month. In some cases, the unearned income that counts when calculating the SSI payment may be higher or lower than the actual income the person receives. For example, SSI recipients who also receive a Title II disability benefit (such as SSDI) may be paying the Medicare Part B premium. When determining countable income, the SSI program will count the full Social Security disability payment before Medicare premiums are deducted even though the individual doesn’t actually receive that amount to spend.

Another instance when SSI would count more income than the individual actually receives is when funds are withheld from unearned income because of a garnishment or to pay a debt or other legal obligation. For example, if a SSDI beneficiary is entitled to $450 per month in SSDI benefits, but the government garnishes $150 each month to pay for back child support, the individual would only receive $300 each month. For SSI purposes, Social Security will count the full $450 as unearned income.

On the other hand, if an eligible individual is due a cash settlement, Social Security will subtract the expenses the individual incurs in getting the payment, before it uses the remaining amount in the benefit calculation. For example, if an individual receives damages from an accident, Social Security will only count what the person receives after it deducts the amount paid for the individual’s medical, legal, or other expenses connected with the accident.

Unearned Income Exclusions

Social Security must determine the amount and source of all unearned income for SSI eligibility and payment purposes. Many federal statutes, in addition to the Social Security Act, provide assistance or benefits to individuals with little income and few resources. Under these statutes, Social Security may not consider the assistance or benefits as income, when deciding eligibility for SSI. Examples include SNAP, rental subsidies, home energy assistance payments, and educational grants or loans. Because other federal statutes exclude these programs, Social Security never counts them as income for the SSI program.
Social Security applies other unearned income exclusions after the agency deducts all other federal statutory exclusions. Because there are numerous forms of excludable income, and the regulations change regularly to add more, the best advice is to look in the Program Operations Manual Systems (POMS), seek technical assistance from VCU’s NTDC, or check with the local Social Security field office as specific situations arise. Refer to **SI 00830.050 Overview of Unearned Income Exclusions** found online here: (https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830050).

**Other Income Exclusions – Infrequent or Irregular Income**

Beginning September 8, 2006, Social Security defines infrequent income as income an individual receives only once during a calendar quarter from a single source and which the individual didn’t receive in the month immediately preceding that month or in the month immediately subsequent to that month, regardless of whether or not those payments occur in different calendar quarters. For SSI purposes, Social Security will exclude the following amount of income, which the individual received either infrequently or irregularly: the first $30 per calendar quarter of earned income, and the first $60 of unearned income. For more information on how Social Security applies this regulation, see POMS SI 00810.410.

**Income Limits**

The limit for countable income is the current FBR applicable to either the individual, or the SSI-eligible couple. Once Social Security determines how much unearned income to attribute to an individual, the only exclusion that applies to unearned income is the $20 GIE. For example, if an individual receives an Unemployment Insurance benefit in the amount of $400 per month, and no other income exclusions apply, the countable unearned income would be $400 − $20, or $380 each month. Social Security subtracts this amount from the FBR when determining the individual’s SSI eligibility. When countable income exceeds the FBR for the current month, ineligibility for both SSI cash payments and Medicaid will result (unless earned income caused the income to exceed the FBR, in which case the recipient may qualify for 1619(b), which protects Medicaid. We discuss the 1619(b) provisions in detail in Module 4.

You will find a detailed discussion of how SSI treats various forms of income in the VCU NTDC resource document entitled **“How Income Affects SSI Eligibility and Payment Amount,”** online
Deemed Income

When Social Security determines the eligibility and amount of payment for an SSI beneficiary, it also considers the income and resources of people responsible for the recipient’s welfare. This concept is called “deeming” and is based on the idea that those who have a responsibility for one another share their income and resources. Because SSI is a means-tested program, Social security “deems” the portion of income and resources shared with an SSI-eligible person as being available to that person for the purposes of SSI eligibility and payment. It doesn’t matter if the deemor actually provides money to an SSI-eligible individual for deeming to apply.

Deemed Income is Income Attributed to the Beneficiary

Deemed income or resources can cause Social Security to find ineligible an SSI claimant who meets all other SSI eligibility criteria. This may occur at the time of initial application, or at any other point at which a recipient becomes subject to deeming rules (i.e., when a recipient marries).

Three Types of Deeming

Social Security applies deeming only in three specific instances:

- From parents to a child,
- From a spouse to a spouse, and
- From a sponsor to an alien.

Parent-to-Child Deeming only applies to deeming of income and resources from an ineligible parent (or parents) to an SSI-eligible child below the age of 18. If one or both of the parents also receives SSI cash payments, then deeming does NOT apply. Once the child reaches age 18, deeming of income and resources from the parent(s) no longer applies under any circumstances. Generally, the child needs to live with the parent(s), but there are some exceptions to the rule (e.g., a child away at school but under parental control).

Spouse-to-Spouse Deeming only applies to the deeming of income and resources from a spouse that isn’t eligible for SSI to a spouse that is
eligible for SSI. If both members of a married couple are SSI eligible, another set of rules governing eligible couples applies. We will discuss eligible couples in more detail later in this module.

Generally, spouse-to-spouse deeming applies only when the two spouses live together in the same household, but there are some exceptions. Under some circumstances, Social Security may treat individuals who aren’t legally married as a married couple for the purposes of deeming.

**Sponsor-to-Alien Deeming** only applies to the deeming of income and resources from an ineligible individual (and the individual’s ineligible spouse if the individual is married) who sponsors an alien’s legal entry into the United States. Deeming applies whether or not the alien lives with the sponsor.

**Deeming Computations**

Deeming computations are very complex and are beyond the scope of this manual. However, it’s important for CWICs to understand that income belonging to a spouse, a parent, or an alien sponsor may affect entitlement or payment amount for an SSI beneficiary who is the child, spouse, or sponsored alien. Social Security can deem both resources (see resource discussion later in this unit) and income. There are also special exclusions for some types of resources and income that apply to deeming. Social Security makes deeming determinations at initial application and during redeterminations. Though CWICs should understand that deeming could occur, only Social security personnel can determine the amount of deemed income or resources.

For more information, refer to several VCU NTDC resource documents on deeming found online (https://vcu-ntdc.org/resources/resourceDetail.cfm?id=1)

There are three briefing papers on the subject of deeming posted on this website. One covers deeming basics, one focuses on spouse-to-spouse deeming, and the third describes parent-to-child deeming.

**In-kind Support and Maintenance (ISM)**

Because Congress intended SSI to cover the basic costs of food and shelter, if an SSI recipient receives food or shelter from another person, Social Security will consider these gifts to be unearned income. The
specific type of unearned income is called “in-kind support and maintenance” or ISM. In-kind support and maintenance or ISM is unearned income in the form of food or shelter that an eligible individual receives a gift or because someone else pays for it.

**Determining the Value of In-kind Support and Maintenance**

When determining the value of ISM, Social Security applies one of two basic rules:

1. The Value of the One-Third Reduction Rule (VTR), or
2. The Presumed Maximum Value Rule (PMV).

These rules are mutually exclusive, meaning that Social Security may only apply one at any given time. Social Security personnel follow policies about exactly when each of these rules they should apply, and these policies relate to what specific type of living arrangement in which the beneficiary resides.

The Value of the One-Third Reduction (VTR) rule applies when the eligible individual lives in another person’s household for a full calendar month and receives both food and shelter from that person. When the VTR rule applies, Social Security reduces the SSI payment by a full one-third of the current applicable FBR. When Social Security values ISM under the VTR rule, it actually results in a one-third reduction in the beneficiary’s base SSI rate. Because SSI is intended to pay for the basic living expenses of food and shelter, it stands to reason that Social Security would reduce the payment if someone else were paying a portion of the individual’s food and shelter expenses.

**Example of VTR rule:**

Ann and Mustapha (an SSI recipient) decide to live together in an apartment that Ann is renting. Ann neither charges Mustapha rent, nor does he pay for any of his food. Because he lives in the household of another person who is providing him with both food and shelter, Social Security values Mustapha’s ISM under the VTR rule.

Social Security applies the Presumed Maximum Value (PMV) rule when an eligible individual receives ISM and the VTR rule doesn’t apply, meaning that the eligible individual doesn’t live in the household of another person
and doesn’t receive both food and shelter from the household. Under the PMV rules, Social Security will determine the household expenses, then figure out how much of these expenses represent the SSI recipient’s “pro-rata” share. Next, Social Security will ask the individual how much he or she actually pays to the householder and will subtract that amount from the pro-rata share of expenses. Social Security counts the difference as in-kind support and maintenance up to a presumed maximum value of one third of the current FBR plus the $20. If the actual value of in-kind support and maintenance is LESS than the “presumed maximum value,” Social Security will count that lower figure to adjust the SSI payment. Under the PMV rule Social Security counts in-kind support and maintenance as unearned income when it calculates the SSI benefit amount. ISM determinations Social Security makes under the PMV rule are “rebuttable.” This means the eligible individual can ask to rebut the ISM determination made by Social Security.

Under the PMV rule, Social Security may consider the actual value of ISM and count it as unearned income. If the contributions to the SSI beneficiary’s or eligible couple’s food or shelter exceed the cap discussed previously, Social Security limits how much of the food or shelter counts against the person’s SSI. If the item of food or shelter is small and infrequent, then Social Security may exclude the item entirely from consideration as unearned income under the infrequent or irregular income exclusion previously discussed.

**Example of ISM:**

Jose, who lives alone, receives assistance with food from his friend Ann. She gives him $150 worth of groceries each month. Jose has no other income from any other source, other than SSI. To estimate Jose’s countable ISM, subtract the $20 General Income Exclusion (GIE) from the $150 in unearned income Jose receives to determine Jose’s countable income. Jose receives $130 in countable ISM. Subtract this amount from the current FBR for an individual to determine Jose’s SSI payment.

If the unearned income value of the beneficiary’s or eligible couple’s ISM is high enough, Social Security will cap the amount that counts against the SSI beneficiary. This cap is called the Presumed Maximum Value (PMV) and it provides some protections for SSI beneficiaries who receive help with food or shelter. The PMV is always one-third of the applicable...
Federal Benefit Rate + $20. This is the maximum amount at which Social Security could value the ISM. The PMV rule guarantees that if the beneficiary contributes some portion of the cost of food and shelter, he or she will not be penalized more than would be the case if nothing were contributed.

**Example of PMV rule:**

Instead of giving Jose $150 in groceries, Ann decided to buy $500 in groceries for Jose the next month. Although Social Security considers groceries to be unearned income, the PMV rule decreases the effect on Jose’s benefits. The PMV caps the value Social Security places on the ISM at the “presumed maximum” of one-third of the FBR plus the $20 GIE. Even though Jose is receiving far more in groceries than he was before, Social Security capped the value of the ISM. Social Security will not reduce Jose’s check any more than it would have been under the VTR rule — one third of the FBR.

ISM determinations can be very complex, and inexperienced WIPA personnel often misunderstand them. When in doubt, refer ISM computations to the local field office.

For more information on this subject, refer to the VCU NTDC resource document titled “**Understanding In-Kind Support and Maintenance**” found online (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=19).

**Reporting Income in the SSI Program**

The Social Security Administration requires all SSI recipients to report any and all income when it’s received. This requirement applies equally to earned income such as wages and unearned income such as child support or Workers’ Compensation payments.

In the SSI program, many things can affect a recipient’s eligibility for benefits as well as the amount of SSI payment he or she receives. The following list represents the most common information that recipients should report to Social Security, but there may be other items an individual should report based upon his or her unique circumstances:
• Unearned income including things like Title II benefit payments, child support payments, or any other cash he or she receives that isn’t wages.

• Any gross wages or earnings and net earnings from self-employment. This includes in-kind items he or she receives in lieu of wages (like room and board).

• In-kind support and maintenance he or she receives from others. This includes any assistance with food and shelter provided by another person.

• Change of address.

• Changes in living arrangements.

• Changes in marital status.

• Resources or assets near or at the SSI resource limit of $2,000

• Use of any specific work incentives.

When in doubt about whether or not a recipient should report a piece of information it’s best to recommend that the beneficiary go ahead and inform Social Security about it. If the information isn’t relevant, then no harm has been done. If the information is relevant, then reporting will help ensure that Social Security pays benefits only when they are actually due and that the amount of the SSI cash payment is correct. It’s always best to work proactively to avoid over or underpayments whenever possible.

SSI recipients can report relevant information by visiting, calling, or writing the local Social Security office (https://secure.ssa.gov/ICON/main.jsp). Individuals may report earned income by using the automated toll-free SSI Telephone Wage Reporting Service (https://www.ssa.gov/ssi/spotlights/spot-telephone-wage.htm), the free SSI Mobile Wage Reporting Smartphone app, or the “my Social Security” online wage reporting tool at www.ssa.gov/myaccount.

More information about options for reporting is available at Social Security’s website (https://www.ssa.gov/benefits/ssi/wage-reporting.html).
How Social Security Verifies Income—Periodic Redeterminations

Social Security conducts periodic SSI redeterminations for all SSI recipients. A redetermination is a review of a beneficiary’s or couple’s non-medical eligibility factors such as income, resources, and living arrangements to be sure they are still eligible for and receiving the correct SSI payment. Social Security conducts SSI redeterminations at periodic intervals that may vary depending on the likelihood of payment error that may affect an individual’s or couple’s SSI eligibility and payment amount. Generally, Social Security conducts a redetermination for SSI recipients at least once per calendar year.

During the redetermination, Social Security personnel examine income available to the SSI recipient on a month-by-month basis over the entire period since they conducted the last redetermination and determined how much in SSI payments the recipients were actually due. Social Security then compares this information to the monthly SSI payments the recipient received, and calculates any differences. It’s not at all uncommon for there to be either an overpayment or underpayment which Social Security must settle. When Social Security recovers an overpayment from an individual, they will typically withhold it from future SSI payments. By federal statute, Social Security isn’t permitted to withhold more than 10 percent of the current SSI FBR for recovery of overpayments without consent.

Social Security also receives information from other sources. When possible, Social Security will verify relevant information from other sources to ensure eligibility, and confirm that payment amounts are correct. There is usually a delay between the month an individual receives income, and the month income is reflected in the SSI payment. This is because the SSI program uses a system called Retrospective Monthly Accounting (RMA) to figure payment amounts. In most cases, RMA methods will cause a 2-month gap between when an individual actually received other income and when Social Security adjusted the SSI check to reflect this income. As previously stated, however, Social Security makes SSI eligibility determinations using the current month’s income. It’s only during SSI payment computation that Social Security uses RMA procedures.

For more information about the redetermination process in the SSI program, refer to POMS SI 02305.000 Redeterminations of
Eligibility and/or Payment Amount found online (https://secure.ssa.gov/apps10/poms.nsf/lnx/0502305000).

A Closer Look at Retrospective Monthly Accounting

Social Security calculates SSI payments for a given month based on circumstances from an earlier, closed month. This is known as Retrospective Monthly Accounting (RMA). RMA has two elements:

- The income eligibility test, which is based on the individual’s or couple’s income, in the month for which the payment calculation is made; and
- The payment computation, which is generally based on the income received two months before the month for which payment is being computed.

Eligibility is for the current month and applies to that month, but Social Security usually bases an individual or couple’s SSI payment on the income received two months earlier. Note: RMA is an income computation. Other factors of eligibility don’t apply; Social Security considers them separately.

Budget Month and Eligibility Month

Social Security personnel check to see if the person is eligible and due a payment whenever they calculate SSI benefits. In most circumstances, Social Security looks at the month the person will receive the payment as the eligibility month, and the month two months prior to the eligibility month as the budget month. If the SSI recipient isn’t eligible in a given eligibility month, even if he or she was in the budget month, the recipient isn’t due a payment.

Example of determining SSI eligibility:

Billie didn’t have any income in January through May of the current year. On June 5, Billie won $900 in the lottery. Even though Billie had no income in June’s budget month of April, she is ineligible for SSI payments in June because of her excess unearned income.

Transitional Computation Cycle

There are certain circumstances in which Social Security doesn’t apply RMA because it isn’t possible to use the month occurring two months
prior to the computation month as the budget month. This may occur when an individual becomes eligible after a period of ineligibility. In these instances, Social Security uses the Transitional Computation Cycle (TCC) to determine which month to use as the budget month. The TCC uses the first month that the individual becomes re-entitled after a period of suspension as the budget month for that month and for the next two months. Therefore, if a person isn’t due an SSI payment in a given month, the first month that the person is again eligible for SSI is the budget month for itself, and for the next two months.

Example of determining SSI eligibility:

Sharon received an inheritance in August that made her ineligible for SSI. In September and October, she still had more than $2,000 of the inheritance as a resource, and was ineligible for SSI in those months. In October, Sharon bought the small condo she has been renting with the inheritance as a down payment. Because the condo is Sharon’s residence, it’s excluded as a resource for SSI. Sharon is again due SSI for the month of November. Sharon worked in November and earned $275.

Because of the RMA provision, Social Security will calculate Sharon’s SSI for November, December, and January using November’s income. This is called the Transitional Computation Cycle (TCC). Sharon’s payment in February will use December’s income. From that point on, Social Security will base Sharon’s SSI payments on the usual RMA cycle. That means that the budget month will be the closest month occurring two months before the Computation, or payment month.

The Importance of RMA

It’s valuable to understand and be able to explain RMA to SSI recipients. Without that information, it may be difficult to plan for fluctuations in monthly income that occur because of the Retrospective Monthly Accounting provision.

Example of determining RMA:

Stella works and receives SSI. In June, she earns $285. In August she earns $435. Because of RMA, Social Security
bases Stella’s August payment on her June, not August earnings. In this situation, Social Security would call June the “budget month” for RMA.

It’s helpful to remind SSI recipients that there is a delay in the effect earnings have on the cash benefit. Stella, for example, will have extra to live on in August because her earnings were higher and Social Security based her SSI on June’s lower earnings. In October, however, when Stella doesn’t have work income, Social Security based her SSI payment on August and she has much less income in the month for her living expenses. This fluctuation, if not anticipated, can leave someone without enough funds to pay living expenses in a given month.

The Retrospective Monthly Accounting provisions are complex and often confusing. It helps to keep the following facts in mind:

- For most types of income, there is a two-month lag between a person’s income and its effect on SSI payment.
- When payments start up, there is a period of up to three months where the payment amount won’t fluctuate with changes in earning, but instead Social Security will base the payment on the same budget month’s earnings for three months of payments.
- Once that cycle has passed, the SSI program resumes the rhythm of determining benefit payment amounts by calculating the benefit based on a month that occurred two months before the payment month.

**WARNING about Income Determinations**

Income determinations within the SSI program are one of the most complex aspects of administering these benefits. No matter what type of income a SSI recipient has, only Social Security can make the final determination as to when and how it counts. This manual only touches on the broadest concepts regarding what counts as income for SSI purposes, and provides very general information about how Social Security treats various types of income. For determinations on specific types of income, it’s always best to seek assistance from the local Social Security field office.
For more information on this subject, see the VCU NTDC resource document entitled “Retrospective Monthly Accounting” found online (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=4).

How Resources Affect SSI

As explained earlier, SSI is a means-tested program intended for aged, blind, or disabled people who have little income and few resources. Both income and resources affect SSI eligibility, but unlike income, resources don’t affect the amount of the SSI payment.

The basic definitions of income and resources applicable to the SSI program are as follows:

**Income** is defined as any item an individual receives in cash or in-kind that can be used to meet his or her need for food or shelter. Social Security counts any income an eligible individual receives for SSI purposes in the actual calendar month the person receives it.

**Resources** are defined as cash and any other personal property, including any real property, that an individual (or spouse, if any):

- Owns;
- Has the right, authority, or power to convert to cash (if not already cash); and
- Isn’t legally restricted from using for his or her support and maintenance.

Social Security determines SSI eligibility with respect to resources as of the first moment of each calendar month, and it applies to the entire month. Subsequent changes in resources within the month have no effect until the following month’s resources determination. In the SSI program, resources eligibility (or ineligibility) exists for an entire month at a time. If countable resources don’t exceed the statutory limit, they have no effect on the amount of an individual’s SSI payment. If countable resources do exceed the limit, an individual (or couple) isn’t eligible for an SSI payment.
Some items may count as both income and resources. For example, someone who wins the lottery would have income the month he or she receives the cash payoff. If the individual doesn’t spend the money by the first day of the next month, the winnings become a countable resource for that month and for any additional months in which the individual retains the funds.

**Resource Limits in the SSI Program**

To be eligible for SSI, an individual’s countable resources must not exceed $2,000 as of the first moment of a given month. For an eligible couple (two SSI recipients married to each other or presenting themselves to the community as married and living together) the combined countable resources of the members must not exceed $3,000. If countable resources are above the limit as of the first of the month, the individual (or couple) isn’t due an SSI payment or associated Medicaid coverage for that month. If an individual has excess resources for more than 12 consecutive months, he or she would have to file a new SSI claim in order to receive SSI and provide evidence that his or her resources are below the statutory the limit.

In some cases, the resources that a family member has might make an individual ineligible for SSI. If a person who is eligible for SSI is married, Social Security assumes that the ineligible spouse shares his or her resources with the eligible spouse. If a child under age 18 lives with his or her parent(s), Social Security may count part of the parents’ resources when determining the child’s eligibility. This is called “deeming” of resources.

**Resource Determinations**

Social Security conducts periodic SSI redeterminations for all SSI recipients. A redetermination is a review of a recipient’s or couple’s non-medical eligibility factors such as income, resources, and living arrangements to be sure they are still eligible for and receiving the correct SSI payment. Social Security conducts SSI redeterminations at periodic intervals, which may vary depending on the likelihood of payment error (i.e., fluctuating wages). During the redetermination, Social Security examines resources available to the SSI recipient at the beginning of each month. If the countable resources are too high, then no SSI payment is due. Remember that eligibility with respect to resources is a determination Social Security makes at the beginning of
each month for the entire month. Thus, changes in resources during a month don’t count until the beginning of the next month.

**Common Resource Exclusions**

Not everything a person owns meets the SSI definition of a resource, and not all resources count against the statutory limit. The Social Security Act and other federal statutes require the exclusion of certain types and amounts of resources. Below is a list of some types of resources that Social Security excludes under the SSI program.

- Household goods and personal effects;
- Medical devices and adaptive equipment;
- Some life insurance policies;
- The home in which the beneficiary lives;
- An automobile used for transportation;
- Some burial funds, burial spaces, and life insurance assigned to funeral provider;
- Student financial assistance received under Title IV of the Higher Education Act of 1965 (HEA) or Bureau of Indian Affairs (BIA) including Pell grants and Work-Study grants;
- Certain Individual Development Accounts (IDAs);
- ABLE account balances up to and including $100,000; and
- Some trusts.

This isn’t a comprehensive list, and the rules governing some resource exclusions are complex. When in doubt, CWICs should consult the Social Security Program Operations Manual System (POMS), contact their VCU NTDC technical assistance liaison, or contact Social Security for clarification. The POMS citation listing resources exclusions is [SI 01110.210 Excluded Resources](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501110210), and you can find it online at (https://secure.ssa.gov/apps10/poms.nsf/lnx/0501110210)

**Work Incentives that Create Excluded Resources**

The SSI program contains several special provisions that allow individuals to set aside resources to use in achieving an occupational goal, or to use as part of a business or are necessary for self-support. These complex
provisions generally require help from Social Security personnel or WIPA professionals to claim and manage. A brief explanation of these provisions is provided below:

**Plan to Achieve Self-Support (PASS)**

One of the most powerful work incentives SSI recipients may access is a Plan to Achieve Self-Support (PASS). A PASS is a formal plan to achieve a vocational goal. To develop a Plan to Achieve Self-Support, the person must have a feasible vocational goal, money other than SSI to set aside in the PASS, and expenses necessary to meet the goal. Individuals writing PASS plans may contribute some or all of their countable income. Individuals may also contribute cash resources to the PASS. Funds set aside in a PASS are excluded as either income or resources for the duration of the PASS. PASS is discussed in detail in Unit 7 of this module.

**Property Essential to Self-Support (PESS)**

Social Security excludes certain resources or property that an individual or eligible couple needs for self-support. Property Essential to Self-Support (PESS) may include property used in a trade or business, non-business income-producing property, and property used to produce goods or services essential to an individual’s daily activities. There are different rules for considering property essential to self-support depending on whether it’s income producing or not. Resources excluded under this provision generally fall into three categories as described below:

1. **Business Property or Property of an Employee:**
   Effective May 1, 1990, Social Security excludes all property a beneficiary uses in the operation of a trade or business as property essential to self-support. For self-employed individuals, this includes inventory, the building where the business is housed, and cash used in operating the business, regardless of value. The beneficiary must be currently using the property as defined by Social Security. The business must be unincorporated and active. Social Security also excludes personal property used by an employee for work such as tools, safety equipment, or uniforms. Social Security excludes these items whether or not the employer requires that the employee have them, provided that the SSI recipient or applicant is currently using them for work.
2. **Non-Business Property Used to Produce Goods or Services Essential to Daily Activities:** Social Security excludes up to $6,000 of the equity value of non-business property used to produce goods or services essential to daily activities. An example might be a plot of land that the family uses to produce vegetables for their own use. Another example might be livestock intended for the family’s dinner table.

3. **Non-Business Income-Producing Property:** Finally, Social Security excludes up to $6,000 of the equity value of non-business income producing property from resources if it produces a net annual income of at least 6 percent of the excluded equity. If the equity is greater than $6000, Social Security will count only the amount over $6,000 toward the allowable resource limit. An example of this type of property is rental property.

**Transfers of Resources**

Social Security not only looks to see what resources an applicant or SSI recipient has, but also whether the person has transferred any countable resources to another person in the recent past. Depending on how the person transferred the resources, Social Security may determine the transfer to be valid or invalid.

**Invalid Transfers**

As of December 14, 1999, giving away or transferring a resource for less than fair market value can result in a period of ineligibility for SSI for up to 36 months. The number of months of ineligibility depends on the value of the resource that the person gave away, but can’t exceed 36 months.

The length of ineligibility depends on the value of the resource the person transferred.

For initial claims, Social Security will ask all SSI applicants if they transferred any resources within 36 months before the date of filing for SSI. In SSI redeterminations, Social Security will ask SSI recipients if they transferred any resources since the last Social Security review.

Social Security will compute the period of ineligibility using the following rules:
1. First, it will determine the total difference between the actual value of any resources a person sold or gave away with what the person received for the resource.

2. Next, it will divide that value by the full amount of current SSI Federal Benefit Rate plus the full amount of the state supplementary payment (if any) based on the individual’s living arrangement.

The result of this calculation represents the number of months the person will be ineligible to receive an SSI payment, up to a maximum of 36 months. The calculation is more complex for eligible couples or when spouse-to-spouse deeming is involved.

There are some special circumstances under which Social Security permits transfers that don’t cause SSI ineligibility. They are described below:

**Valid Transfers**

A valid transfer is based on a legally binding agreement. When there is a valid transfer, the individual no longer owns the resource. Both selling a resource and giving away a resource are valid transfers. If an individual sells a resource for what it’s worth (fair market value or FMV), the 36-month period of ineligibility doesn’t apply. However, what the individual or eligible couple receives for the sale may be countable as a resource in the month following the transfer if the couple or individual retains the resource. For example, the individual owns a parcel of land worth $5,000 that isn’t an excludable resource, so he or she isn’t eligible for SSI. If he or she sells the real estate in April and receives $5,000, this money, if he or she retains it, will count as a resource as of May. The individual then would be ineligible for SSI if he or she were over the $2,000 limit.

For more information about resource transfers, refer to [POMS SI 01150.000 Other Resources Provisions Sub Chapter Table of Contents](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501150000) found online.

**Conditional Benefit Agreements**

An individual who meets all other SSI eligibility requirements but is over the resource limit because he or she owns excess non-liquid resources can receive conditional SSI benefits for up to nine months. The individual must agree in writing to sell the excess resources and reimburse Social
Security for the SSI benefits Social Security paid with the proceeds from the sale of the resources. Non-liquid resources are any resources which aren’t in the form of cash or which an individual can’t convert to cash within 20 workdays.

Conditional benefits are payable for up to nine months while an individual tries to sell real property. Real property includes land or buildings. While trying to sell personal property (such as automobiles), an individual can receive conditional SSI benefits for up to three months. Conditional benefit payments are overpayments that an individual must repay.

Conditional benefits can’t begin until Social Security develops, signs, and accepts a “conditional benefits agreement.” To be eligible for a “conditional” exclusion of excess property, an individual must meet the following circumstances:

1. The person’s liquid resources don’t exceed three times the applicable Federal Benefit Rate (FBR).

2. The SSI recipient(s) agrees in writing to:
   a. Sell the resource at current market value within a specified period; nine months for real property, three months for personal property.
   b. Use the proceeds of the sale to repay the overpayment of conditional benefits.

After nine months of an individual trying unsuccessfully to sell excess real property, Social Security will exclude the property as long as the individual continues to make reasonable efforts to sell the property. These payments are regular benefits and the individual doesn’t have to repay them.

**NOTE:** Social Security will permit one three-month extension for disposal of personal property for good cause. Good cause exists when circumstances beyond an individual’s control prevent him or her from taking the required actions to accomplish the reasonable efforts to sell. Examples might be the person not receiving an offer to buy the property, or being incapacitated by illness.
For more information on this subject, see the VCU NTDC resource document entitled “How Resources Affect SSI Eligibility” found online (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=6).

**12-month Suspension Period**

When an SSI recipient loses eligibility for cash payments due to reasons other than earned income, ineligibility for SSI results. Ineligibility will begin the first day of the month in which income or resources exceeds statutory limits or the individual ceases to meet another eligibility factor (e.g., person is incarcerated). While beneficiaries are ineligible for SSI at this time, most aren’t “terminated” from the SSI program. Unless ineligibility was caused by medical recovery, beginning with the first month of ineligibility, individuals begin a suspension period of up to 12 months. The 12-month suspension period is a critically important safety net for SSI beneficiaries, which unfortunately, they may not understand or know about.

A suspension is a loss of SSI cash benefits or 1619(b) Medicaid coverage. It’s always effective the first day of a month in which an individual no longer meets all SSI eligibility requirements. This may be due to excess resources or income (unearned), being incarcerated in a penal institution, no longer meeting the citizenship requirements, or any other non-disability-related reason for ineligibility. Individuals who lose SSI eligibility due to medical improvement are NOT suspended, but are terminated.

The 12-month suspension period generally allows an individual 12 consecutive months after the effective date of a suspension to regain eligibility and have Social Security reinstate their benefits without having to file a new application. Before Social Security can reinstate benefits, the individual must notify Social Security that resources are below the statutory limits and re-establish eligibility for non-pay month(s). There is NO limit to the number of times a recipient may move into and out of suspension status.

CWICs should understand that in the SSI program, suspension isn’t the same as termination. Termination means Social Security has completely closed a person’s record. A person in suspension status isn’t getting benefits, but is still active in the Social Security computer system. The Social Security computer system automatically terminates certain SSI
records after 12 consecutive suspension months. Social Security will give most recipients a written notice when Social Security is close to terminating them (towards the end of the 12-month suspension period).

Loss of SSI eligibility due to medical recovery causes termination, not suspension. Once Social Security terminates a person due to medical recovery, he or she must either appeal to be reinstated, or re-apply for benefits under a new period of entitlement.

For more information about the 12-month suspension period, see POMS SI 02301.205 - Suspension and Reestablishing Eligibility found online (https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301205).

**Eligible Couples**

Social Security defines an eligible couple as two SSI-eligible individuals who are:

- Legally married under the laws of the state where they have a permanent home, or
- Living together in the same household and holding themselves out as husband and wife to the community in which they live, or
- Determined by Social Security to be entitled to either husband’s or wife’s Social Security benefits as the spouse of the other.

Eligible couples only exist when both members of the couple are SSI eligible, not when an SSI-eligible individual is married to an ineligible spouse. For this reason, spouse-to-spouse deeming in which Social Security “deems” income or resources from an ineligible spouse available to the eligible individual never applies to eligible couples.

Eligible couples may exist even when neither member is actually in SSI cash payment status. An example of this would be when both members of an eligible couple are working and in 1619(b) status. The term “eligible couple” only applies to SSI recipients, not beneficiaries of the Title II disability benefit programs (SSDI/CDB/DWB). In some instances, an eligible couple may also be a “concurrent” couple. This means that both members are SSI eligible and one or both also receive a Title II benefit of some type.
Marital Relationships and SSI

Two people don’t need to be legally married in order for Social Security to consider them in a “marital relationship” for the purposes of SSI. The Social Security Act provides that two people, who aren’t legally married, yet who live in the same household are in a “marital relationship” for SSI purposes if they hold themselves out as husband and wife to the community in which they live. This provision is referred to as “holding out” by Social Security. It applies even in states that don’t recognize common-law marriage.

**IMPORTANT NOTE:** Effective June 20, 2014 Social Security has published new instructions that allow the agency to process more claims in which a same-sex relationship affects entitlement or eligibility. These instructions come in response to the Supreme Court’s decision in U.S. vs. Windsor that found Section 3 of the Defense of Marriage Act unconstitutional.

This latest policy development allows Social Security to recognize some non-marital legal relationships as marriages for determining entitlement to benefits. These instructions also allow Social Security to begin processing many claims in states that don’t recognize same-sex marriages or non-marital legal relationships. Social Security consulted with the Department of Justice and determined that the Social Security Act requires the agency to follow state law in Social Security cases. The new policy also addresses Supplemental Security Income (SSI) claims based on same-sex relationships.

To learn more, please visit [www.ssa.gov/people/same-sexcouples](http://www.ssa.gov/people/same-sexcouples)

Social Security usually accepts a person’s allegation about whether a marital relationship exists. However, Social Security will ask a series of questions to decide if a "holding out" relationship exists when circumstances are uncertain. The agency uses Form SSA-4178, Marital Relationship Questionnaire, for this purpose. The form includes questions listed below:
Social Security Marital Relationship Questionnaire

- By what names are you known?
- How do you introduce the other person to friends, relatives, and others?
- How is mail addressed to you and to the other person?
- Are there any bills, installments, contracts, tax returns, or other papers showing the two of you as husband and wife?
- In what name or names are you renting or buying the place where you live?

Social Security considers individuals to be no longer married for SSI purposes as of the date that:

- Either member of the couple dies;
- An annulment or divorce is finalized;
- Either member of the couple begins living with another person as that person’s spouse;
- Social Security decides that either person isn’t a spouse of the other for purposes of husband’s or wife’s Social Security benefits, if Social Security considered the persons married because of that entitlement; or
- The members of a couple whom Social Security determined to be holding themselves out as husband and wife begin living in separate households (with some exceptions).

If members of a couple report to Social Security that their “holding out” relationship has ended, but they remain in the same household for financial reasons, Social Security will request information from the couple supporting the fact they ended the relationship and are making efforts to live in separate households.

Determinations with Eligible Couples

There are some significant differences in the way Social Security treats eligible couples from the way it treats SSI individuals when determining either SSI eligibility or the cash benefit amount. Social Security basically treats two members of an eligible couple as if they were one person. Social Security considers the couple’s combined income (earned and
unearned) when calculating the benefit amount as a couple. In addition, Social Security applies the $20 GIE and the $65 earned income exclusion (discussed in the next unit of this module) only once to a couple, even when both members have income. Social Security also combines and deducts the eligible couple’s work incentives, where appropriate. Finally, Social Security subtracts the total countable income of the couple from the couple FBR (as opposed to the individual FBR) and gives half of the adjusted check to each member of the couple. Social Security refers to these rules as “couple computation rules.”

Social Security also applies different resource limits to eligible couples and eligible individuals when determining SSI eligibility. Currently, countable resources must not be worth more than $2,000 for an individual or $3,000 for an eligible couple. Social Security establishes the value of a couple’s combined resources (both money and property), subtracts all allowable exclusions, and then compares that amount to the $3,000 couple resource limit when making eligibility determinations. Social Security makes these determinations at the beginning of each month and they are applicable for the entire month. Because of this rule, subsequent changes in resources have no effect until the following month’s resource determination.

For the most part, Social Security applies the resource exclusions to eligible couples in the same way they apply them to individuals. However, Social Security tends to treat an eligible couple as if they were one person in certain instances. For example, Social Security would exclude only one home of an eligible couple, even though two people are involved. In addition, Social Security will only exclude one automobile per couple.

For more information on this subject, see the VCU NTDC resource document titled “Eligible Couples” found online (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=21).

**Emergency Advance Payments and Immediate Payments**

Emergency Advance Payments (EAPs) and Immediate Payments (IPs) are two ways to make payments to persons via Third Party Draft who are due disability benefits and have a financial emergency. Emergency Advance
payments are only available to persons whom Social Security has found eligible for SSI. Social Security makes immediate payments to SSI recipients and Title II beneficiaries, as well as to concurrent beneficiaries receiving both SSI and a Title II benefit.

**Emergency Advance Payment (EAP)**

EAPs are expedited payments made by the Social Security field office (FO) Third Party Payment System (TPPS) to an initial SSI claimant who:

- Has a financial emergency, and
- Is eligible for SSI benefits, but whom Social Security has not yet paid on the claim.

A person must be due SSI benefits to receive an EAP; this provision does NOT apply to individuals receiving Title II disability benefits. A person can receive an EAP if he or she will receive SSI benefits based on a finding of presumptive disability or blindness.

A financial emergency exists when the SSI claimant has insufficient income or resources to meet an immediate threat to health or safety, such as the lack of food, clothing, shelter, or medical care. An emergency can exist when a person has liquid resources but can’t access them quickly enough to meet an immediate threat to health or safety. Absent evidence to the contrary, Social Security will accept the individual’s allegation that he or she doesn’t have enough money to meet an immediate threat to his or her health or safety.

For more information about emergency advance payments, refer to the POMS here:

**SI 02004.005 Emergency Advance Payments**
(https://secure.ssa.gov/apps10/poms.nsf/lnx/0502004005)

**DI 11055.245 Emergency Advance Payment (EAP) in Cases of Disability and Blindness**
(https://secure.ssa.gov/apps10/poms.nsf/lnx/0411055245)

**Immediate Payment (IP)**

Social Security established immediate payments (IP) in 1985 to make expedited payments to beneficiaries in dire need of funds faster than the five-to seven-day period required for delivering Treasury-prepared payments. Immediate payments apply to both SSI and Title II
beneficiaries as well as concurrent cases, and Social Security set them up to help individuals who don’t qualify for EAPs. In order for Social Security to even consider making an immediate payment, the case must meet the following criteria:

- **SSI Cases:** There is a delayed payment of an initial claim, delayed or interrupted payments, or non-receipt of an issued payment.

- **Title II Cases:** A payment is due because of a stop-payment action, nonpayment, or a newly processed claim.

To receive an IP, the beneficiary must have an immediate financial need for payment (i.e., a need for food, shelter, medical treatment, etc.) that the person can’t reasonably meet through other resources available in the community. In Title II cases, each beneficiary who meets the requirements may receive an IP, but Social Security must make the payment to that person (or the person’s representative payee) directly (e.g., a father may not receive an IP for his entitled children unless he is their payee). Each child’s payment requires a separate IP.

Social Security considers both EAPs and IPs to be advances against future SSI and Title II disability payments and Social Security must recover them at a later date. There isn’t additional money due the individual. Social Security personnel must make EAPs and IPs when individuals meet the criteria. See the chart below for a comparison of the EAP and IP provisions.

**Comparison of EAPs and IPs**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>EAP</th>
<th>IP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authority</td>
<td>Section 1631(a) of the Social Security Act</td>
<td>Decision by the Commissioner</td>
</tr>
<tr>
<td>SSI or Title II</td>
<td>SSI</td>
<td>SSI and/or Title II</td>
</tr>
<tr>
<td>When</td>
<td>Initial claims only</td>
<td>Initial claims or post eligibility</td>
</tr>
<tr>
<td>Money Limit</td>
<td>Federal Benefit Rate + State Supplementary Payment level</td>
<td>$999 total Title II and SSI</td>
</tr>
<tr>
<td>Criteria</td>
<td>EAP</td>
<td>IP</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
<td>One time per claim</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Recovery</strong></td>
<td>Six monthly installments; or all at once from a retroactive payment</td>
<td>From first regular payment</td>
</tr>
<tr>
<td><strong>Priority</strong></td>
<td>EAP before IP</td>
<td>EAP before IP</td>
</tr>
<tr>
<td><strong>POMS</strong></td>
<td>SI 02004.005</td>
<td>SI 02004.100</td>
</tr>
</tbody>
</table>

For more information about immediate payments, refer to the POMS here:

**SI 02004.100 Immediate Payments (IPs)**
(https://secure.ssa.gov/apps10/poms.nsf/lnx/0502004100)

**RS 02801.010 Immediate Payment (IP) Criteria and Process**
(https://secure.ssa.gov/apps10/poms.nsf/lnx/0302801010)

**Conclusion**

Benefits Social Security pays under Title XVI of the Social Security Act (SSI) are vastly different from the benefits it pays under Title II of the Social Security Act. SSI is needs based; income and resources available to the individual or eligible couple to meet needs for food and shelter affect payment amounts.

The individual’s living arrangement also affects payment amount. If the individual lives with others and doesn’t pay his or her pro-rate share for food and shelter, for example, Social Security reduces the SSI benefit by up to one third.

**Conducting Independent Research**

A rich source for consumer handouts on the SSI program is found in the SSI “Spotlights.” These brief discussions of specific SSI issues make great handouts for beneficiaries. The Spotlights may be found on
the Social Security website (http://www.socialsecurity.gov/ssi/links-to-spotlights.htm)

**Understanding SSI.** This is an excellent online resource that covers all of the important aspects of the SSI program. The current version of this resource is available online (https://www.ssa.gov/ssi/text-understanding-ssi.htm).

**A Guide to SSI for Groups and Organizations.** This is an excellent resource for professionals who work with SSI recipients (www.ssa.gov/pubs/EN-05-11015.pdf).

**The main Table of Contents for the POMS citations pertaining to the SSI program** (https://secure.ssa.gov/apps10/poms.nsf/chapterlist!openview&restricttocategory=05).
Competency Unit 6 – SSI and Work Incentives

Introduction

In the previous unit, we provided very brief information about the calculations used to determine how much a beneficiary’s SSI payment will be for any given month. The calculations are designed to help Social Security determine how much in earned and unearned income is “countable” for a given month. Social Security subtracts this countable income from the beneficiary’s base SSI rate to determine the adjusted monthly payment due. This unit provides detailed information about how Social Security determines countable income in the SSI program and discusses some of the work incentives it uses to reduce countable earned income. CWICs must understand these work incentives in order to assist beneficiaries to access these valuable tools when they go to work.

How Earned Income Affects SSI Cash Payments – SSI Calculation

Social Security personnel apply the standard calculations presented in this unit after they have evaluated all of the income the recipient receives and have applied all other allowable exclusions or disregards. In Unit 5, a great deal of information was provided about specific types of unearned income that Social Security disregards when making SSI eligibility determinations and when calculating how much in SSI cash payments is due. Social Security applies additional disregards to earned income before the standard calculations, including:

- Earned income tax credit payments and child tax credit payments;
- Up to $30 of earned income in a calendar quarter if it’s infrequent or irregular.
**Earned Income Exclusions in the SSI Program**

The work incentives listed in this section are in the order they appear in the SSI payment calculation, and federal regulation determines this order. Performing the calculations in order is essential to providing a reasonably accurate estimate of the monthly SSI payment to beneficiaries. Remember, only Social Security can ultimately decide if any of these work incentives apply. The CWIC can only assist the beneficiary to estimate the effect of work on SSI payments. The earned income exclusions applicable to SSI benefits are as follows:

- **Student Earned Income Exclusion (SEIE):** Exclusion of income for individuals who are under age 22 and regularly attending school.

- **General Income Exclusion (GIE):** $20 exclusion of any kind of income, earned or unearned, that an SSI beneficiary has. If the SSI beneficiary has no unearned income, or has less than $20 in unearned income, Social Security may deduct the remainder of the $20 exclusion from the person’s gross earnings.

- **Earned Income Exclusion (EIE):** Social Security excludes the first $65 of earnings after it subtracts the applicable Student Earned Income Exclusion (SEIE) or General Income Exclusion (GIE).

- **Impairment Related Work Expenses (IRWEs):** Social Security defines IRWEs the same way under the SSI program that it defines them under the Title II program. However, Social Security uses the deduction differently in the two programs. In the Title II program, Social Security uses IRWEs to assess the value of work to determine if it represents Substantial Gainful Activity (SGA). In the SSI program, IRWEs are a means to increase the SSI payment in order to partially reimburse individuals for the out-of-pocket expenses that relate to working.

- **The 1/2 earnings exclusion or the “one-for-two offset”:** The “1/2” exclusion permits Social Security to exclude half of the earnings that remain after it makes applicable deductions for the exclusions listed above. It’s because of this work incentive that SSI beneficiaries are always better off financially when they choose to work.
• **Blind Work Expenses (BWE):** If the SSI recipient meets the definition of statutory blindness, he or she may deduct any items that meet the IRWE definition, and additional items that meet the BWE definition. A detailed explanation of BWEs is provided in this unit.

• **Plan to Achieve Self-Support (PASS):** A PASS permits individuals to deduct countable income, or exclude resources that would otherwise reduce or eliminate the SSI payment. A PASS is an agreement between Social Security and the beneficiary. The beneficiary agrees to take incremental steps to achieve a specified vocational goal. The plan allows the beneficiary to use “countable income” or resources to pay for goods or services he or she needs in order to reach the goal. In turn, Social Security replaces the PASS expenditures by increasing the individual’s SSI benefit payment up to the maximum FBR rate for the state they live in.

• PASS is discussed extensively in Unit 7 of this module.

To determine “countable” income, Social Security applies work incentives and other income exclusions to both earned and unearned income. Social Security then subtracts the countable income from the Federal Benefit Rate (FBR) that applies to the individual or eligible couple. Social Security uses an eligible couple FBR when SSI recipients are married to each other, or are holding themselves out to the community as married. The individual’s living arrangement and whether or not in-kind support and maintenance is in evidence may also affect the FBR. Individuals and eligible couples who live in the household of another person and receive full in-kind support and maintenance values under the VTR rule have a reduced FBR. For a review of in-kind support and maintenance, see Unit 5. Finally, the FBR typically changes every calendar year to reflect increases in the cost-of-living.

**SSI Federal Benefit Rates for 2020**

- $783 for individuals
- $522 for individuals who have full ISM valued under the VTR rule
- $1,175 for SSI-eligible couples
- $783 for SSI-eligible couples who have full ISM valued under the VTR rule
After Social Security determines the applicable FBR and deducts the total countable income, what remains is the adjusted SSI payment. If the beneficiaries are members of an eligible couple, Social Security divides the amount in half and sends two payments — one check to each member of the couple.

Keep in mind that Social Security will subtract countable earned income received in prior years from whatever FBR it established for that year. For a complete listing of past FBRs, refer to POMS SI 02001.020 Title XVI - Rate Increases and Rate Charts (https://secure.ssa.gov/apps10/poms.nsf/lnx/0502001020#b)

**SSI Calculation Sheet**

The following is a calculation sheet for WIPA personnel to use when estimating SSI payments. To make the estimation of SSI payments as close to accurate as possible, remember to do the calculation steps in order. It’s also important to remember that not all forms of unearned or earned income count due to numerous federal rules. By using the chart below, CWICs will arrive at an **estimate** of the adjusted SSI payment, which may vary from the actual payment if other, less common exclusions or deductions Social Security permits based upon the individual recipient’s unique circumstances. CWICs must ensure that SSI recipients understand that the standard SSI calculation sheets used by WIPA programs merely result in estimated adjusted payments. Only Social Security personnel can determine the actual adjusted SSI payment amount.

**NOTE:** We provide this **SSI Calculation Sheet** as a blank template at the end of this unit. It’s also available at the VCU NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=2)

A key to this sheet follows the example below.

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.Unearned Income</td>
<td></td>
</tr>
<tr>
<td>2.General Income Exclusion (GIE)</td>
<td>−</td>
</tr>
<tr>
<td>3.Countable Unearned Income</td>
<td>=</td>
</tr>
<tr>
<td>Step</td>
<td>Calculation</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>4. Gross Earned Income</td>
<td></td>
</tr>
<tr>
<td>5. Student Earned Income Exclusion (SEIE)</td>
<td>−</td>
</tr>
<tr>
<td>6. Remainder</td>
<td></td>
</tr>
<tr>
<td>7. General Income Exclusion (if not used above)</td>
<td>−</td>
</tr>
<tr>
<td>8. Remainder</td>
<td></td>
</tr>
<tr>
<td>9. Earned Income Exclusion (EIE)</td>
<td>−</td>
</tr>
<tr>
<td>10. Remainder</td>
<td></td>
</tr>
<tr>
<td>11. Impairment Related Work Expense (IRWE)</td>
<td>−</td>
</tr>
<tr>
<td>12. Remainder</td>
<td></td>
</tr>
<tr>
<td>13. Divide by 2</td>
<td></td>
</tr>
<tr>
<td>14. Blind Work Expenses (BWE)</td>
<td>−</td>
</tr>
<tr>
<td>15. Total Countable Earned Income</td>
<td>=</td>
</tr>
<tr>
<td>16. Total Countable Unearned Income</td>
<td></td>
</tr>
<tr>
<td>17. Total Countable Earned Income</td>
<td>+</td>
</tr>
<tr>
<td>18. PASS Deduction</td>
<td>−</td>
</tr>
<tr>
<td>19. Total Countable Income</td>
<td>=</td>
</tr>
<tr>
<td>20. Base SSI Rate (check for VTR)</td>
<td></td>
</tr>
<tr>
<td>21. Total Countable Income</td>
<td>-</td>
</tr>
<tr>
<td>22. Adjusted SSI Payment</td>
<td>=</td>
</tr>
</tbody>
</table>
Step-by-Step Instructions for Completing the SSI Calculation Sheet

1. **Calculate Countable Unearned Income:**
   Include income an individual or either member of an eligible couple receives, such as:
   - Title II or other benefits (other than SSI);
   - In-kind Support and Maintenance (ISM) valued under the Presumed Maximum Value (PMV) rule;
   - Any other unearned income that isn’t excluded under the Act (See Unit 5).

   Place result on “unearned income” line of calculation sheet.

   Subtract General Income Exclusion (GIE) of $20.

   Result is Countable Unearned Income (CUI). Write result on Countable Unearned Income line on 3rd line of calculation, and also on Countable Unearned Income line that appears on line 16 of the calculation sheet.

2. **Calculate Countable Earnings**
   Add together any earned income an individual or either member of an eligible couple received in a month, including:
   - Gross earnings paid in the month for all employment;
   - Value of in-kind income received as remuneration for work;
   - 1/12 of Net Earnings from Self-Employment (NESE) averaged over calendar year.

   Place the total gross monthly earnings on Earned Income line (Line 4 of calculation sheet).

   If the individual or either member of an eligible couple is a student, subtract applicable Student Earned Income Exclusion (SEIE) if the beneficiary is:
   a. Under age 22,
   b. Working, AND
   c. Regularly attending school.
Subtract the $65 Earned Income Exclusion. Remember, eligible couples only receive one $65 Earned Income Exclusion.

Subtract the value of any applicable Impairment Related Work Expenses (IRWE) for an individual or member of an eligible couple who is working. DON’T deduct work expenses for blind individuals on this line.

Divide the remainder by 2.

If the individual or member of an eligible couple meets the definition of statutory blindness, subtract any applicable Blind Work Expense (BWE), if applicable.

The remainder is Countable Earned Income (CEI). Write countable earnings both in line 15 and in line 17.

3. **Determine Total Countable Income**

Add countable unearned income to countable earned income. Then subtract applicable PASS deductions from this combined total to determine Total Countable Income (CI).

4. **Determine SSI payment**

Enter applicable FBR (remember the lower Value of the One-Three Reduction FBR if VTR is applicable), subtract the Total Countable Income (CI), and the result is estimated SSI payment.

Common SSI Calculation Errors to Avoid:

- When estimating an SSI payment, never show it on the SSI calculation sheet as a negative figure — this confuses beneficiaries.

- Never apply unused earned income exclusions to unearned income.

- Don’t carry over an unused portion of a monthly exclusion for use in subsequent months.

- The $20 General Income Exclusion and $65 Earned Income Exclusion apply only once to an eligible couple, even when both members have income, because the couple’s earned income is combined when Social Security determines SSI payments.

- Because the purpose of the SSI calculation is to determine the SSI payment for a given month, never enter the person’s current
SSI payment on the “Unearned Income” line, as SSI doesn’t count against itself.

- Some work incentives apply only to the Title II disability programs and don’t apply to the SSI program. One of these is called subsidy. Subsidy doesn’t apply to SSI benefits once Social Security finds an individual eligible and he or she starts receiving payments, so it never appears in the SSI calculation.

- Remember that an individual or SSI-eligible couple may have several exclusions. Use all exclusions that apply to the person or eligible couple’s situation.

- Don’t change the order of the calculation steps. The steps occur in the order they do because of federal regulations. Taking them out of order will cause the estimated payment amount to be incorrect.

- Whenever estimating payments, make sure the person knows that Social Security has the final say in any calculation, or in the application of any exclusion.

- Finally, remember that in most circumstances, there is a two-month delay between a person’s income and the adjusted SSI payment that is affected by that income. For more information, see the section on Retrospective Monthly Accounting (RMA) in Unit 5 of this module.

**SSI Calculation Examples**

Now that we have discussed the remaining deductions Social Security uses when estimating SSI payments, here are examples of how it performs computations.

**Example of individual living in his or her own household, with no earnings, but $320 in unearned income:**

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned Income</td>
<td>$320.00</td>
</tr>
<tr>
<td>General Income Exclusion (GIE)</td>
<td>− $20.00</td>
</tr>
<tr>
<td>Countable Unearned Income</td>
<td>= $300.00</td>
</tr>
<tr>
<td><strong>Step</strong></td>
<td><strong>Calculation</strong></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Gross Earned Income</td>
<td>0</td>
</tr>
<tr>
<td>Student Earned Income Exclusion</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>0</td>
</tr>
<tr>
<td>General Income Exclusion (if not used above)</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>0</td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE)</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>0</td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE)</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>0</td>
</tr>
<tr>
<td>Divide by 2</td>
<td>0</td>
</tr>
<tr>
<td>Blind Work Expenses (BWE)</td>
<td>− 0</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>=0</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td>$300.00</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>+ 0</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>− 0</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>= $300.00</td>
</tr>
<tr>
<td>Base SSI Rate (check for VTR)</td>
<td>$783.00</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>− $300.00</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>=$483.00</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>$483.00</td>
</tr>
<tr>
<td>Gross Unearned Income Received</td>
<td>+$320.00</td>
</tr>
</tbody>
</table>
### Gross Earned Income Received

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gross Earned Income Received</strong></td>
<td>+0</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>=$803.00</td>
</tr>
<tr>
<td><strong>PASS, BWE, or IRWE Expenses</strong></td>
<td>− 0</td>
</tr>
<tr>
<td><strong>Total Financial Outcome</strong></td>
<td>=$803.00</td>
</tr>
</tbody>
</table>

**Example with $885 in earnings, but no unearned income:**

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unearned Income</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>General Income Exclusion (GIE)</strong></td>
<td>− 0</td>
</tr>
<tr>
<td><strong>Countable Unearned Income</strong></td>
<td>= 0</td>
</tr>
<tr>
<td><strong>Gross Earned Income</strong></td>
<td>$885.00</td>
</tr>
<tr>
<td><strong>Student Earned Income Exclusion</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>Remainder</strong></td>
<td>$885.00</td>
</tr>
<tr>
<td><strong>General Income Exclusion (if not used above)</strong></td>
<td>− $20.00</td>
</tr>
<tr>
<td><strong>Remainder</strong></td>
<td>$865.00</td>
</tr>
<tr>
<td><strong>Earned Income Exclusion (EIE)</strong></td>
<td>− $65.00</td>
</tr>
<tr>
<td><strong>Remainder</strong></td>
<td>$800.00</td>
</tr>
<tr>
<td><strong>Impairment Related Work Expense (IRWE)</strong></td>
<td>− 0</td>
</tr>
<tr>
<td><strong>Remainder</strong></td>
<td>$800.00</td>
</tr>
<tr>
<td><strong>Divide by 2</strong></td>
<td>$400.00</td>
</tr>
<tr>
<td><strong>Blind Work Expenses (BWE)</strong></td>
<td>− 0</td>
</tr>
<tr>
<td><strong>Total Countable Earned Income</strong></td>
<td>=$400.00</td>
</tr>
<tr>
<td>Step</td>
<td>Calculation</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td>0</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>+$400.00</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>−0</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>=$400.00</td>
</tr>
<tr>
<td>Base SSI Rate (check for VTR)</td>
<td>$783.00</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>−$400.00</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>=$383.00</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>$383.00</td>
</tr>
<tr>
<td>Gross Unearned Income Received</td>
<td>+0</td>
</tr>
<tr>
<td>Gross Earned Income Received</td>
<td>+$885.00</td>
</tr>
<tr>
<td>Subtotal</td>
<td>=$1,268.00</td>
</tr>
<tr>
<td>PASS, BWE, or IRWE Expenses</td>
<td>−0</td>
</tr>
<tr>
<td>Total Financial Outcome</td>
<td>=$1,268.00</td>
</tr>
</tbody>
</table>

**Example of In-kind Support and Maintenance (ISM)**

Unit 5 of this module discusses In-kind Support and Maintenance (ISM). When Social Security values ISM under the Presumed Maximum Value (PMV) rule, it treats ISM as a kind of unearned income that isn’t cash, but is either food or shelter, or something that an individual could convert to food and shelter.

If the person lives in the household of another and receives both food and shelter from the household, Social Security will value the ISM under the VTR rule. That means the person will actually have a lower base SSI rate for calculation purposes, and that rate is always two-thirds of the current FBR.

The following three examples simply show how ISM affects the SSI calculation. ISM may be the only income, or it may occur when other unearned income or earnings are involved.
**Example of ISM valued using the PMV rule:**

James lives with his brother in an apartment. All James pays toward the cost of his share of the food and shelter is $100 each month for groceries. Social Security determines that James receives ISM valued under the PMV rule in the amount of $200 each month. James also has a job in which he earns an estimated $125 each month.

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned Income</td>
<td>$200.00</td>
</tr>
<tr>
<td>General Income Exclusion (GIE)</td>
<td>− $20.00</td>
</tr>
<tr>
<td>Countable Unearned Income</td>
<td>= $180.00</td>
</tr>
<tr>
<td>Gross Earned Income</td>
<td>$125.00</td>
</tr>
<tr>
<td>Student Earned Income Exclusion</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>$125.00</td>
</tr>
<tr>
<td>General Income Exclusion (if not used above)</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>$125.00</td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE)</td>
<td>− $65.00</td>
</tr>
<tr>
<td>Remainder</td>
<td>$60.00</td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE)</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>$60.00</td>
</tr>
<tr>
<td>Divide by 2</td>
<td>$30.00</td>
</tr>
<tr>
<td>Blind Work Expenses (BWE)</td>
<td>− 0</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>=$30.00</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td>$180.00</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>+$30.00</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>−0</td>
</tr>
</tbody>
</table>
### Example when Social Security values the ISM under the PMV rule at the maximum amount:

To demonstrate how the PMV rule works when Social Security values the ISM at the actual maximum amount (one-third of the FBR + $20), suppose that James continues to pay $100 each month toward the cost of groceries, but that his remaining share of the household expenses is actually $400. Fortunately, Social Security won’t count that full $400 against James as unearned income. Under the PMV rule, the MAXIMUM amount of ISM Social Security can assess against James is one-third of the current FBR ($261) plus $20 or $281 in 2020. James actually gets ISM from his brother in the amount of $400, but the SSI program will only assess the value of his ISM at the maximum amount of $281.
<table>
<thead>
<tr>
<th>Step</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Earned Income</td>
<td>$125.00</td>
</tr>
<tr>
<td>Student Earned Income Exclusion</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>$125.00</td>
</tr>
<tr>
<td>General Income Exclusion (if not used above)</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>$125.00</td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE)</td>
<td>− $65.00</td>
</tr>
<tr>
<td>Remainder</td>
<td>$60.00</td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE)</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>$60.00</td>
</tr>
<tr>
<td>Divide by 2</td>
<td>$30.00</td>
</tr>
<tr>
<td>Blind Work Expenses (BWE)</td>
<td>− 0</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>= $30.00</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td>$261.00</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>+ $30.00</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>− 0</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>= $291.00</td>
</tr>
<tr>
<td>Base SSI Rate (check for VTR)</td>
<td>$783.00</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>− $291.00</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>= $492.00</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>$492.00</td>
</tr>
<tr>
<td>Gross Unearned Income Received</td>
<td>+ $281.00</td>
</tr>
</tbody>
</table>
### Example when Social Security values ISM under the Value of the One-Third Reduction (VTR) rule:

In this example, suppose that James continues to live with his brother in an apartment, but James pays nothing toward his pro-rata share of the household expenses. His brother is paying all of James’ food and shelter expenses, and James is making no contribution. When this happens, Social Security determines that James is receiving full ISM and applies the VTR rule. The VTR rule simply reduces the base rate Social Security uses in the SSI calculations. Social Security does NOT apply it as a form of unearned income. James continues to work in a part-time job earning an estimated average of $125 each month.

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step Calculation</strong></td>
<td></td>
</tr>
<tr>
<td>Gross Earned Income Received</td>
<td>+$125.00</td>
</tr>
<tr>
<td>Subtotal</td>
<td>=$898.00</td>
</tr>
<tr>
<td>PASS, BWE, or IRWE Expenses</td>
<td>− 0</td>
</tr>
<tr>
<td>Total Financial Outcome</td>
<td>=$898.00+help with household expenses not counted as ISM</td>
</tr>
<tr>
<td>Step</td>
<td>Calculation</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Remainder</td>
<td>$40.00</td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE)</td>
<td>-0</td>
</tr>
<tr>
<td>Remainder</td>
<td>$40.00</td>
</tr>
<tr>
<td>Divide by 2</td>
<td>$20.00</td>
</tr>
<tr>
<td>Blind Work Expenses (BWE)</td>
<td>-0</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>= $20.00</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td>0</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>+ $20.00</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>-0</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>= $20.00</td>
</tr>
<tr>
<td>Base SSI Rate (check for VTR)</td>
<td>$522.00</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>= $20.00</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>= $502.00</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>$502.00</td>
</tr>
<tr>
<td>Gross Unearned Income Received</td>
<td>+0</td>
</tr>
<tr>
<td>Gross Earned Income Received</td>
<td>+ $125.00</td>
</tr>
<tr>
<td>Subtotal</td>
<td>= $627.00</td>
</tr>
<tr>
<td>PASS, BWE, or IRWE Expenses</td>
<td>- 0</td>
</tr>
<tr>
<td>Total Financial Outcome</td>
<td>= $627.00</td>
</tr>
</tbody>
</table>

By looking at these calculations, it’s apparent that the way Social Security counts ISM can affect the SSI payment amount. Social Security determines whether or not someone has ISM and whether to value the
ISM under the PMV or VTR rule. It’s important for CWICs to understand that this might be a factor when estimating how work will affect benefits.

**Student Earned Income Exclusion (SEIE)**

The Student Earned Income Exclusion (SEIE) is a work incentive that allows certain SSI recipients who are under age 22 and regularly attending school to exclude a specified amount of gross earned income per month up to a maximum annual exclusion. The SEIE decreases the amount of countable earned income, thus permitting SSI recipients to keep more of the SSI check when they work. In many cases, the SEIE allows students to test their ability to work without experiencing any reduction in the SSI check at all.

Only SSI beneficiaries who meet all of the SEIE eligibility criteria will receive this important work incentive. To qualify for the SEIE, an individual must be:

- Under the age of 22,
- Regularly attending school, college or training to prepare for a paying job, and
- Working.

Under the current SEIE rules, any SSI beneficiary who is under age 22, a student regularly attending school, and working is eligible for this exclusion.

**Regularly Attending School**

Regularly attending school means that the person takes one or more courses of study and attends classes:

- In a college or university for at least 8 hours per week under a semester or quarter system;
- In grades 7-12 for at least 12 hours per week;
- In a course of training to prepare him or her for a paying job for at least 15 hours per week if the course involves shop practice, or 12 hours per week if it doesn’t involve shop practice. This training includes anti-poverty programs, such as the Job Corps and government-supported courses in self-improvement; or
• For less than the amount of time indicated above for reasons beyond the student’s control, such as illness, if circumstances justify the reduced credit load or attendance.

Examples of School Attendance

**School attendance less than the required hours:** Kim is a physically disabled student who attends vocational school only one day per week due to the unavailability of transportation. Although her enrollment for attendance is less than 12 hours per week, Kim qualifies as regularly attending school because the lack of transportation is a circumstance beyond her control.

**Enrollment in special course of study:** Edward is a 19-year-old student attending a public high school. He doesn’t attend regular classes but receives special training to meet self-improvement skills such as combing hair, dressing, and eating. Edward isn’t a student for SSI purposes despite attendance at a secondary school facility because he isn’t attending a curriculum for grades 7-12.

**Student in a training course:** Sara is a 21-year-old student who attends Perkins School for the Blind. She is in a training course 20 hours per week. Sara spends 15 hours per week learning office skills and 5 hours per week learning personal grooming skills. At the conclusion of the course, Sara will be able to use her office skills for a paying job (sheltered or in a competitive job market). The 15 hours per week that she spends on learning office skills meets the required attendance hours and qualifies her as a student for SSI purposes.

Additional Types of Students

In addition to the general requirements above, a person may qualify as a student in any of the following categories provided he or she meets the additional criteria:

**Homeschooled students**

Homeschooling is a private educational program in which a parent or tutor educates the student at home. It’s a program of study a student
completes by choice. Social Security considers a homeschooled student regularly attending school if he or she receives instruction at home in grades 7-12 for at least 12 hours a week. Homeschool instruction must be in accordance with the homeschool laws of the state or other jurisdiction of the student’s residence.

**Homebound students**

A homebound student is an individual who is forced to cease actual physical presence in the classroom due to illness, injury, or other circumstances beyond the student’s control. A homebound student may be regularly attending school, if he or she:

- Must stay home because of a disability;
- Studies a course or courses given by a school in grades 7-12, college, university, or government agency; and
- Has a home visitor or tutor from school who directs the studying or training.

**Online School**

Effective August 21, 2015, Social Security may consider online schooling as a form of regular school attendance, if the student meets certain requirements. An online school is one that offers Internet-based courses to students. Online schools vary considerably in the methods they use to provide education to students. Some features of online schools may include:

- Virtual classrooms;
- E-mail for submission of assignments and communication with teachers;
- Telephone for communication with teachers;
- Access to teachers, either online, by telephone or in-person;
- Completion of credits and tests;
- Requirements for time spent online monitored by the school; and
- Individualized instruction.

Social Security considers a recipient who receives his or her education through online schooling to be a student regularly attending school if:
• He or she studies a course or courses given by an online school in grades 7-12, a college or university, or a government agency; and

• The online school is authorized by the laws of the state in which it is located. In the case of a foreign school, the foreign school can qualify provided it’s part of a secondary or post-secondary school system in a country or facility approved or authorized by the educational authorities in that country to provide secondary or post-secondary education.

For more information see [POMS SI 00501.020 Student – SSI](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500501020#c4).

**Applying the Student Earned Income Exclusion**

Social Security applies SEIE to a student’s gross earnings before any other allowable exclusion. Social Security will exclude all gross earnings up to a maximum amount per month until the beneficiary exhausts the full annual SEIE exclusion, or the individual becomes ineligible for SEIE by reaching the age of 22 or stops attending school.

Social Security establishes both the maximum monthly SEIE exclusion and the maximum annual exclusion amount each calendar year. The annual SEIE maximum applies to the calendar year that begins in January and ends in December. Social Security will exclude all earnings an individual receives in a month up to the current monthly maximum as long as the individual has not reached the annual maximum.

As of January 2001, Social Security indexes SEIE amounts annually, meaning they go up (or at least remain the same) each year in January. Here are the current and past monthly and annual amounts:

<table>
<thead>
<tr>
<th>For Months</th>
<th>Maximum Exclusion Per Month</th>
<th>Maximum Annual Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>In calendar years before 2001</td>
<td>$400.00</td>
<td>$1,620.00</td>
</tr>
<tr>
<td>In calendar year 2001</td>
<td>$1,290.00</td>
<td>$5,200.00</td>
</tr>
<tr>
<td>In calendar year 2002</td>
<td>$1,320.00</td>
<td>$5,340.00</td>
</tr>
<tr>
<td>For Months</td>
<td>Maximum Exclusion Per Month</td>
<td>Maximum Annual Exclusion</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-----------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>In calendar year 2003</td>
<td>$1,340.00</td>
<td>$5,410.00</td>
</tr>
<tr>
<td>In calendar year 2004</td>
<td>$1,370.00</td>
<td>$5,520.00</td>
</tr>
<tr>
<td>In calendar year 2005</td>
<td>$1,410.00</td>
<td>$5,670.00</td>
</tr>
<tr>
<td>In calendar year 2006</td>
<td>$1,460.00</td>
<td>$5,910.00</td>
</tr>
<tr>
<td>In calendar year 2007</td>
<td>$1,510.00</td>
<td>$6,100.00</td>
</tr>
<tr>
<td>In calendar year 2008</td>
<td>$1,550.00</td>
<td>$6,240.00</td>
</tr>
<tr>
<td>In calendar year 2009</td>
<td>$1,640.00</td>
<td>$6,600.00</td>
</tr>
<tr>
<td>In calendar year 2010</td>
<td>$1,640.00</td>
<td>$6,600.00</td>
</tr>
<tr>
<td>In calendar year 2011</td>
<td>$1,640.00</td>
<td>$6,600.00</td>
</tr>
<tr>
<td>In calendar year 2012</td>
<td>$1,700.00</td>
<td>$6,840.00</td>
</tr>
<tr>
<td>In calendar year 2013</td>
<td>$1,730.00</td>
<td>$6,960.00</td>
</tr>
<tr>
<td>In calendar year 2014</td>
<td>$1,750.00</td>
<td>$7,060.00</td>
</tr>
<tr>
<td>In calendar year 2015</td>
<td>$1,780.00</td>
<td>$7,180.00</td>
</tr>
<tr>
<td>In calendar year 2016</td>
<td>$1,780.00</td>
<td>$7,180.00</td>
</tr>
<tr>
<td>In calendar year 2017</td>
<td>$1,790.00</td>
<td>$7,200.00</td>
</tr>
<tr>
<td>In calendar year 2018</td>
<td>$1,820.00</td>
<td>$7,350.00</td>
</tr>
<tr>
<td>In calendar year 2019</td>
<td>$1,870.00</td>
<td>$7,550.00</td>
</tr>
<tr>
<td>In calendar year 2020</td>
<td>$1,900.00</td>
<td>$7,670.00</td>
</tr>
</tbody>
</table>

In future years, Social Security will adjust annually the monthly amount and the yearly limit based on any increases in the cost-of-living index. The SEIE may apply in addition to other allowable exclusions such as, Impairment Related Work Expenses (IRWE), Plan to Achieve Self-Support (PASS), or the Blind Work Expense (BWE). Social Security always
deducts the SEIE from earned income first, before applying any other work incentive.

**Example of SEIE:**

Alfonzo is 20 years old and attends college. He has a summer internship and will earn $2,000 per month for the summer. Alfonzo worked part-time earlier in the year, making $600 per month, and will return to that job on September 1. Alfonzo has no unearned income.

**Alfonzo’s Earnings:**

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earnings</td>
<td>600</td>
<td>600</td>
<td>600</td>
<td>600</td>
<td>600</td>
<td>2,000</td>
<td>2,000</td>
<td>2,000</td>
<td>600</td>
<td>600</td>
<td>600</td>
<td>600</td>
</tr>
</tbody>
</table>

**Alfonzo and the Student Earned Income Exclusion (SEIE)**

Because Alfonzo meets the criteria for regularly attending school, is under 22, and has earned income, the SEIE applies. This means that the amount Social Security excludes will be subject to the monthly and annual limits. The chart below will show how this works.

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earnings</td>
<td>600</td>
<td>600</td>
<td>600</td>
<td>600</td>
<td>600</td>
<td>2,000</td>
<td>2,000</td>
<td>2,000</td>
</tr>
<tr>
<td>SEIE</td>
<td>600</td>
<td>600</td>
<td>600</td>
<td>600</td>
<td>600</td>
<td>1,900</td>
<td>1,900</td>
<td>870</td>
</tr>
<tr>
<td>Used</td>
<td>600</td>
<td>1,200</td>
<td>1,800</td>
<td>2,400</td>
<td>3,000</td>
<td>4,900</td>
<td>6,800</td>
<td>7,670</td>
</tr>
</tbody>
</table>

**2020 continued**

<table>
<thead>
<tr>
<th></th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earnings</td>
<td>600</td>
<td>600</td>
<td>600</td>
<td>600</td>
</tr>
<tr>
<td>SEIE</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Used</td>
<td>7,670</td>
<td>7,670</td>
<td>7,670</td>
<td>7,670</td>
</tr>
</tbody>
</table>
Alfonzo used the last of his SEIE in August. By August, Social Security could exclude only $870, leaving countable earnings of $1,130. For the rest of the year, Alfonzo doesn’t have access to the SEIE again. In January of the next year, because Alfonzo is still under age 22 and regularly attending school, he will be able to access the SEIE in effect for that calendar year.

**Alfonzo’s Estimated Payment for August 2020:**

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned Income</td>
<td>0</td>
</tr>
<tr>
<td>General Income Exclusion (GIE)</td>
<td>– 0</td>
</tr>
<tr>
<td>Countable Unearned Income</td>
<td>=0</td>
</tr>
<tr>
<td>Gross Earned Income</td>
<td>$2,000.00</td>
</tr>
<tr>
<td>Student Earned Income Exclusion</td>
<td>–$1,900.00</td>
</tr>
<tr>
<td>Remainder</td>
<td>$100.00</td>
</tr>
<tr>
<td>General Income Exclusion (if not used above)</td>
<td>– $20.00</td>
</tr>
<tr>
<td>Remainder</td>
<td>$80.00</td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE)</td>
<td>– $65.00</td>
</tr>
<tr>
<td>Remainder</td>
<td>$15.00</td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE)</td>
<td>– 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>$15.00</td>
</tr>
<tr>
<td>Divide by 2</td>
<td>$7.50</td>
</tr>
<tr>
<td>Blind Work Expenses (BWE)</td>
<td>– 0</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>=$7.50</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td>0</td>
</tr>
<tr>
<td>Step</td>
<td>Calculation</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>+$7.50</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>− 0</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>=$7.50</td>
</tr>
<tr>
<td>Base SSI Rate (check for VTR)</td>
<td>$783.00</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>−$7.50</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>=$775.50</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>$775.50</td>
</tr>
<tr>
<td>Gross Unearned Income Received</td>
<td>+0</td>
</tr>
<tr>
<td>Gross Earned Income Received</td>
<td>+$2,000.00</td>
</tr>
<tr>
<td>Subtotal</td>
<td>=$2,775.50</td>
</tr>
<tr>
<td>PASS, BWE, or IRWE Expenses</td>
<td>− 0</td>
</tr>
<tr>
<td>Total Financial Outcome</td>
<td>=$2,775.50</td>
</tr>
</tbody>
</table>

**Eligible Couples and Student Earned Income Exclusion (SEIE)**

Since Social Security can apply the SEIE to individuals who are married, how does it work? Remember that Social Security considers an eligible couple to be one unit for SSI purposes. An eligible couple gets one $20 General Income Exclusion and one $65 Earned Income Exclusion. Resource limits for a couple are $3,000 instead of the $2,000 limit individuals have. Eligible couples only get to exclude one house in which they live and one car used by the family. Unfortunately, they also only get to exclude one monthly maximum under SEIE, with an annual limit for the couple being the same as for an individual.

The following chart outlines what happens with eligible couples:
<table>
<thead>
<tr>
<th>IF...</th>
<th>THEN...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neither of the members of an eligible couple is working</td>
<td>No SEIE.</td>
</tr>
<tr>
<td>Neither member of the couple is regularly attending school</td>
<td>No SEIE.</td>
</tr>
<tr>
<td>One member of the couple is working, and the other member is regularly attending school</td>
<td>No SEIE.</td>
</tr>
<tr>
<td>One member of the couple is under age 22, working and attending school while the other member is working, but not attending school</td>
<td>The earnings of the one SEIE eligible member are subject to the SEIE, but the earnings of the other member of the couple aren’t.</td>
</tr>
<tr>
<td>Both members of the couple are under age 22, working and regularly attending school</td>
<td>Earnings for both members of the couple are subject to the SEIE, but only 1 total deduction up to the monthly maximum may be applied. Monthly SEIE deductions may be applied to the combined income of the couple until the annual maximum is reached. For SEIE purposes, this couple would be treated as if they were one person.</td>
</tr>
</tbody>
</table>

**NOTE:** Students who are also members of an eligible couple are unlikely to occur every day in the practice of a CWIC. Mark this chart for reference for when the situation does arise. Remember, though, that most SEIE situations will be individual SSI beneficiaries who are under age 22 and regularly attending school.

**Applying the SEIE during Periods of Non-Attendance**

An individual remains a student for the purposes of the SEIE when classes are out if he or she actually attends classes regularly just before the time classes are out and:

- Tells Social Security that he or she intends to resume attending regularly when school reopens; or
- Actually does resume attending regularly when school reopens.
For most students, this would allow Social Security to apply the SEIE to summer employment when school isn’t in session. When an SSI recipient graduates from school and doesn’t intend to resume school later, the SEIE will apply for the last month during which the recipient attended school, and then will stop. When a student changes his or her intent to return, and doesn’t return to school, the individual is no longer considered a student effective with the month the intent changed.

In some cases, a student’s counselor or teacher may believe the student needs to stay out of class for a short time to enable him or her to continue studying or training. The POMS instructs Social Security personnel to consider the recipient to be a student regularly attending school, college, or training that prepares him or her for a paying job during this type of non-attendance.

**How Social Security Verifies Student Status**

Social Security verifies student status during the SSI re-determination process. An individual may document school enrollment by presenting a school record such as an ID card, tuition receipt, or other comparable evidence. If the individual doesn’t have any evidence to present, Social Security may contact the school to verify attendance. If Social Security is aware of the child’s student status, Social Security generally will apply the SEIE automatically when the student reports earnings. However, Social Security recommends that an individual clearly indicate student status in writing when notifying Social Security of employment. The student doesn’t need a special form or process to request the SEIE.

For more information on this subject, see our VCU NTDC resource document titled “**Student Earned Income Exclusion factsheet**” found online (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=7)

**IRWE and SSI**

As under the Title II disability program, Impairment Related Work Expenses (IRWEs) for SSI recipients permit the deduction of the value of goods or services that are:

- Related to the disability or to an impairment for which the person is receiving treatment from a health care provider,
- Necessary for work,

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- Paid out of the beneficiary’s pocket and not reimbursed by any other source,
- Reasonable, and
- Paid in the month the person received earnings, although Social Security may prorate the cost of durable items over a 12-month period.

Individuals must have receipts to prove they paid all approved expenses. Whether or not an item is deductible as IRWE is up to Social Security.

**When Individuals May Deduct IRWEs**

- Payments the beneficiary makes for items needed in order to work are deductible whether the person with a disability purchases the item before or after he or she begins working, if the person needs the item in order to work.

- Payments the beneficiary makes for services are deductible if the beneficiary receives the services while working. Social Security may make deductions for services even though a person must leave work temporarily to receive the services. The costs of any services a person receives before he or she begins working aren’t deductible.

- The amount of an IRWE Social Security deducts from earned income is the total allowable amount (subject to reasonable limits) that the person with a disability pays for the item or service. Social Security doesn’t usually determine the amount deducted by assigning a certain portion of the expense to work activity and a certain portion to non-work activity (e.g., 40 percent of the time at work and 60 percent of the time at home). Attendant care services may be an exception to this general rule, depending on the situation.

- When determining countable income in an SSI calculation, IRWEs aren’t deductible from earned income if Social Security deducts the income used for the purchase of the impairment-related item or service as part of a Plan to Achieve Self-Support (PASS) for the same period.

- Deductions from gross receipts of a business that Social Security uses to determine net earnings from self-employment (NESE)
can’t be deducted again as IRWE. If the expense meets the IRS rules for a legitimate business expense, Social Security should always apply it to reduce NESE because this approach has the benefit of lowering countable income for tax purposes as well as for SSI purposes.

- Social Security may pay some IRWEs on a recurring basis. For example, in some cases the cost of durable equipment (respirator, wheelchair, etc.) may be paid over a period of time under an installment purchase plan. In addition to the cost of the purchased item, interest and other normal charges (e.g., sales tax) that a person with a disability pays to purchase the item will also be deductible. Generally, the amount the person pays monthly will be the deductible amount.

- Part or all of a person’s IRWE may not be recurring (e.g., the person with a disability makes a one-time payment in full for an item or service). Social Security may deduct such nonrecurring expenses either entirely in one month, or may prorate them over a 12-consecutive month period. Social Security will use the method that provides more benefits, including the amount of SSI payment in SSI cases.

- A person with a disability may make a down payment on an impairment-related item, or possibly a service, to be followed by regular monthly payments. Social Security deducts such down payments either entirely in one month, or allocated over a 12-consecutive month period, whichever is most beneficial.

- When a person with a disability rents or leases an item while working, the allowable deductible amount is the actual monthly charge. Where he or she makes the rental or lease payments other than monthly (e.g., weekly), it’s necessary to compute monthly payment amounts. As with other costs, rental or lease payment is subject to the reasonable limits provision.

- Payments made by the person with a disability for services rendered to someone else aren’t deductible. Payments are deductible only when the services are provided for, or the items are used by, the beneficiary. For example, any payment by a person with a disability to care for his or her child isn’t deductible.
All of the above rules also apply to the Title II program except where specified. When individuals receive both SSI and Title II disability benefits, the entire amount paid for the item or service is deductible when Social Security determines if work is SGA, and Social Security also deducts the amount from countable earnings when the SSI program calculates the SSI payment amount. In this manner, concurrent beneficiaries may apply the IRWE in two different ways for the two different benefits.

**Example of IRWE with earned and unearned income:**

Kathleen works and receives SSI. She has $150 a month in unearned income from an annuity that her parents purchased for her when she turned 21. She is working 20 hours a week for $10 per hour. She will have four paychecks in the month, each representing one week’s work. This results in a monthly gross earned income of $800 for most months, and an estimate of $1,000 in the months when she receives five paychecks. Kathleen is neither a student, nor under 22, so she isn’t eligible for the SEIE. She lives in a state that doesn’t supplement SSI payments. Kathleen pays all of her own living expenses. She takes special transportation that Social Security counts as an IRWE. That transportation costs $120 per month.

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned Income</td>
<td>$150.00</td>
</tr>
<tr>
<td>General Income Exclusion (GIE)</td>
<td>– $20.00</td>
</tr>
<tr>
<td>Countable Unearned Income</td>
<td>= $130.00</td>
</tr>
<tr>
<td>Gross Earned Income</td>
<td>$800.00</td>
</tr>
<tr>
<td>Student Earned Income Exclusion</td>
<td>– 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>$800.00</td>
</tr>
<tr>
<td>General Income Exclusion (if not used above)</td>
<td>– 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>$800.00</td>
</tr>
<tr>
<td>Step</td>
<td>Calculation</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE)</td>
<td>– $65.00</td>
</tr>
<tr>
<td>Remainder</td>
<td>$735.00</td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE)</td>
<td>– $120.00</td>
</tr>
<tr>
<td>Remainder</td>
<td>$615.00</td>
</tr>
<tr>
<td>Divide by 2</td>
<td>$307.50</td>
</tr>
<tr>
<td>Blind Work Expenses (BWE)</td>
<td>– 0</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>=$307.50</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td>$130.00</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>+$307.50</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>–0</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>=$437.50</td>
</tr>
<tr>
<td>Base SSI Rate (check for VTR)</td>
<td>$783.00</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>–$437.50</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>=$345.50</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>$345.50</td>
</tr>
<tr>
<td>Gross Unearned Income Received</td>
<td>+$150.00</td>
</tr>
<tr>
<td>Gross Earned Income Received</td>
<td>+$800.00</td>
</tr>
<tr>
<td>Subtotal</td>
<td>=$1,295.50</td>
</tr>
<tr>
<td>PASS, BWE, or IRWE Expenses</td>
<td>– $120.00</td>
</tr>
<tr>
<td><strong>Total Financial Outcome</strong></td>
<td>=$1,175.50</td>
</tr>
</tbody>
</table>

**NOTE:** Please refer to the development templates in Module 6 for Impairment-Related Work Expense
Blind Work Expenses (BWE)

Individuals receiving SSI due to statutory blindness are eligible for an additional work incentive. Social Security refers to this work incentive as Blind Work Expenses or BWE. In addition to goods or services that Social Security would normally deduct under the IRWE provisions outlined above, BWE provisions also allow exclusion of any other work-related items that a person pays out of pocket. The biggest difference between BWE and IRWE is that BWEs don’t need to be related to any impairment.

REMEMBER — Blind Work Expense provisions ONLY apply in the SSI program! BWEs only apply to SSI recipients who meet Social Security’s definition of statutory blindness and who receive benefits based on blindness.

Examples include, but aren’t limited to:

- State and federal taxes
- Union dues
- Mandatory pension contributions
- Uniforms
- Reader services
- Driver services
- Cost of service animal’s care
- Childcare
- Transportation
- Meals consumed at work
- Adaptive equipment purchased by the beneficiary

NOTE: Social Security may only deduct BWEs from earned income; Social Security can’t use the BWE exclusion to reduce countable unearned income.

In the vast majority of cases, it’s safe to assume that any individual who receives SSI due to blindness and is earning more than $85 per month would have at least some BWEs to claim. The CWIC should help the beneficiary identify the types of BWEs they are incurring and should
estimate the total average cost of these BWEs when they submit the BWE request to Social Security for a formal determination.

**Work Incentive Deductions for Blind Beneficiaries**

If an individual meets the definition of statutory blindness, and receives both Social Security Title II disability and SSI, there are a few things to keep in mind:

- The BWE provisions ONLY apply to the SSI benefit. BWEs don’t exist in the Title II disability program.
- For Title II, the SGA level is higher for individuals who meet the definition of statutory blindness.
- CWICs shouldn’t assume that someone meets Social Security’s definition of statutory blindness. Social Security needs to make a formal determination before blind individuals may access the special work incentives.
- SGA determinations never apply to SSI applicants who meet the statutory definition of blindness.
- Remember that Social Security deducts IRWEs under Title II for blind individuals, and the definition is the same for everyone. In the SSI program, however, all goods and services that would normally meet the definition of IRWE would also meet the definition of BWE, in addition to expenses that would only apply as BWE. In almost every case, an individual who receives SSI due to blindness should claim allowable expenses as a BWE instead of an IRWE, as it provides for greater reduction in countable earned income. Examples showing Social Security applying this deduction come later in this unit.

**Example if Kathleen were blind:**

In the example below, $200 was added to approximate work expenses that wouldn’t fit the criteria for IRWE, but would meet the criteria for BWEs. This would only apply if Kathleen met the disability standard of statutory blindness.

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned Income</td>
<td>$150.00</td>
</tr>
<tr>
<td>Step</td>
<td>Calculation</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>General Income Exclusion (GIE)</td>
<td>− $20.00</td>
</tr>
<tr>
<td>Countable Unearned Income</td>
<td>=$130.00</td>
</tr>
<tr>
<td>Gross Earned Income</td>
<td>$800.00</td>
</tr>
<tr>
<td>Student Earned Income Exclusion</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>$800.00</td>
</tr>
<tr>
<td>General Income Exclusion (if not used above)</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>$800.00</td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE)</td>
<td>− $65.00</td>
</tr>
<tr>
<td>Remainder</td>
<td>$735.00</td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE)</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>$735.00</td>
</tr>
<tr>
<td>Divide by 2</td>
<td>$367.50</td>
</tr>
<tr>
<td>Blind Work Expenses (BWE)</td>
<td>− $320.00</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>=$47.50</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td>$130.00</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>+$47.50</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>− 0</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>=$177.50</td>
</tr>
<tr>
<td>Base SSI Rate (check for VTR)</td>
<td>$783.00</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>−$177.50</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>=$605.50</td>
</tr>
<tr>
<td>Step</td>
<td>Calculation</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>$605.50</td>
</tr>
<tr>
<td>Gross Unearned Income Received</td>
<td>+$150.00</td>
</tr>
<tr>
<td>Gross Earned Income Received</td>
<td>+$800.00</td>
</tr>
<tr>
<td>Subtotal</td>
<td>=$1,555.50</td>
</tr>
<tr>
<td>PASS, BWE, or IRWE Expenses</td>
<td>− $320.00</td>
</tr>
<tr>
<td>Total Financial Outcome</td>
<td>=1,235.50</td>
</tr>
</tbody>
</table>

**NOTE:** Please refer to the development templates in Module 6 for Blind Work Expense

**Examples of Deductible BWEs as Compared to IRWEs**

This chart below is distilled from a Program Operations Manual System section and is an example of types of expenses, indicating whether they meet the definition of IRWE or BWE, or both. For more information, refer to the original chart in [POMS SI 00820.555 - List of Type and Amount of Deductible Work Expenses](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820555) found online.

<table>
<thead>
<tr>
<th>Item or Service</th>
<th>Is it IRWE?</th>
<th>Is it BWE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medications</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical supplies</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Taxes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Service animal expenses</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Mandatory pension deductions</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Meals at work</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Item or Service</td>
<td>Is it IRWE?</td>
<td>Is it BWE?</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------</td>
<td>------------</td>
</tr>
<tr>
<td>Child care costs</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Uniforms</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Tools for work</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Adaptive devices</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Prosthesis</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Structural modifications</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Union dues</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Remember that the beneficiary must pay any cost and receive no reimbursement from any other source in order for Social Security to approve the expense under the IRWE and BWE rules. Also, this list is only a sampling of the many expenses that a person may deduct under IRWE or BWE, depending on the situation, and depending on whether or not the expense is reasonable. With IRWE or BWE, the individual should submit any possible expense. Only Social Security personnel can make a determination about what an individual may or may deduct as an IRWE or a BWE, although these determinations are subject to the appeal’s process as long as the individual puts them in writing.

**Estimating Monthly Wages**

When Social Security personnel calculate SSI payments, they use the amount of income a beneficiary received in past months. To avoid SSI overpayments, Social Security estimates future earnings by projecting amounts based on the beneficiary’s recent earnings. For CWICs and Social Security, there is value in projecting the beneficiary’s earnings into the future to help the beneficiary understand the effect of work.

Remember that SSI treats earnings differently than the Social Security Title II disability programs. Under Title II, Social Security determines the
value of work effort. Under SSI, however, Social Security is looking at income available for food and shelter. That means that the SSI program is interested in what an employer pays in the month, not what the beneficiary earned.

**Example of estimating monthly wages:**

Derrick worked in February and March. He earned $300 in each month. He received his pay of $600 at the end of March, when the job was finished. For Social Security Title II purposes, Derrick earned $300 per month February and March. For SSI purposes, however, Derrick received $600 in earned income in March.

If the beneficiary has a regular work schedule, one can easily estimate the beneficiary’s monthly gross wages by looking at a calendar and counting the number of paychecks expected per month, then multiplying that number by the usual pre-tax amount per paycheck.

**Example of estimating monthly wages:**

Maria receives her weekly paycheck on Friday. Maria’s wages are $200 per week before anything withholding for taxes. There are five paychecks in the month of May. Maria’s earnings for May are $1,000. In June, Maria would have $800 in earnings, because she would only receive four paychecks in that month.

**SSI and Net Earnings from Self Employment (NESE)**

If the beneficiary is self-employed, Social Security will average the beneficiary’s estimate of the year’s Net Earnings from Self-Employment (NESE) over a full calendar year to determine self-employment earnings for each month. This is true regardless of when an SSI beneficiary begins working in self-employment during a calendar year.
Example of determining self-employment monthly earnings:

Martika is self-employed in a sole proprietorship. Martika started her business in December and made $1,200 in NESE after all business deductions, including deductions for the extra Social Security taxes she pays as a self-employed individual. Although Martika didn’t start her business until December 2020, Social Security will consider Martika’s earnings to be $100 per month throughout the 2020 calendar year.

We provide a complete discussion of how self-employment income affects SSI and how work incentives apply in self-employment situations in Unit 8 of this module.

When Countable Income is Too High for SSI Payments – Understanding the Break Even Point (BEP)

The break-even point or BEP is the point at which an SSI recipient’s countable income causes Social Security to reduce the SSI cash benefit to zero. Basically, the break-even point is reached when the countable income equals or exceeds the SSI individual’s or couple’s applicable Federal Benefit Rate (FBR). The break-even point is not the same for every SSI recipient, but varies depending upon the individual’s or couple’s applicable FBR (which is affected by the living arrangement) and countable income. The break-even point may be affected by each of the following specific factors alone or in combination:

- Living arrangement – specifically when an individual resides in a Medicaid funded facility;
- Amount of in-kind support and maintenance (ISM) received and whether ISM is valued under the VTR or PMV rule;
- Amount of unearned income received;
- Amount of earned income received other than wages;
- Eligible couple status or spouse-to-spouse deeming; and
- Use of specific work incentives such as IRWE, BWE and/or PASS.

If the beneficiary was entitled to SSI and the countable income based upon the SSI calculations is too high to permit payment (i.e.: the
individual’s countable income is over the BEP), then the individual experiences one of two results. If unearned income makes the person ineligible for cash payments, then the 12-month suspension period begins. However, if it’s earnings that make payment impossible, then the individual may be able to continue Medicaid coverage under the Section 1619(b) provisions.

Section 1619(b) provides continued eligibility for SSI and SSI related Medicaid when a SSI beneficiary’s earnings either alone, or combined with other income (for example, a Title II benefit) are too high to allow a cash payment. The great thing about this provision is that it allows the beneficiary to stay on the SSI rolls and continue to receive Medicaid until earnings exceed the state threshold limit for Medicaid. In other words, the SSI file remains open even though the beneficiary’s check is in non-pay status. When a SSI recipient is in non-pay status, the Benefits Planning Query or BPQY will indicate “Non-Pay due to excess income.” Non-payment is simply an interruption in payment. It’s not a suspension nor is it a loss of eligibility for SSI. This means that a recipient is section 1619(b) SSI eligible, and will stay in 1619(b) status as long as they meet five criteria:

1. Must meet the Social Security disability requirement;
2. Must have been eligible for a SSI cash payment for at least one month prior to ineligibility;
3. Must continue to meet all other non-disability SSI requirements (i.e., resources and citizenship);
4. Must need Medicaid benefits in order to continue working; and
5. Must not have earnings sufficient to replace SSI cash benefits, Medicaid benefits, and publicly funded personal or attendant care that would be lost due to earnings (in other words, earnings above the state threshold or when applicable above the individual threshold). SSA - POMS: SI 02302.010 - 1619 Policy Principles

**Example of section 1619(b) SSI eligibility:**

Ruth receives SSI only. She began working in January, earning $1,800 per month. Given that she has no SEIE, IRWE, BWE, or PASS exclusions, her total countable income
is $857.50 after applying the General Income Exclusion, Earned Income Exclusion, and the 2-for-1 reduction. This is higher than the standard FBR of $783 in 2020. As long as she meets the criteria for 1619(b), she enters non-pay status.

Ruth continues working, and in June, her employer reduces her hours. She is now earning $1,150 per month. After exclusions, her total countable income is now $532.50. This is below the 2020 FBR of $783. She notifies Social Security of her reduced earnings, and the agency places her SSI benefits in pay status again, because her countable income is below the standard FBR. In October, Ruth resumes earning $1,800 per month and again moves into 1619(b), and her SSI returns to non pay status.

For 1619(b) eligible individuals, Social Security will conduct annual redeterminations to ensure individuals still meet the 1619(b) criteria. See POMS: SI 02302.060 - Quarterly Verification of Earnings (https://secure.ssa.gov/poms.nsf/lnx/0502302060).

We discuss the 1619(b) provisions in detail in Module 4.

**Conclusion**

The SSI program is designed to gradually reduce income supports as earnings increase. Provisions in the law protect Medicaid eligibility through SSI entitlement and assist beneficiaries in making work pay. If individuals on SSI are working, their financial situation is almost always improved. Social Security uses these deductions and exclusions as a way to determine how much other income counts, or is “countable” as available to meet the beneficiary’s needs for food and shelter. Social Security may calculate an SSI payment by deducting “this countable” income from the applicable FBR. The result is the Supplemental Security Income (SSI) payment.

**Conducting Independent Research**

As noted in Unit 5, the SSI Spotlights are a wonderful tool for CWICs to use when explaining these complex concepts to SSI beneficiaries. The
spotlights are posted online (https://www.ssa.gov/ssi/links-to-spotlights.htm)

**Understanding SSI.** This is an excellent online resource that covers all of the important aspects of the SSI program. The current version of this resource is available (https://www.ssa.gov/ssi/text-understanding-ssi.htm)

**The main Table of Contents for the POMS citations pertaining to the SSI program is available** (https://secure.ssa.gov/apps10/poms.nsf/chapterlist!openview&restrictto category=05)
Competency Unit 7 – Plan to Achieve Self-Support (PASS)

Introduction

In earlier units of this module, we discussed various SSI work incentives that beneficiaries can use to ease the transition from dependency on benefits to self-supporting employment. None of these provisions seem as complex or challenging as the work incentive known as a Plan to Achieve Self-Support (PASS). While PASS is certainly complicated, it’s also one of the most flexible and powerful work incentives available. It can help beneficiaries succeed in a work goal that might otherwise not be possible.

CWICs need to keep PASS in mind as a possibility whenever a beneficiary is trying to access training, equipment, services, or anything else that they need to start work, even the clothes an individual needs for interviewing. PASS is incredibly valuable and is far less difficult than it seems at first glance. It’s worth the effort for you to understand PASS and to help disabled or blind SSI beneficiaries use the PASS work incentives to achieve greater independence through employment or self-employment.

This unit simply explains the rules that Social Security uses to determine if a PASS is appropriate. The CWIC’s role in PASS, and suggestions about how best to support beneficiaries to access the PASS provisions, are discussed in Unit 4 of Module 6.

Overview of the Plan to Achieve Self Support (PASS)

A Plan to Achieve Self-Support (PASS) is a work incentive that allows a person with a disability to set aside income or resources for a specified period of time in order to pay for items or services needed to achieve a specific work goal. Under an approved PASS, an individual may set aside income or resources to pay for education or training, counseling, job coaching or other support services, transportation, job-related items,
equipment needed to start a business, or just about anything else needed to achieve an occupational goal.

Social Security doesn’t count income or resources set aside in a PASS when determining SSI eligibility or when determining the amount of SSI payment an eligible individual is due. This means that a person whose income or resources are too high to qualify for SSI may develop a PASS to set aside the excess income or resources for use in their work goal, thus establishing initial SSI eligibility. For someone whom Social Security has already found eligible for SSI, the individual may use a PASS to set aside income or resources that would normally cause ineligibility or reduced benefit payments. A distinct advantage of a PASS is that it allows a person to direct his or her own career plan and secure the necessary items or services to reach his or her work goal.

Strengths of the PASS Work Incentive

While the PASS work incentive is widely unknown in the disability community, the original SSI statute over 40 years ago included this provision. The legislative history shows that Congress expressed a “desire to provide every opportunity and encouragement to the blind and disabled to return to gainful employment.” Congress intended that the PASS provision “be liberally construed if necessary to accomplish these objectives.” Several characteristics of the PASS work incentive make it an unusually effective tool for individuals who want to work and decrease their dependency on Social Security disability benefits. These characteristics include the following:

- **PASS reflects individual choice.** Individuals choose their own work goal and develop their own plan for achieving that goal.

- **PASS is self-financed.** Individuals use their own funds to pursue the plan. The receipt of, or an increase in SSI benefits up to the amount of the Federal Benefit Rate (FBR), and any applicable state supplement replaces some or all of the funds that the individual uses for the PASS.

- **PASS is largely self-directed.** With Social Security’s approval, individuals decide what goods and services they need to reach the work goal.
• **PASS is highly individualized.** Each PASS specifically reflects the needs of a unique individual.

### Individuals Who May Benefit from a PASS

To qualify for a PASS, a person must meet the following criteria:

- Be under age 65, or be previously entitled to an SSI benefit based on blindness or disability the month prior to reaching age 65;
- Meet Social Security’s definition of disability or blindness;
- Meet all SSI eligibility criteria with the exception of the income and resources test; and
- Have earned income, unearned income, deemed income, in-kind support, or countable resources to set aside in the PASS.

### Likely PASS Candidates

Not everyone who is eligible for a PASS is actually a good candidate for using this work incentive. Like all work incentives, PASS isn’t intended to be a “one size fits all” solution to every problem or to meet the employment support needs of every beneficiary. A likely PASS candidate would typically have one or more of the following characteristics:

- Eligible for or already receiving rehabilitation services from a State Vocational Rehabilitation (VR) agency, a state agency for the blind, other public agency (e.g., Department of Veterans Affairs) or a private agency (e.g., United Cerebral Palsy, Goodwill Industries, etc.);
- Enrolled in school or other training program, or interested in obtaining post-secondary education or occupational skill training of some type;
- Currently working, seeking employment, or interested in pursuing employment or self-employment;
- Interested in reducing dependency on public benefits and becoming financially independent;
• In need of services or items in order to achieve a desired work or self-employment goal; or
• Social Security would otherwise deny initial SSI eligibility or suspend or terminate continued eligibility solely due to excess income or resources, or Social Security would otherwise reduce SSI benefits due to some form of countable income.

**Unlikely PASS Candidates**

Some individuals with disabilities may not qualify for a PASS, while still others may qualify, but simply wouldn’t benefit from developing a PASS. Unlikely PASS candidates would include those who:

• Already secured the needed items and services under a previous PASS and haven’t tried to seek employment in the work goal for which they obtained the required items or services that they identified as being sufficient to make them employable;
• Are ineligible for SSI benefits for any reason other than excess income or resources;
• Are under age 15 or over 65 (with some exceptions);
• Don’t have any income or resources to set aside in the PASS and don’t expect to have any, or are unwilling to use set aside funds strictly for the PASS;
• Don’t require any additional items or services to become employed or self-employed; or aren’t interested in working or decreasing dependency on public benefits.

**Example of an unlikely PASS candidate:**

Oona receives a VA compensation benefit based on permanent and total disability of $1,342 each month. She also owns investment property from which she earns rental income, and she and her husband have two cars. Oona’s husband has a full-time job earning $62,000 per year. Oona would like to write a PASS to help her pay for her current graduate degree.

**Is Oona a good PASS candidate?**

Oona probably fits the disability definition, and has income and resources other than SSI to put into the PASS. However, Oona wouldn’t be a good
PASS candidate because she has resources and deemed income that she isn’t willing to use to meet her vocational goal. Because of this, the PASS wouldn’t make her eligible for SSI. Oona decided to pay for her graduate school herself.

**Title II Disability Beneficiaries as PASS Candidates**

There is widespread belief that beneficiaries who receive Title II disability benefits such as SSDI, CDB, or DWB can’t utilize the PASS work incentive. Many people think that only individuals who already are receiving SSI benefits can develop and use a PASS. In fact, nothing could be further from the truth.

Remember that the SSI program views the Title II disability benefits as a form of unearned income. Because many Title II disability beneficiaries receive more than the current SSI FBR in monthly payments, they often have too much countable unearned income to qualify for SSI. By setting the Title II disability payment aside under an approved PASS, the SSI program essentially disregards this income when determining eligibility for SSI. If Social Security approves the PASS, the Title II payment continues and the beneficiary uses it to pay for the items or services needed to achieve their occupational goal. In return, the individual will receive SSI cash payments during the life of the PASS.

It’s important to keep in mind that if a Title II disability beneficiary uses the PASS to establish eligibility for SSI and sets aside Social Security disability benefits, the goal must be likely to result in work above the SGA level and lead to the eventual loss of the Social Security disability benefit. More information on this point will be provided at a later point in this unit.

A major benefit of using a PASS for an individual who has been ineligible for SSI because of too much unearned income is that Medicaid eligibility comes with SSI entitlement in most states.

**Example of PASS affecting benefits:**

Manuel has been receiving a SSDI benefit of $800 a month. Manuel only has Medicare for health insurance and must pay out over $300 each month of his $800 out-of-pocket in medical costs to survive. If Manuel were to write a PASS to help pay for expenses to reach a vocational goal, he would likely become eligible for Medicaid. Instead of living on the $500 he has left after paying for his medical costs, Manuel
not only would have the current FBR + $20 to live on, but he would have as much as $780.00 of his SSDI benefit earmarked to help him achieve his employment goal.

When working with Title II disability beneficiaries who are interested in pursuing a PASS, keep in mind that the individual must meet all other SSI eligibility criteria. This means that countable resources must be under allowable limits.

**REMEMBER:** SSI also considers the income and resources of ineligible spouses and ineligible parents (for SSI recipients under 18). A Title II disability beneficiary who is married or who is under age 18 may have deemed income in the mix that you will need to take into account when determining if PASS is a viable option.

**PASS Requirements**

**Feasible Occupational Goal**

First and foremost, in order for Social Security to approve a PASS, it must include a specific occupational goal. Basic living skills or homemaking skills aren’t occupational goals, but Social Security can approve training in such skills if the individual needs them to achieve an occupational goal. The occupational goal contained in the PASS must meet several requirements:

- **Each PASS must specify and clearly describe a single occupational goal.** Additionally, the occupational goal must be the earliest point on the person’s chosen career path that would generate earnings sufficient to be self-supporting. This means that the income is enough to cover all living expenses, all out-of-pocket medical expenses, and all work-related expenses.

- **Social Security limits beneficiaries to one PASS per occupational goal.** If a beneficiary had a previous PASS with a goal, and the person wasn’t successful in meeting that goal, it’s not possible to develop another PASS for that same goal. However, under some circumstances the individual may resume a previous PASS with the same work goal.
• **The occupational goal must be “feasible.”** This means that the individual must have a reasonable chance of performing the work associated with the occupational goal, taking into account his or her impairment, and the limitations imposed by it; age, in some cases; and strengths and abilities.

**Important point to consider: What constitutes an occupational goal?**

Beneficiaries, VR agency personnel, and even CWICs may become confused about what Social Security means by “occupational goal.” Social Security isn’t likely to approve a beneficiary’s PASS with the goal being “to buy a car.” Buying a car isn’t an occupational or employment goal. It may be a means to achieving employment, but in and of itself, it’s not an employment goal. A person who establishes an occupational goal of being a delivery driver may include purchasing a car as part of the PASS expenses, but buying a car can’t be the goal.

Some special PASS rules apply to a few specific occupational goals in supported employment and self-employment situations:

• **Supported Employment Goals:** An individual in a supported employment program may submit a PASS whose goal is to achieve stabilization in that job, to work more hours, or to work with less support (fewer hours of job coaching per week, for example). Such plans should specify the targeted level of performance in terms of the supports required, and how long it will take the individual to reach the goal. If it subsequently appears that the individual can change the targeted level of performance in order to provide additional countable income, you can amend the PASS accordingly.

• **Self-Employment Goals:** For individuals with a work goal of self-employment, Social Security may approve general small business start-up costs through the first 18 months, or longer if needed, for business operations. A PASS with a self-employment goal must include a detailed business plan, and this plan must meet very stringent requirements set by Social Security.

**NOTE:** The lack of a business plan shouldn’t delay an individual’s submission of a request for a PASS. An individual can get help with developing a business plan.
from State VR Agencies, the Small Business Administration (SBA) personnel, Service Corp of Retired Executives (SCORE), Small Business Development Centers (SBDC), or local Chambers of Commerce. For specific information about the business plan requirements of the PASS work incentives, go to POMS SI 00870.026 - Business Plans which can be found online here: (https://secure.ssa.gov/poms.nsf/lnx/0500870026)

**VR Evaluation Goals**

Social Security may approve a PASS with the goal of “VR evaluation” in order to help the person select a specific work goal. Until the individual chooses a specific goal, the PASS will only cover the costs associated with having a public or private vocational rehabilitation (VR) agency or professional perform a diagnostic study or evaluation. A VR evaluation usually takes three to six months. An individual must justify a requested evaluation period of more than six months.

**NOTE:** Vocational evaluation expenses can include certain self-employment focused activities, but those activities have to be the same kind of activities one might see in an employment-focused vocational evaluation, such as:

- Is self-employment practical for this person?
- Is the business in question a good fit for this person?

**Viable Plan for Achieving the Goal**

Not only must the occupational goal be feasible, but also the plan for achieving the stated occupational goal must be viable. By this, Social Security means that the plan for achieving the occupational goal must be realistic, taking into account the individual’s education and training needs, any assistive technology required, and the interval steps (and the corresponding time frame to complete each step) necessary to actually secure employment or start a business. These steps, or “milestones,” which demonstrate the person’s progress towards achieving the goal, should be described sufficiently so that completion of the steps can be readily discernible and, if appropriate, measurable. The plan should also examine whether the person will have sufficient means to cover PASS expenses, living expenses, and other necessary expenses.
**Important Point to Consider:** Can the individual live on the amount of disposable income he or she has once a PASS is in effect?

This question is critically important. Consider the case of an SSDI beneficiary who receives $1,800 each month in benefit payments. Under an approved PASS, it’s certainly possible to take this unearned income and set it aside each month to pay for things the beneficiary needs to achieve the work goal. The only problem is that this beneficiary may be accustomed to living off of $1,800 each month in income and may not be able to afford to live on less. With an approved PASS, the most SSI this person could receive in a month would be the current FBR (plus any state supplement available). Even under the best of circumstances, this amount of income won’t equal $1,800 a month in SSDI payments.

When this type of situation occurs, Social Security will look closely at the individual’s living expenses to make sure the individual can afford to set aside the income and live on the SSI payment. The PASS application includes questions about the individual’s monthly living expenses. If an individual isn’t able to prove that he or she can live off of the available income, Social Security isn’t likely to approve the PASS.

**Earnings Requirements**

For Social Security to approve a PASS, the agency must expect the individual’s plan to result in a level of earnings that will decrease the individual’s dependence on public benefits. This level will vary depending on the individual’s benefits status before using the PASS work incentive. For a person who was already eligible for SSI before the PASS, Social Security has to expect the occupational goal to generate earnings sufficient to substantially reduce, or eliminate the person’s SSI cash benefit. The reduction doesn’t have to occur as soon as the individual begins working, but Social Security expects it to occur within a reasonable amount of time, which would generally be 12-18 months.

Title II disability beneficiaries who wouldn’t otherwise be SSI eligible without utilizing a PASS must choose an occupational goal that will generate earnings that demonstrate the individual’s ability to engage in Substantial Gainful Activity (SGA). The occupational goal should result in earnings sufficient to replace the cash and medical benefits of the individual and any auxiliaries receiving benefits on that person’s record.
There is a common misunderstanding that a PASS must generate earnings sufficient to cause the loss of ALL benefits — including cash payments and Medicaid or Medicare. This isn’t the case now and has never been the case. Social Security does NOT expect beneficiaries to achieve employment that fully replaces the cost of public health insurance (particularly Medicaid), although some individuals who use a PASS do achieve this end.

PASS Expenditures

The PASS must show how the individual will spend the money set aside to achieve his or her work goal. A listing must include planned expenditures on a monthly basis and how they are connected to the work goal. Expenses must be reasonable, and cost estimates for items or services included in the PASS must show how the cost estimate was calculated. When possible, indicate providers of services paid for through the PASS.

Some examples of possible PASS expenditures include:

- Equipment, supplies, operating capital, and inventory required to start a business;
- Supported employment services including job development and job coaching;
- Costs associated with educational or vocational training, including tuition, books, fees, tutoring, counseling, etc.;
- Additional costs incurred for room and board away from principal residence required to attend educational, employment, trade, or business activities;
- Dues and publications for academic or professional purposes;
- Attendant care;
- Child care;
- Equipment or tools either specific to the individual’s condition or designed for general use; e.g., similar to what persons without disabilities would use for work;
- Uniforms, specialized clothing, safety equipment;
- Least costly alternatives for transportation, including:
a. Public transportation and common carriers,
b. Hire of private or commercial carriers,
c. Assistance with purchase of a private vehicle;
- Operational access modifications to buildings or vehicles to accommodate disability; and
- Licenses, certifications, and permits necessary for employment.

It’s important to understand that Social Security may not allow all expenses at the beginning of the PASS. In some cases, approval of certain goods and services may be contingent based on the successful completion of milestones that justify the expense. Social Security refers to this as “deferred expenses.”

In addition to meeting the requirements above, the PASS must clearly describe:
- When the individual will use the items and services;
- What income or resources the individual will set aside to purchase the items and services;
- Whether the individual will use the funds for periodic payments of expenses or save them for a future payment; and
- How the individual will keep the funds being set aside under the PASS separate and identifiable from other funds.

**Expenses that are not Allowed**

The PASS provisions do not allow certain types of expenses. A expense that is not allowed is one that:
- Isn’t purchased by the individual;
- Is for items or services that the individual can readily obtain from the providing agency for free;
- Is for items or services for which Social Security will promptly reimburse the individual;
- Is for items or services purchased in connection with a prior PASS, unless the individual provides a satisfactory justification (e.g., the individual paid for certain college courses in connection
with a prior PASS but, for medical reasons, was unable to complete them); or

- Reflects an outstanding debt unrelated to the current PASS (with some exceptions).

In addition, the beneficiary must demonstrate to Social Security that he or she is able to live on the income available for living expenses after the PASS begins. This last point is essential to remember. Many beneficiaries misunderstand how PASS funds work and think that the PASS will provide additional money for living expenses. Instead, they must use money set aside in the PASS for approved expenses to meet the vocational goal. Social Security requires proof that they have used the money appropriately. PASS doesn’t provide more money in the monthly food and shelter budget; in fact, the individual will usually have the same or possibly less income available to meet living expenses with, or without, a PASS.

**Disbursements – Spending PASS Funds**

Ordinarily, beneficiaries should make disbursements for items and services included in the PASS as soon as possible and should follow the schedule described in the PASS. For periods during which no disbursements are planned but for which beneficiaries are setting aside funds, Social Security will verify accumulated savings at predetermined intervals. Social Security will conduct reviews at least every six months in this situation to monitor that PASS funds are being appropriately conserved.

Beneficiaries need to understand that they may only use PASS funds to pay for items approved by Social Security as part of the plan. The beneficiary will have to replace any PASS funds he or she withdrew or spent on non-approved items. Beneficiaries must keep receipts and other financial records to substantiate all purchases made with PASS funds.

**Time Considerations for PASS**

A PASS must specify beginning and ending dates. It also must specify target dates for reaching intermediate milestones that reflect the beneficiary’s progress toward achieving the occupational goal. These dates must reflect the amount of time the individual needs to achieve the
milestones and complete the PASS, considering relevant factors. Social Security may extend these dates if circumstances beyond the individual’s control delay reaching a milestone or completing the plan and the person continues to meet all of the other requirements for continuation of the PASS.

When the occupational goal is self-employment, the initial PASS will include a minimum start-up period of 18 months unless the individual indicates that he or she will need less time for the business to sustain its operations. The individual must justify a request for a business start-up period of a longer duration than 18 months.

As of January 1, 1995, the Social Security Act requires that the time limits for PASS take into account “the length of time that the individual needs to achieve the individual’s employment goal (within such reasonable period as Social Security may establish).” Prior to that date, a PASS couldn’t exceed 36 months, or 48 months when a lengthy educational or training program was involved.

**When a PASS May Begin**

CWICs often express confusion about exactly when a beneficiary may begin a PASS. Basically, Social Security can make a PASS effective with any month of eligibility for SSI or any month of potential eligibility assuming approval of the PASS subject to the rules of administrative finality (see POMS SI 00870.007 - When To Start a PASS and SI 04070.001 - Title XVI Administrative Finality). While this may sound simple, it actually offers numerous possibilities for starting a PASS depending upon the unique circumstances of the beneficiary. These start-date options are as follows:

- **Starting Month:** Social Security generally sets the PASS start date as the date that Social Security receives the plan, unless another month applies and is more advantageous to the beneficiary.

- **Retroactive Month:** Subject to the rules of administrative finality, a PASS will start with the earliest month in which the individual was entitled to SSI and was incurring expenses or setting aside money for future expenses related to the occupational goal. By having a retroactive start date the PASS can exclude previously counted income that the individual used or set aside (in a manner that clearly identifies its purpose) for
allowable PASS expenses. By applying this exclusion retroactively, the individual becomes entitled to more SSI than he or she actually received for that period. Upon PASS approval, the beneficiary is provided this additional SSI. (Note: Individuals with an outstanding SSI overpayment may not be able to establish a retroactive PASS start date.)

• **Future Month:** Sometimes, Social Security will start a PASS in a future month, meaning a month at some point AFTER Social Security received the PASS. This happens when it’s more advantageous to the individual (e.g., using the month Social Security receives the plan as the starting month would provide the person with a lower SSI payment than expected due to proration), or the individual requests it and the system is able to accept the future month.

**Important Note:** Prior to Fall 2009, Social Security allowed an individual to have a retroactive start date, pursuant to rules of administrative finality, if he or she was SSI eligible and demonstrated he or she had been pursuing his or her work goal. In other words, the individual wasn’t required to have incurred expenses or set aside money for future expenses related to the occupational goal. A new interpretation in Fall 2009 clarified that Social Security can’t retroactively exclude funds that a beneficiary used for purposes unrelated to the PASS on the basis that the resulting windfall in SSI could then be used for PASS expenses. SSI is a program based on need and is meant to pay for an individual’s food and shelter costs.

Beneficiaries requesting a retroactive start date will need to provide clear documentation with the PASS application to demonstrate that the expenses are related to the vocational goal and that the beneficiaries have already paid the expenses or saved for them in a clearly identifiable manner. Some examples of clear identification include:

• The beneficiary purchased a $100 business license with his or her own funds prior to PASS approval and had a receipt as documentation.

• A concurrent beneficiary saves $50 per month of his or her SSDI benefit in a savings account for five months prior to PASS
approval for school expenses and can show the accumulation of saved funds in the amount of $250.

What this policy change means to CWICs and the beneficiaries they serve is that Social Security will approve fewer retroactive plans. Careful planning will be necessary when you work with a beneficiary to develop a PASS.

**Administrative Finality and Retroactivity for a PASS**

As stated above, Social Security may approve a PASS to begin retroactively subject to the limits imposed by the rules governing “administrative finality.” The concept of administrative finality is an important protection for both beneficiaries and Social Security. These rules protect beneficiaries by allowing Social Security to re-examine certain determinations or decisions during a set period of time if it appears that the original determinations or decision wasn’t correct. Administrative finality also protects Social Security because the agency shouldn’t be required to establish findings of fact after the lapse of a considerable time from the date of the events involved. Under most circumstances, the rules of administrative finality limit retroactivity for a PASS to no more than two years, although there are some exceptions to this limit. A detailed discussion of administrative finality is provided in Unit 9 of this module.

**Tips for CWICs — Requesting a PASS Start Date**

Because the start date for a PASS has important implications for the beneficiary, CWICs must make sure they explore the various options with beneficiaries while developing the plan. CWICs should ask individuals who are already eligible for SSI whether they began pursuing their work goal in the past, and if so, when did these efforts begin. CWICs may need to help the beneficiary gather documentation that pursuit of the work goal began prior to the submission of the PASS in order for Social Security to grant it retroactivity. If the applicant has an outstanding SSI overpayment, retroactivity may not be possible because any underpayment created by PASS will net against the pending overpayment. However, if the individual incurred PASS expenses in the past, allowing a retroactive date may reduce the amount of any overpayment. The PASS Specialist handling the request can best determine if retro-activity is possible.
While it’s possible to request retroactivity on a PASS for up to two years (the limit based on administrative finality), it’s up to the PASS Specialist’s discretion to approve months of retroactivity. If the beneficiary doesn’t agree with the determination the PASS Specialists makes with regard to retroactivity, the individual should request a personal conference to discuss it.

Beneficiaries who don’t currently receive SSI, but receive only a Title II disability benefit, must apply for SSI as part of the PASS application. In applying for SSI, the beneficiary must communicate that he or she is also applying for a PASS. The beneficiary must be prepared to submit his or her completed PASS application to Social Security within the 30-day SSI application timeline. Because a PASS can’t start until the beneficiary is SSI eligible, and SSI eligibility can’t begin until the month after the individual requests an SSI application, the soonest a PASS could potentially begin for an individual who doesn’t currently receive SSI is the month after he or she requests the SSI application.

**Example of PASS affecting SSI:**

In March 2020, Jenny, who receives $795 of SSDI, is planning to go to massage therapy school in September 2020. She meets with the CWIC and they work together to complete the PASS application by the end of April 2020. On April 25 Jenny goes to the local Social Security office and asks to apply for SSI, clarifying that she is applying for SSI as part of a PASS application. If Social Security finds Jenny eligible for SSI, based on a PASS excluding her SSDI, then the soonest Social Security could find her eligible for that SSI would be May 2020 (the month after she requests the SSI application). So, even though she began working on her PASS application in March 2020, the soonest the PASS could begin is May 2019, the month after she requested the SSI application.

**Developing and Submitting a PASS**

A beneficiary can develop and submit a PASS to Social Security at any time. The agency requires beneficiaries to submit their plans in writing and use a **standardized form, SSA-545-BK**. We provide a copy of this...
form at the end of this unit, but CWICs can also find it at Social Security’s website in PDF format (https://www.ssa.gov/forms/ssa-545.html).

Individuals who develop a PASS but who aren’t currently receiving SSI will have to complete the initial eligibility and application process for SSI and submit this with the completed PASS form. For those individuals already receiving SSI, they have already met the initial eligibility for SSI, so this step isn’t necessary. It’s important to remember that for an individual to be eligible for SSI, he or she has to meet the income and resources tests (other than the income and/or resource they will set aside for the PASS) and also be earning under the Substantial Gainful Activity (SGA) guideline.

**PASS Specialists**

When a beneficiary submits a PASS to the local Social Security field office, the PASS goes to a group of specialized Social Security employees referred to collectively as the regional PASS Cadre. The PASS Cadre members are Social Security employees, referred to as “PASS Specialists” or sometimes “PASS Experts” who specialize in reviewing and approving PASS applications. The PASS Cadre is responsible for direct contact with any claimant filing for a PASS. This includes not only developing the initial PASS, but also conducting progress reviews and progress checks, and dealing with the recipient on other post-eligibility PASS events. In most cases, Social Security prefers that a beneficiary submit his or her plans directly to the PASS Cadre that covers the area in which the beneficiary resides. CWICs can find a [listing of PASS Specialists with service areas and contact information](http://www.socialsecurity.gov/disabilityresearch/wi/passcadre.htm).

PASS Specialists determine if the occupational goal is feasible and that the plan for achieving the goal is viable. Social Security policy directs PASS Specialists to assume that an occupational goal is feasible and the plan for achieving it is viable when there is no evidence to the contrary and when the PASS was prepared or supported by any of the following:

- A state VR counselor;
- A public or private vocational counselor, case manager, social worker, or other individual who is licensed or certified by: (1) A government agency, (2) the Commission on Rehabilitation
Counselor Certification (CRCC), or (3) the Certification of Insurance Rehabilitation Specialists Commission (CIRSC); or

- An individual acting on behalf of an agency that has been certified by the above or accredited by an appropriate but unrelated local or nationally recognized organization such as the American Association for Counseling and Development or the National Rehabilitation Association.

If in doubt, PASS Specialists must ask for evidence of the preparer’s credentials or those of the organization for which the preparer works, and to create a precedent file.

**Getting Help with Developing a PASS**

Social Security permits beneficiaries to receive assistance in developing a PASS and may even include fees paid for PASS preparation in the plan. A PASS Specialist, a WIPA project, a vocational rehabilitation counselor, other professionals providing benefits counseling, or anyone else may provide assistance in developing a PASS. Assisting someone with a PASS is an important part of your role as the CWIC. CWICs may not indicate to beneficiaries that they don’t assist with developing PASS plans, and CWICs may not charge beneficiaries for PASS preparation. A detailed explanation of the CWIC role in assisting beneficiaries to develop a PASS is provided at the end of this unit.

A PASS applicant or participant may authorize a third party to act on his or her behalf in matters pertaining to the PASS. The PASS application includes a section in which the applicant may identify others who assisted with developing the plan. To facilitate communication, the applicant should include a statement authorizing Social Security to communicate openly with the third party about all matters pertaining to the PASS.

**PASS Progress Checks**

Once Social Security has approved the PASS, the agency will continue to monitor the beneficiary’s progress. The PASS Specialist generally will make an initial progress check within 30-60 days of approval, or by the first milestone, if earlier. A brief telephone call to ascertain progress can be sufficient. After this initial progress check, the PASS Specialist will set
up a schedule of subsequent progress checks between progress reviews based on the circumstances of each PASS. The PASS Specialist will schedule regular progress reviews on the basis of various factors including:

- Critical milestones;
- Six-month intervals during which the beneficiary will be accumulating but not disbursing funds for PASS expenses;
- When the individual files a self-employment tax return;
- When the individual expects to achieve his or her occupational goal; and
- Any other factor the PASS Specialist considers appropriate.

Making Changes to a PASS

A PASS may change in several ways. First, Social Security should offer the individual an opportunity to modify the plan before disapproving a PASS. This allows the individual to make any changes needed so that Social Security can approve the PASS. The PASS Specialist will identify and describe the needed changes and explain to the individual the reasons why the changes are necessary.

Social Security can also “amend” an approved PASS. The types of changes that require plan amendment include the following:

- Change in the amounts of income or resources to be set aside, i.e., the amount excluded;
- Change in planned expenditures;
- Change in the scheduled attainment date for the occupational objective or the milestones leading to that work goal; or
- Modification of the work goal regarding the level of independent performance from that originally anticipated, (as in a supported employment situation).

Any other substantive change in the occupational objective (i.e., a different job than stated in the original plan) requires a new plan. Social Security’s PASS experts must approve any amendments to an existing plan.
Suspending or Terminating a PASS

Social Security will suspend a PASS when the individual’s PASS isn’t terminated and the individual hasn’t met criteria for extending the PASS. The agency will also suspend a PASS when a beneficiary requests a new PASS with a new work goal. Social Security may suspend a PASS for up to 12 consecutive months. If the beneficiary does not resume the PASS within 12 months, Social security will terminate the PASS.

A suspended PASS may resume when the individual resolves the reason for the suspension and the PASS Specialist approves the individual’s request, including any amendment, to pursue the PASS. At the PASS Specialist’s discretion, an individual may resume a PASS that Social Security suspended for more than 12 months as long as Social Security does not terminate the individual for SSI benefits.

A PASS terminates when one of the following events occur:

- The individual’s eligibility for SSI benefits terminates; or
- Twelve consecutive months have elapsed from the date of the PASS suspension decision without the plan resuming.

Social Security does not penalize an individual if he or she does not reach his or her work goal at the end of his or her PASS if the individual:

- Followed his or her PASS steps to reach his or her work goal as established or revised;
- Spent the set aside income or resources as outlined in the PASS;
- Kept records of the expenses including receipts; and
- Actively sought employment at the end of the PASS.

Number of Plans to Achieve Self-Support

There is no limit to the number of plans an individual can have, but an individual can have only one PASS at a time. Before Social Security can approve a subsequent PASS, an individual must complete a final accounting for the prior PASS and must show that he or she can either no longer work at, or obtain work in, a prior occupational goal for which the he or she obtained all of the necessary goods and services.
Though there is officially no limit, it’s important to remember that a PASS is an agreement made by the beneficiary to work towards self-sufficiency. If the individual isn’t successful with one PASS, he or she will need to make a compelling argument showing how they will achieve self-sufficiency in the subsequent PASS application in order for Social Security to approve further investment.

**Using Various Forms of Income to Fund a PASS**

There are different ways to set aside various forms of income to fund a PASS. Unfortunately, there are a great many misunderstandings about what types of income an individual can use and how he or she applies the types of income. An individual can use any form of “countable income” to fund a PASS. Countable income is the income remaining after Social Security applies all allowable deductions or exclusions that Social Security uses to determine eligibility for SSI as well as the monthly payment amount. For example, if an individual receives unemployment insurance benefits of $690 each month, Social Security would deduct the $20 general income exclusion from this and would count $670 of unearned income for SSI purposes. The person would have the $670 available to fund the PASS.

Income that Social Security doesn’t count in SSI determinations isn’t useful in funding a PASS. Because the income doesn’t count, there’s no benefit from setting it aside — it would have no effect on SSI eligibility or monthly payment amount. This would include income such as SNAP, welfare payments, energy assistance, HUD rental subsidies, proceeds from a loan, or any other form of income specifically disregarded or excluded by the SSI program.

**Using In-kind Support and Maintenance (ISM) to Fund a PASS**

As discussed in Unit 5 of this module, because SSI is intended to pay for a recipient’s food and shelter, Social Security may reduce SSI payments if someone else is paying all or part of these expenses on behalf of the recipient. This type of assistance is called “in-kind support and maintenance” or ISM.
When the beneficiary lives in another person’s household and someone else pays for both food and shelter, Social Security considers the individual to be receiving full in-kind support and maintenance, and reduces the SSI check by one third of the full FBR. This reduction is known as “the value of the one-third reduction” or VTR.

If the recipient doesn’t live in another person’s household and receives help paying for the cost of his or her food and shelter, Social Security may reduce the SSI check under a different rule called the “presumed maximum value” or PMV. Under the PMV rule, Social Security determines the actual dollar value of the ISM and counts this as unearned income up to a maximum dollar amount called the presumed maximum value. This presumed maximum dollar amount equals one-third of the current FBR + $20. Social Security counts this form of ISM as unearned income when calculating the SSI check amount. When entering ISM under the PMV rule into the SSI calculation form, Social Security enters either the presumed maximum value or the actual value of ISM, whichever is less. Social Security subtracts the $20 general exclusion from that amount, leaving countable unearned income.

There is one significant advantage to having ISM valued under the PMV rules instead of the VTR rule. Under PMV, the in-kind support and maintenance has a specific dollar value and counts as a unique form of unearned income. This income is attributable to the beneficiary, and can be set aside under a PASS. If an SSI recipient develops a written PASS, he or she would have up to one third of the current FBR available to fund the occupational goal.

What this means in the most simple terms is that Social Security will increase the individual’s SSI check to the full FBR each month, Social Security will require the individual to put one third of the current FBR into the PASS account. In effect, the SSI recipient and his or her family are putting the in-kind support and maintenance into the PASS each month, and Social Security is reimbursing them for that contribution. The PASS allows Social Security to “disregard” this unique form of unearned income which otherwise caused the beneficiary to get a reduced SSI payment.

**Example of determining a beneficiary’s PASS contribution:**

Jerry lives alone in an apartment. Jerry’s mother pays the landlord and vendors $700 per month for Jerry’s rent, food, and utility expenses. Because Jerry lives in his own
apartment, Social Security determines his ISM under the PMV rule. The $700 his mother contributes exceeds the PMV amount (one-third of the FBR + $20), so Social Security caps the amount of ISM Jerry receives at the PMV amount. Jerry wants to pursue a PASS to help fund his occupational goal and wants to know how much he would have available to set aside in his PASS each month if Social Security approves his plan. See the SSI calculation chart below for the answer to this question.

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculation (no PASS)</th>
<th>Calculation (PASS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned Income (ISM)</td>
<td>$277.00</td>
<td>$277.00</td>
</tr>
<tr>
<td>General Income Exclusion (GIE)</td>
<td>− $20.00</td>
<td>− $20.00</td>
</tr>
<tr>
<td>Countable Unearned Income</td>
<td>= $257.00</td>
<td>= $257.00</td>
</tr>
<tr>
<td>Gross Earned Income</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Student Earned Income Exclusion</td>
<td>− 0</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>= 0</td>
<td>= 0</td>
</tr>
<tr>
<td>General Income Exclusion (if not used above)</td>
<td>− 0</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>= 0</td>
<td>= 0</td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE)</td>
<td>− 0</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>= 0</td>
<td>= 0</td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE)</td>
<td>− 0</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>= 0</td>
<td>= 0</td>
</tr>
<tr>
<td>Divide by 2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Blind Work Expenses (BWE)</td>
<td>− 0</td>
<td>− 0</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>= 0</td>
<td>= 0</td>
</tr>
<tr>
<td>Step</td>
<td>Calculation (no PASS)</td>
<td>Calculation (PAS)</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td>$257.00</td>
<td>$257.00</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>0</td>
<td>$257.00</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>$257.00</td>
<td>0</td>
</tr>
<tr>
<td>Base SSI Rate (check for VTR)</td>
<td>$771.00</td>
<td>$771.00</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>$257.00</td>
<td>0</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>$514.00</td>
<td>$771.00</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>$514.00</td>
<td>$771.00</td>
</tr>
<tr>
<td>Gross Unearned Income Received</td>
<td>+ 0</td>
<td>+ 0</td>
</tr>
<tr>
<td>Gross Earned Income Received</td>
<td>+ 0</td>
<td>+ 0</td>
</tr>
<tr>
<td>Subtotal</td>
<td>$514.00</td>
<td>$771.00</td>
</tr>
<tr>
<td>PASS, BWE, or IRWE Expenses</td>
<td>+ 0</td>
<td>$257.00</td>
</tr>
<tr>
<td><strong>Total Financial Outcome</strong></td>
<td><strong>$514.00</strong></td>
<td><strong>$514.00</strong></td>
</tr>
</tbody>
</table>

**Using Earned Income to Fund a PASS**

In some cases, a beneficiary may already be working part-time when he or she decides to pursue a PASS in order to attain a higher-paying career. There is no rule prohibiting an individual from submitting a PASS when he or she is already employed part time, because the purpose of PASS is to help beneficiaries pay for the things necessary to obtain employment that will result in substantial reduction of SSI benefits or SGA-level earnings.

The thing to remember is that countable earnings are all the PASS can compensate for in terms of increased SSI cash payments, because it’s countable earned income that Social Security uses to reduce monthly payments. If the beneficiary wants to fund the PASS using gross earnings, then less disposable income may be available to pay for day-to-day living expenses. That doesn’t mean that beneficiaries may never set
aside more than the countable earned income, only that they will be
required to show Social Security that they can cover living expenses on
the income left over. Another important point to consider is that Social
Security defines countable income what is left after Social Security
applies all applicable work incentives. This refers to provisions such as
Student Earned Income Exclusion and Impairment Related Work
Expenses, as well as Blind Work Expenses. The interaction of PASS with
these other work incentives is discussed in greater detail later on in the
module.

**Example of using earned income to fund a PASS:**

Aaron works part-time as a stocker at Walmart, but would
like to pursue a professional career that would lead to full-
time employment at a much higher salary than he currently
receives. He currently earns an average of $575 a month
and receives SSI only. He wants to know how much he has
available to fund a PASS. He doesn’t have any other work
incentives to apply. Here is how this works:

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculation (no PASS)</th>
<th>Calculation (PASS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned Income</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>General Income Exclusion (GIE)</td>
<td>− 0</td>
<td>− 0</td>
</tr>
<tr>
<td>Countable Unearned Income</td>
<td>= 0</td>
<td>= 0</td>
</tr>
<tr>
<td>Gross Earned Income</td>
<td>$575.00</td>
<td>$575.00</td>
</tr>
<tr>
<td>Student Earned Income Exclusion</td>
<td>− 0</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>= $575.00</td>
<td>= $575.00</td>
</tr>
<tr>
<td>General Income Exclusion (if not used above)</td>
<td>− $20.00</td>
<td>− $20.00</td>
</tr>
<tr>
<td>Remainder</td>
<td>= $555.00</td>
<td>= $555.00</td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE)</td>
<td>− $65.00</td>
<td>− $65.00</td>
</tr>
<tr>
<td>Remainder</td>
<td>= $490.00</td>
<td>= $490.00</td>
</tr>
</tbody>
</table>
### Step Calculation (no PASS) | Calculation (PASS)
--- | ---
Impairment Related Work Expense (IRWE) | − 0 | − 0
Remainder | $490.00 | $490.00
Divide by 2 | $245.00 | $245.00
Blind Work Expenses (BWE) | − 0 | − 0
Total Countable Earned Income | = $245.00 | = $245.00
Blind Work Expenses (BWE) | 0 | 0
Total Countable Earned Income | = $245.00 | = 0
Total Countable Earned Income | $245.00 | $245.00
PASS Deduction | − 0 | − $245.00
Total Countable Income | = $245.00 | = 0
Base SSI Rate (check for VTR) | $771.00 | $771.00
Total Countable Income | − $245.00 | − 0
Adjusted SSI Payment | = $526.00 | = $771.00
Adjusted SSI Payment | $526.00 | $771.00
Gross unearned income received | + 0 | + 0
Gross earned income received | + $575.00 | + $575.00
Subtotal | = $1,101.00 | = $1,346.00
PASS, BWE or IRWE Expenses | + 0 | − $245.00
**Total Financial Outcome** | = $1,101.00 | = $1,101.00

Keep in mind that Aaron actually earns gross wages of $575 each month. His PASS contribution of $245 only includes his countable earned income. Social Security disregards the remainder of the money he earns each month when determining Aaron’s monthly SSI payment. Aaron will have $771 in SSI payments plus his remaining earned income of $330 to pay.
for his day-to-day living expenses. Aaron could use more of his earned income to fund the PASS if he chose to and if Social Security approved it, but he would not receive more money from SSI and he would have less disposable income available to meet his living expenses.

**Using Deemed Income to Fund a PASS**

Using deemed income to fund a PASS is very similar to using ISM valued under the PMV rule. For a child under the age of 18 with parental deemed income, Social Security counts this income as a form of unearned income when it determines SSI eligibility and monthly payment amount. Assuming that the child had no other forms of income, the amount available to fund the PASS would be the amount of deemed income less the $20 general income exclusion.

**Example of using parental deemed income to fund a PASS:**

Frank is 17 and lives with his parents. Frank’s SSI is being reduced each month due to parental deemed income of $450. He has no other form of income. Frank has submitted a PASS application in which he proposes to fund his PASS with the deemed income from his parents. He plans to set aside all of the countable deemed income which will allow his SSI cash payment to be increased to the full FBR.

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculation (no PASS)</th>
<th>Calculation (PASS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned Income (Deemed income from the parents as determined by Social Security using the parent to child deeming rules)</td>
<td>$450.00</td>
<td>$450.00</td>
</tr>
<tr>
<td>General Income Exclusion (GIE)</td>
<td>− $20.00</td>
<td>− $20.00</td>
</tr>
<tr>
<td>Countable Unearned Income</td>
<td>= $430.00</td>
<td>= $430.00</td>
</tr>
<tr>
<td>Gross Earned Income</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Student Earned Income Exclusion</td>
<td>− 0</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>= 0</td>
<td>= 0</td>
</tr>
<tr>
<td>Step</td>
<td>Calculation (no PASS)</td>
<td>Calculation (PASS)</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>-----------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>General Income Exclusion (if not used above)</td>
<td>− 0</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>= 0</td>
<td>= 0</td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE)</td>
<td>− 0</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>= 0</td>
<td>= 0</td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE)</td>
<td>− 0</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>= 0</td>
<td>= 0</td>
</tr>
<tr>
<td>Divide by 2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Blind Work Expenses (BWE)</td>
<td>− 0</td>
<td>− 0</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>= 0</td>
<td>= 0</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td>$430.00</td>
<td>$430.00</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>− 0</td>
<td>− $430.00</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>= $430.00</td>
<td>= 0</td>
</tr>
<tr>
<td>Base SSI Rate (check for VTR)</td>
<td>$771.00</td>
<td>$771.00</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>− $430.00</td>
<td>− 0</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>= $341.00</td>
<td>= $771.00</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>$341.00</td>
<td>$771.00</td>
</tr>
<tr>
<td>Gross unearned income received</td>
<td>+ $450.00</td>
<td>+ $450.00</td>
</tr>
<tr>
<td>Gross earned income received</td>
<td>+ 0</td>
<td>+ 0</td>
</tr>
<tr>
<td>Subtotal</td>
<td>= $791.00</td>
<td>= $1,221.00</td>
</tr>
</tbody>
</table>
Spouse-to-spouse deeming situations are more complex as the income from the spouse may be either earned, unearned or both, and Social Security combines it with any income the eligible individual has when the agency determines SSI eligibility and monthly payment amount. As a first step, Social Security determines the countable income attributed to the eligible individual using the spouse-to-spouse deeming rules. This is the amount of money the individual now has to fund the PASS.

**Example of determining income by spouse-to-spouse deeming:**

Louise is an SSI recipient married to Victor, who is an ineligible individual. Louise gets $200 each month in CDB payments and Victor has a part-time job earning $800 each month. There are no children in the household. Louise is interested in using a PASS to help fund her occupational goal. How much money would Louise have to set aside each month if Social Security approves her plan?

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculation (no PASS)</th>
<th>Calculation (PASS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PASS, BWE or IRWE Expenses</td>
<td>− 0</td>
<td>− $430.00</td>
</tr>
<tr>
<td><strong>Total Financial Outcome</strong></td>
<td>= $791.00</td>
<td>= $791.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculation (no PASS)</th>
<th>Calculation (PASS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned Income (Louise’s CDB payment – Victor doesn’t have any unearned income to add)</td>
<td>$200.00</td>
<td>$200.00</td>
</tr>
<tr>
<td>General Income Exclusion (GIE)</td>
<td>− $20.00</td>
<td>− $20.00</td>
</tr>
<tr>
<td>Countable Unearned Income</td>
<td>= $180.00</td>
<td>= $180.00</td>
</tr>
<tr>
<td>Gross Earned Income (Victor’s wages from his part-time job – Louise doesn’t have any earnings)</td>
<td>$800.00</td>
<td>$800.00</td>
</tr>
<tr>
<td>Student Earned Income Exclusion</td>
<td>− 0</td>
<td>− 0</td>
</tr>
<tr>
<td>Step</td>
<td>Calculation (no PASS)</td>
<td>Calculation (PASS)</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Remainder</td>
<td>$800.00</td>
<td>$800.00</td>
</tr>
<tr>
<td>General Income Exclusion (if not used above)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Remainder</td>
<td>$800.00</td>
<td>$800.00</td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE)</td>
<td>$65.00</td>
<td>$65.00</td>
</tr>
<tr>
<td>Remainder</td>
<td>$735.00</td>
<td>$735.00</td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Remainder</td>
<td>$735.00</td>
<td>$735.00</td>
</tr>
<tr>
<td>Divide by 2</td>
<td>$367.50</td>
<td>$367.50</td>
</tr>
<tr>
<td>Blind Work Expenses (BWE)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>$367.50</td>
<td>$367.50</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td>$180.00</td>
<td>$180.00</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>$367.50</td>
<td>$367.50</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>$547.50</td>
<td></td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>$547.50</td>
<td>0</td>
</tr>
<tr>
<td>Base SSI Rate (check for VTR)</td>
<td>$771.00</td>
<td>$771.00</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>$547.50</td>
<td>0</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>$223.50</td>
<td>$771.00</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>$223.50</td>
<td>$771.00</td>
</tr>
<tr>
<td>Gross unearned income received</td>
<td>$200.00</td>
<td>$200.00</td>
</tr>
<tr>
<td>Gross earned income received</td>
<td>$800.00</td>
<td>$800.00</td>
</tr>
</tbody>
</table>
Using Title II Disability Benefits to Fund a PASS

A Title II disability benefit is nothing more than a specific form of unearned income from the perspective of the SSI program. What seems to confuse CWICs about using a Title II payment to fund a PASS is the fact that this is a benefit provided by Social Security. The fact of the matter is, however, that Social Security treats this income in exactly the same manner as any other form of unearned income when determining how much to set aside in the PASS.

Example of using Title II disability benefits to fund a PASS:

Amanda receives an SSDI benefit of $680. She has no other income. Amanda isn’t blind, she’s not married, she’s not a student under age 22, and she doesn’t live in a state that supplements SSI. Amanda wants to develop a PASS to fund her vocational goal of being a social worker. She wants to know how much she has to fund her PASS each month. The calculation sheet below shows how this works:

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculation (no PASS)</th>
<th>Calculation (PASS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subtotal</td>
<td>= 1,223.50</td>
<td>= $1,771.00</td>
</tr>
<tr>
<td>PASS, BWE or IRWE Expenses</td>
<td>− 0</td>
<td>− $547.50</td>
</tr>
<tr>
<td>Total Financial Outcome</td>
<td>= $1,223.50</td>
<td>= $1,223.50</td>
</tr>
<tr>
<td>Step</td>
<td>Calculation (no PASS)</td>
<td>Calculation (PASS)</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Remainder</td>
<td>= 0</td>
<td>= 0</td>
</tr>
<tr>
<td>General Income Exclusion (if not used above)</td>
<td>− 0</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>= 0</td>
<td>= 0</td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE)</td>
<td>− 0</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>= 0</td>
<td>= 0</td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE)</td>
<td>− 0</td>
<td>− 0</td>
</tr>
<tr>
<td>Blind Work Expenses (BWE)</td>
<td>− 0</td>
<td>− 0</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>= 0</td>
<td>= 0</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td>$660.00</td>
<td>$660.00</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>+0</td>
<td>+0</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>− 0</td>
<td>− $660.00</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>= $660.00</td>
<td>= 0</td>
</tr>
<tr>
<td>Base SSI Rate (check for VTR)</td>
<td>$771.00</td>
<td>$771.00</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>− $660.00</td>
<td>− 0</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>= $111.00</td>
<td>= $771.00</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>$111.00</td>
<td>$771.00</td>
</tr>
<tr>
<td>Gross unearned income received</td>
<td>+ $680.00</td>
<td>+ $680.00</td>
</tr>
<tr>
<td>Gross earned income received</td>
<td>+ 0</td>
<td>+ 0</td>
</tr>
<tr>
<td>Subtotal</td>
<td>= $791.00</td>
<td>= $1,451.00</td>
</tr>
<tr>
<td>PASS, BWE or IRWE Expenses</td>
<td>-0</td>
<td>− $660.00</td>
</tr>
<tr>
<td><strong>Total Financial Outcome</strong></td>
<td>= <strong>$791.00</strong></td>
<td>= <strong>$791.00</strong></td>
</tr>
</tbody>
</table>
WARNING: Remember that Title II benefits are affected by earned income differently than SSI benefits! Although Social Security doesn’t count income or resources that are set aside in a PASS, SSI eligibility determinations or when calculating payment amounts, setting aside earned income in a PASS does NOT exclude Social Security from counting these funds during TWP or SGA determinations conducted for Title II disability beneficiaries. The only way a beneficiary may deduct a PASS expense under the Title II program is if the goods or services he or she purchased also met the definition of Impairment Related Work Expenses (IRWEs). It’s quite possible for SGA-level earnings to cause the LOSS of Title II cash payments while a PASS is in place. Social Security can’t use PASS to reduce countable earnings for the purposes of SGA determinations.

EXAMPLE of how PASS affects other benefits:

Sammi is 25, unmarried, not blind, and lives in her own apartment. She receives CDB of $343 per month and earns $1,300 a month working part-time. She wants to work full-time for her current employer but doesn’t have reliable transportation. She has been setting aside the countable portion of her CDB and her earnings in a PASS to purchase a modified van.

Using her countable CDB benefits and her countable wages of $567.50 to pay PASS expenses allows Sammi to receive SSI payments at the full FBR. However, Social Security can’t deduct the $567.50 from the monthly wages of $1,300 when the agency deciding if Sammi is performing SGA.

One of the PASS expenses, though, is the cost of special transportation to and from work. Sammi pays $200 per month for an adapted paratransit van service. That part of the PASS expense meets all of the criteria for IRWE, so Social Security may deduct $200 of the PASS expenses as IRWE during the SGA determination. Because her earnings are $1,300, subtracting IRWE of $200 would mean that Sammi isn’t performing SGA in 2020.

The important thing to remember about beneficiaries like Amanda from our earlier example is that when she goes to work, the earned income will
count one way for SSI purposes and another way for Title II disability purposes. Let’s continue looking at Amanda’s case.

**Example of how PASS affects other benefits:**

Because Amanda is using her Title II benefit to fund the PASS, we have to think about how paid employment will affect her Title II cash payment when we plan what funds will be available over time to meet her vocational goal. If Amanda engages in SGA, her Title II cash payments will eventually end. This may cause a disruption in her PASS if we don’t plan for it carefully, because she won’t have any of this income to contribute to her PASS once cessation occurs.

Amanda used her Trial Work Period about ten years ago. However, she hasn’t performed SGA since she was first entitled to cash benefits under the Title II program, so she still has access to the cessation month and grace period if she performs SGA.

One of the milestones for Amanda’s PASS is to find a part-time job in the social work field while she is earning her master’s degree. Amanda finds a job working in a group home on weekends. Amanda places her countable earned income from this job into the PASS to assist in paying for her education.

After a year in her job at the group home, Amanda’s employer offers her additional hours and a raise that would pay her $1,800 per month, instead of her prior wages of around $800 per month. Amanda increases her contribution of countable earned income into her PASS. With her PASS amendment, however, Amanda also indicates that she will no longer have her SSDI benefit after three months at her new level of earnings. Because of the excellent counseling she has received from her local WIPA project Amanda knows that her SSDI benefits will stop after the grace period now that Social Security would consider her work to be SGA. Her PASS continues until she completes her master’s degree and attains full-time employment.
Although Amanda’s income would normally make her ineligible for SSI, placing the countable SSDI, and later the countable earnings in the PASS permits her to have a full SSI check for living expenses while saving towards her goal. As an SSDI beneficiary who was entitled for more than 24 months, Amanda has Medicare. She also has Medicaid in that state as an SSI beneficiary. When Amanda’s Title II benefit ends because she is performing SGA, she remains an SSI beneficiary. As long as her earnings remain at the SGA level, she won’t be entitled to the Title II benefit again, but she will retain her Medicaid entitlement through the 1619(b) program even when she is working full-time, until her earnings are high enough to replace SSI and the services she receives under Medicaid. She will also retain her Medicare benefit for at least 78 months after her checks stop, under the Extended Period of Medicare Coverage.

**Budgeting the PASS Excluded Income**

Once Social Security determines how much a beneficiary can set aside in a PASS, as described in the previous section, the CWIC can then help the individual determine whether he or she needs to request that Social Security exclude all of his or her countable income, or only a portion, for the life of the PASS. For example, if Amanda receives $680/month of SSDI, has $8,500 in social work training expenses, and anticipates needing 18 months to reach her goal of being a full-time social worker, then she won’t need to request that Social Security exclude all her countable income during the life of the PASS. If she set aside $660/month of her countable SSDI for the full 18 months of the PASS, she would end up with a total of $11,880 in excluded income. Because she only needs $8,500 to reach her goal, the PASS could only exclude up to the amount of the necessary expenses. So, when Amanda is ready to complete her PASS application, she only needs to request that Social Security exclude $8,500 of her SSDI during the life of her PASS.

A simple way to help a beneficiary determine if he or she will have too much, too little, or just enough PASS-excluded income to cover his or her expenses is to take the monthly countable income expected during the life of the PASS and multiply it by the expected length of the PASS. In Amanda’s case, the CWIC would take $660 (her monthly countable SSDI)
and multiply it by 18 (total number of months of the PASS), resulting in $11,880.

Another important area of budgeting with PASS is in helping beneficiaries understand how much in PASS-excluded funds they will have available and when. Because the individual is simply setting aside each month the approved countable income, it could take time to save up to purchase one or more of their PASS-approved items. For example, Social Security approved Amanda to pay $2,000 for a social worker training program, and she planned to start it the month after her PASS started, she would quickly find that she won’t have enough PASS funds set aside to pay the tuition. If she is only setting aside $660/month, and her PASS has only been going for two months, then she will only have saved $1,320. Therefore, it’s important that CWICs assist beneficiaries in budgeting for when they will have sufficient PASS funds to cover each of the requested PASS expenses.

How PASS Interacts with Other SSI Work Incentives

There are a few things to keep in mind about the interaction of PASS and other SSI work incentives.

Student Earned Income Exclusion (SEIE)

While SEIE is a powerful work incentive, one of its drawbacks is how it interacts with PASS. Because SEIE allows Social Security to exclude so much earned income, it leaves little countable income with which to fund a PASS. There are some instances in which a PASS would be more beneficial for the long-term career development of a student, but isn’t usable due to SEIE. A potential solution to this problem lies in the SEIE. Because Social Security can exclude so much earned income, students could take these wages and put them in the bank. An individual could use the PASS not to set aside income, but resources. By using the SEIE and PASS in combination like this, the young adult could actually save for post-secondary education or training that would lessen future dependency on VR funds or educational loans. While using the SEIE, the student would keep most, if not all, of the SSI payment intact while saving for an education.
Impairment Related Work Expense (IRWE)
A PASS can pay for the goods or services that would normally fit the definition of IRWE, provided that the beneficiary needs the goods or services to achieve the work goal. However, an expense that Social Security deducts under PASS, may not simultaneously be deducted as IRWE in the same calculation for SSI purposes. When this occurs, it’s generally most advantageous to include the expense under the PASS instead of claiming it as an IRWE because IRWEs only offer approximately one dollar of reimbursement for every two dollars in expense.

The individual may claim expenses as both an IRWE and under a PASS simultaneously when he or she has both Title II disability benefits and SSI. The individual could claim the expense as an IRWE to reduce countable income during an SGA determination for the Title II disability benefits and include it as a PASS expense for the purposes of SSI.

Blind Work Expenses (BWE)
Like IRWE, an expense that Social Security pays under the PASS, the beneficiary may not also deduct under the Blind Work Expense provisions in the same month. Unlike IRWE, however, BWE offers the same rate of return as a PASS, so the beneficiary simply needs to decide where the expense best fits and apply it accordingly.

Section 301 Continuation of Benefits after Medical Recovery
As discussed in earlier units from this Module, the section 301 provision allows continuation of disability or blindness benefit payments to certain individuals whose disability or blindness medically ceases while he or she is participating in an appropriate program of vocational rehabilitation (VR) services, employment services, or other support services.

Effective March 1, 2006, a PASS qualifies as an appropriate program for the purpose of section 301 determinations. A PASS qualifies because it’s a program of employment or other support services carried out with an agency of the federal government (Social Security) under an individualized written employment plan similar to an Individualized Plan for Employment (IPE) used by state VR agencies. Eligibility for section 301 payments will apply if:
• The individual is participating in a PASS that Social Security approved before the date of disability or blindness cessation;
• Participation continues beyond the two grace months after disability or blindness cessation; and
• Social Security has determined that the individual’s completion of the plan, or continuation in the plan for a specified period of time, will increase the likelihood that he or she won’t return to the disability or blindness benefit rolls.

**Appealing PASS Determinations**

When a beneficiary disagrees with a PASS Specialist’s determination, there is a process for appealing this decision. We describe the standard Social Security appeals process for all initial determinations in Unit 9 of this module. Generally, these rules also apply to PASS cases. However, there are also a few differences in how Social Security handles appeals with respect to PASS cases. First, current regulations provide individuals with the option of having an informal conference instead of a formal case review as part of the first step of the appeals process, which is generally known as “reconsideration.” The regulations further state that the conference is to be conducted by the Social Security staff person who will make the decision on the case. Because of this, the PASS Specialists handle most reconsideration requests. If the individual requests a formal case review rather than an informal conference, Social Security requires that a PASS expert other than the one who made the initial determination review the case.

PASS Specialists conduct most PASS reconsideration interviews by telephone, although there are certain instances when PASS Specialists may be permitted to conduct the interview in person. If the individual has pertinent material to submit, he or she may submit it to the PASS Specialist by mail, fax, or email. After the PASS Specialist has conducted the interview and reviewed all pertinent materials, he or she makes a written decision and issues a notice of the decision to the beneficiary.

If, after the reconsideration, the beneficiary remains dissatisfied with the determination related to the PASS, the beneficiary may request a hearing before an administrative law judge (ALJ). This written request should include:
• The individual’s name and Social Security number;
• The name and Social Security number of the individual’s spouse, if any;
• The reasons the individual disagrees with the previous determination or decision;
• A statement of additional evidence the beneficiary will submit and the date he or she will submit it; and
• The name and address of any designated representative.

The beneficiary must file the request at a Social Security office or send it directly to the PASS Specialist within 60 days after the date the individual receives notice of the previous determination or decision. If the beneficiary doesn’t meet the 60-day deadline, it’s possible under some circumstances for Social Security to grant him or her more time to make the request. The request for an extension of time must be in writing and it must give the reasons why the individual didn’t file the request for a hearing within the stated time period. If the beneficiary shows that there was good cause for missing the deadline, Social Security will extend the time period.

The CWIC’s Role in Assisting with Plans to Achieve Self-Support (PASS)

Social Security expects CWICs to be actively involved in the process of assisting beneficiaries with developing Plans to Achieve Self-Support. When an individual indicates the desire to pursue a PASS to achieve his or her work goal, the CWIC should begin by fully explaining the particulars of this complex work incentive and utilizing a variety of tools to help define appropriate candidacy and development of information to be included in the PASS application. A variety of sample templates to assist in this activity are in the Conducting Independent Research section, including the PASS Candidate Checklist and PASS Monthly Expense Sheet.

As you assist the beneficiary in completing the PASS form, it’s helpful if you break it up into small sections for the individual to work on one at a time. The PASS application can be overwhelming when a beneficiary sees it in its entirety. Tackling small sections individually makes the task more manageable and helps the beneficiary stay focused. The CWIC’s job isn’t
to write the plan for the individual. It’s the CWIC’s role to function as a teacher and facilitator for plan preparation. An effective strategy in the planning phase is to communicate regularly with the individual and assign “homework” at the conclusion of each consultation. The beneficiary should be prepared to present his or her finished “homework” assignment at the next scheduled contact for discussion and addition to the plan. Each homework assignment reflects a component of information required by the PASS application. Once the individual has completed the PASS application, it’s ready for the individual to send to the designated PASS Cadre in the region. Although the PASS is now in Social Security’s hands, the CWIC’s role doesn’t end. The CWIC may have interaction with the PASS Specialist assigned to review the plan. The CWIC will also be following up with the individual periodically to ensure that things are going smoothly and that he or she requests amendments if things change in regards to the plan.

Another role for the CWIC arises when a Title II beneficiary wants to initiate a PASS. An extra step is required in these cases because the beneficiary will need to submit an application for SSI at the same time as he or she submits the PASS for review. The two processes typically occur simultaneously for persons interested in establishing a PASS who are currently not SSI eligible. These individuals will have to go through the Social Security application process to determine eligibility prior to the PASS resulting in Social Security issuing the SSI cash benefit. The CWIC should alert the beneficiary that he or she will need to submit both the PASS application AND the SSI application to the local Social Security field office at the same time. The local Social Security office will forward the PASS application on to the appropriate PASS Cadre for review while they determine eligibility.

As we have discussed, the CWIC has an integral role in facilitating the development of a PASS. Despite this, CWICs make the following common mistakes when working with beneficiaries who want to pursue a PASS:

- **The beneficiary has already achieved the desired vocational goal.** Too often CWICs try to use a PASS to pay for items needed to maintain the job the beneficiary already has. For example: Mark is employed full-time at the local high school cafeteria and he relies on his parents to drive him to and from work. Mark’s parents are divorcing, causing his mother to return to full-time work. Mark no longer has transportation to work,
thus he wants to write a PASS to purchase a car. Mark has no desire to pursue a different vocational goal; he simply wants to buy a car. This isn’t a viable PASS, as he has already achieved his work goal.

- **You describe the PASS to the individual, provide an application, and refer the beneficiary to the PASS Cadre for further assistance.** As previously mentioned, Social Security expects that CWICs will be involved with the entire PASS development process. This isn’t an area where you simply explain the work incentive and then pass it off to others for development assistance. It’s the CWIC’s job to work closely with beneficiaries who are interested in developing a PASS.

- **CWICs write the PASS.** It’s critical to remember that the CWIC’s role is to guide and facilitate the process. This is the beneficiary’s plan, and he or she must be directly involved in the development. The beneficiary needs to have a vested interest in the development in order to successfully complete the PASS.

**Strategies for Success:**

- Thoroughly explain the whole process of PASS development, approval, and follow-through.

- Utilize the PASS Candidate Checklist when an individual indicates desire to establish a PASS to help determine if a PASS is a good fit and to identify possible areas of weakness that you will need to address.

- Schedule regular communication with the beneficiary to begin PASS development. This can be done face-to-face, by phone, or by email.

- Assign “homework” to the individual in small sections, and set deadlines by which the sections are due.

- Remember that the CWIC’s role is to be a guide through the process, NOT the author of and decision-maker for the PASS.

- Encourage the individual to thoroughly participate in the process. The PASS is likely to be more successful if the individual has invested his or her own time and effort into developing the plan.
• Strategize with other agencies, such as VR, for cooperation and buy-in to the PASS.

• CWICs should be prepared to work closely with PASS Specialists to advocate on behalf of the beneficiary during the PASS review and approval process.

NOTE: It’s not up to the CWIC to determine who can or can’t have a PASS. Approval of these plans is solely the responsibility of the Social Security PASS Specialists. An individual who wishes to pursue a PASS has the right to do so, even if the CWIC doesn’t feel that Social Security will approve the PASS, or that the individual is a strong PASS candidate. While the CWIC may want to limit the amount of time spent developing a PASS that has little or chance of approval based on the current regulations, the CWIC can’t flatly refuse to assist.

Frequently Asked Questions about Helping Facilitate PASS Development

CWICs have lots of questions about how to help beneficiaries with the development, submission, approval, and subsequent management of a PASS. The PASS form is long and appears very intimidating at first. CWICs may become confused about whom to even talk to about PASS and how far to go in the facilitation process. Below are the most common questions CWICs pose about supporting PASS development:

How do I know with whom to even discuss PASS?

Certain beneficiaries are in situations that are more conducive to use of PASS than others. These are the people CWICs should watch for:

• Concurrent beneficiaries;

• SSI recipients with some form of countable income (earned or unearned); and

• Title II beneficiaries with relatively low monthly payments (under $1,000 per month).
Keep in mind that PASS candidates must have clear career goals, and the goal must require that the beneficiary pay for something in order to reach the goal. The beneficiary must NEED items or services in order to achieve the career goal for a PASS.

**How do I spot a really good PASS candidate?**

All three of these items must be in place for a PASS to work:

1. The person MUST have a feasible occupational goal which is expected to result in SGA-level earnings or substantial reduction in SSI; and
2. The person must have some form of countable income or resources to set aside in the PASS; and
3. The person must need items or services in order to achieve the occupational goal.

There are also certain situations in which a PASS simply won’t work:

- The individual has no desire to work, or the occupational goal clearly won’t lead to SGA-level employment or substantial reduction in SSI.
- The individual is already working at a substantial level.
- There is no income or resources to set aside in the PASS.
- The individual simply can’t establish eligibility for SSI, even with a PASS.
- The person can’t live on disposable income left after a PASS is in place.

**What can I do to help a beneficiary decide whether or not a PASS is right for him or her?**

CWICs need to help beneficiaries assess their strengths and potential weaknesses as a PASS candidate BEFORE they invest time and effort in developing the PASS. There is absolutely no point in developing a PASS that has zero chance of being approved. This wastes the time of both the CWIC and the beneficiary, and needlessly raises the beneficiary’s expectations and hopes, only to see him or her suffer a letdown when Social Security denies the PASS. Using the PASS Candidate Checklist is a great way to conduct an assessment of PASS appropriateness. This tool
will highlight any vulnerability the beneficiary will have in terms of PASS approval in advance. The CWIC can use these indicators to either help the beneficiary determine NOT to pursue the PASS, or to identify those areas that will require extra attention when writing the PASS. A copy of the PASS Candidate Checklist is provided at the end of this unit.

**What is the best way to introduce PASS to a beneficiary who is a solid PASS candidate?**

The best approach involves four simple tasks:

1. Focus on the possibilities and benefits of a PASS: Don’t dwell on how much time and work it entails.
2. Cover the basic concepts: Don’t overwhelm beneficiaries with too much detail in the beginning.
3. Explain your role and what you can do to assist with developing and managing the PASS.
4. Ask for a decision: yes or no?

**When the decision to pursue PASS is a “go,” what are the steps I need to take to get started?**

1. Explain the PASS submission, review, and approval process carefully.
2. Introduce the PASS form and go over it in detail to answer questions.
3. Assign a manageable amount of “homework” to the beneficiary and support system.
4. Establish a deadline for completion of first homework assignment and next meeting.

**NOTE:** When self-employment is the goal, the first step MUST be the individual’s development of his or her business plan. Don’t begin the PASS until the beneficiary has developed the business plan in accordance with PASS requirements.
**How exactly do I “facilitate” completion of the PASS homework?**

CWICs shouldn’t jump in and write the PASS for the beneficiary. The objective is to support the beneficiary to complete as much of the work as possible. If possible, have the beneficiary write or at least outline sections independently, and you merely advise and edit. If this doesn’t work or if the capabilities of the beneficiary make this impossible, the next option is to have the beneficiary use his or her employment support team to assist with writing or outlining sections with your advising and editing. This could include a job coach, a case manager, the VR counselor, the representative payee, or any combination of people collaborating to support the beneficiary with PASS development. The final fallback position is for you to interview the beneficiary and support system and develop the written content. The beneficiary’s employment support team would review and approve the final product.

**How do I know when the PASS is good enough to submit for review?**

Don’t wait until the PASS is perfect. Submit the PASS when an acceptable working version is ready. As long as the beneficiary has addressed every section at some level, it should be sufficient for initial submission. As the CWIC, you should be identified in the PASS with contact information provided. Beneficiaries need to be prepared to answer questions from the PASS Specialist — it’s THEIR PASS, not the CWIC’s.

**One of the beneficiaries I work with just had their PASS approved. Now what?**

Beneficiaries often view the approval as the end of the PASS process, but it’s really just the beginning — now the hard part begins! You should invest significant time in educating the beneficiary about his or her responsibilities and offer advice about managing the PASS over time. The handout at the end of this unit should guide your discussions with beneficiaries about how to successfully manage their PASS. This handout *(Tips for Managing Your PASS)* can also be found on the VCU NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=61).
How much am I supposed to follow up with a beneficiary who has an approved PASS?

Beneficiaries with approved PASS plans are extremely high-priority WIPA clients. These are the very people who MOST need the CWIC’s time and attention. Start by setting up a calendar of contact points with the beneficiary. Contact points will depend upon the milestones contained in the PASS and the unique needs of the beneficiary. You should initiate contact with the beneficiary on a regular basis to help keep things on track.

Intervals between contacts will depend on the individual and his or her plan, but all beneficiaries with active PASS plans should receive regular contact from WIPA personnel throughout the life of the plan.

What do I do when something goes wrong with the PASS?

In life, rarely does everything go exactly as planned, and managing PASS plans is no exception to this rule. Here are some tips for how you can handle PASS problems:

- Check in with the beneficiary on a regular basis to identify potential problems that you can catch before they become serious.
- Discuss problem areas openly and honestly with the beneficiary. Encourage the beneficiary to discuss problems with the PASS Specialist. Offer assistance with this as needed.
- Help the beneficiary develop a plan of correction — how will the problem be resolved?
- Hold the beneficiary accountable for following the steps needed for resolution.

Conclusion

Earlier in this module, you learned that people who work and receive SSI usually have more money for living expenses than SSI beneficiaries who don’t work. SSI, discussed in the last three units, is a benefit based on financial need. PASS offers a unique opportunity for beneficiaries to achieve vocational goals, increase their available income, reduce their
dependence on benefits, and improve their quality of life. Coupled with
the other work incentives discussed earlier, particularly the Medicaid
protection afforded under the 1619(b) provisions, PASS may assist
individuals to also retain essential supports until they are able to fully
support themselves. While PASS isn’t a work incentive that every
beneficiary is eligible for or could benefit from, it provides incredible
advantages for individuals who truly want to establish a successful career
that leads to economic self-sufficiency.

Remember that facilitating use of work incentives such as PASS is what
CWICs do — it’s the primary function of the job. CWICs who never
facilitate PASS development aren’t doing their whole job — it’s just that
simple. As a general rule of thumb, CWICs should strive to have at least
one PASS being developing or managed at any given time. CWICs
shouldn’t let the PASS form intimidate them — it’s only a form and really
isn’t that difficult to complete. Just take the sections one by one and
work with the beneficiary to address the items to the best of your ability.
The very best way to learn how to develop a PASS is to jump right in and
do it. If you get stuck, seek help from your VCU NTDC technical
assistance liaison.

**Conducting Independent Research**

**PASS Online**

This is a great website sponsored by Cornell University that provides
specific information about PASS as well as an online tutorial to help
CWICs learn how to develop a PASS (http://www.passonline.org).

POMS Reference

**POMS SI 00870.000 – Plans to Achieve Self-Support for Blind or
Disabled People – Subchapter Table of Contents**

(https://secure.ssa.gov/apps10/poms.nsf/Inx/0500870000)

**Additional Resources**

This section contains four important resources related to PASS:

1. **PASS Candidate Checklist** (https://vcu-
ntdc.org/resources/viewContent.cfm?contentID=58)
2. Handout for beneficiaries entitled “So, Your PASS was Approved – Now What? Tips for Helping Beneficiaries Manage a Plan to Achieve Self Support” (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=61)

3. PASS Form SSA-545-BK dated 8/2019 found online (https://www.ssa.gov/forms/ssa-545.pdf)

All of these documents are available on the VCU NTDC website (https://vcu-ntdc.org/resources/resourceDetail.cfm?id=3)
Competency Unit 8 – Self Employment and Social Security Disability Benefits

Introduction

There are several important reasons why the CWIC training manual includes an entirely separate unit on the effect of self-employment income (SEI) on Social Security disability benefits. First, Social Security treats self-employment income differently than wages in both the SSI and Title II disability programs in some important ways and CWICs need to be aware of these critical differences. Second, several unique work incentives apply to self-employed individuals that don’t apply to individuals in wage employment. In addition, some work incentives that apply in both wage employment and self-employment situations apply differently when the beneficiary is self-employed. You will need to counsel beneficiaries who are pursuing a goal of self-employment or small business ownership on the unique manner in which self-employment income affects disability benefits and the ways in which an individual may apply work incentives to help achieve a self-employment goal.

Self-employment is an increasingly popular employment objective for individuals with disabilities because it offers both significant flexibility as well as earnings potential. State VR agencies and ENs are supporting a growing number of beneficiaries who are pursuing a self-employment goal, and the volume of WIPA referrals on self-employment cases has also increased significantly in the past few years. Now more than ever, CWICs need to develop specific expertise in handling self-employment cases and must be skilled at counseling self-employed beneficiaries on benefits issues.

Telling the Difference between Wage Employment and Self-Employment

When providing WIPA services, there will be times when it’s difficult to determine if the earned income a beneficiary gets is from wage
employment (i.e., an employer-employee relationship exists) or if the person is actually self-employed. Determinations about whether earned income represents “wages” or “self-employment income (SEI)” can get very complicated. To add further difficulty, these issues don’t fall simply under the jurisdiction of the Social Security Administration. Both the U.S. Department of Labor (DOL) and the Internal Revenue Service (IRS) have a stake in these determinations and often have overlapping laws and regulations. These determinations are critically important because the Title II and SSI programs treat various forms of income differently. If CWICs are unclear about whether income is wages or self-employment income, they may give incorrect information about how Social Security will treat it. In turn, this may cause a beneficiary to make a series of poor choices about work.

This unit isn’t designed to make CWICs experts in determinations of wage employment or self-employment. There are literally hundreds of POMS citations covering this topic, and the issues involve complex legal interpretations. The following sections will provide a general understanding of how wage employment and self-employment differ, and how Social Security decides which situation applies to a beneficiary with earned income.

**Social Security and the IRS make Independent Employment Determinations**

Social Security’s regulations state: “If there is a question about whether you are working as an employee or are self-employed, we or the Internal Revenue Service (IRS) will make a determination after examining all of the facts of your case.”

It’s important to understand that the IRS and the Social Security Administration have very different rules that govern these determinations. Social Security will make an independent employer-employee relationship determination to establish a worker’s coverage status or to resolve earnings discrepancies. The IRS makes an independent employer-employee relationship determination to establish a worker’s obligation to make Federal Insurance Contributions Act (FICA) contributions and for tax withholding purposes. Social Security doesn’t need to ask for copies of IRS determinations or rulings on employer-employee relationships. Social Security will make its own employment determination, regardless of whether or not there is an existing IRS determination. In addition, Social Security doesn’t defer to the IRS’
determination that a worker is, or isn’t, an employee. The IRS will make its employment determination based on tax liability. The Social Security employment determination is for Social Security coverage purposes. Because of this, it’s possible for the IRS to consider a beneficiary to be self-employed for IRS purposes, but in wage employment for Social Security purposes, and vice versa. This can be very confusing for beneficiaries and CWICs.

**Social Security’s Procedures for Making Employment Determinations**

When a beneficiary’s employment situation is unclear, local Social Security personnel may use Form SSA-7160 (Employment Relationship Questionnaire) to make an employment determination. The field office will request the worker and his or her alleged employer to complete this form to determine the worker’s employment status. When possible, both the worker and the employer should complete the form independently of each other. In some cases, Social Security personnel may assist the worker and the employer in completing the form to ensure that they fully understand the questions. Form SSA-7160 is a questionnaire that gathers information from the worker and the alleged employer to determine the worker’s employment status using a set of rules known as the Common Law Control Test.

**Common Law Control Test**

Social Security uses common law rules to establish the status of a worker (e.g., employee, contractor, or self-employed) by determining whether a relationship exists between the worker and the person receiving the services. Social Security examines facts and circumstances of individual cases to determine the degree of control the employer has over the worker. The courts identified various factors that Social Security can use to determine if an employment relationship exists. These factors are described in detail in [POMS RS 02101.000](https://secure.ssa.gov/apps10/poms.nsf/lnx/0302101020), which can be found online (https://secure.ssa.gov/apps10/poms.nsf/lnx/0302101020).

Social Security will consider an individual an employee if his or her relationship with the person receiving the services meets the common-law control test. Under this test, the individual is subject to control by the person receiving the services as to when, where, and how the work is
done. The control doesn’t need to be exercised for an employer-employee relationship to exist; the right to exert such control is enough. In borderline cases, a determination as to whether an individual is subject to the right of sufficient direction and control by the person for whom the services are performed is often a difficult one to make. Social Security must examine the relationship of the business and the worker. The three categories of evidence and key facts that demonstrate the right to direct and control are:

1. **Behavioral control**

The following are examples of behavioral control:

- Worker receives instructions from the business
- Worker receives training from the business

2. **Financial control**

The following are examples of financial control:

- Method of payment — worker receives an hourly wage or salary rather than a lump sum payment for a particular task
- Worker doesn’t have the opportunity for profit or loss
- Worker doesn’t make his or her services available to the relevant market
- Worker doesn’t make significant investments
- Worker doesn’t have unreimbursed expenses

3. **Relationship of the parties**

Examples of relationships between a business and a worker:

- Discharge or termination — either business or worker can end the relationship before the job is completed
- Employee benefits (beyond monetary compensation)
- Intent of parties — written contracts that indicate both parties believe they are in an employer-employee relationship
- Worker’s services are a part of business’s regular business activity
A finding that an individual is an employee means the individual was subject to control over when, where, and how (the means and methods) to perform the work. This finding indicates that the employer has the right to direct and control the worker. Social Security determines a worker to be an employee when the majority of these conditions are met:

- The employer furnishes the worker with tools or equipment and a place to work. (However, some artisans such as carpenters and plumbers usually provide some or all of their own tools.);
- The employer may fire the worker;
- The employer pays the worker’s business or travel expenses;
- The employer sets the work hours, requires that the worker work full-time, or restricts the worker from working for others;
- The employer pays the worker by the hour, week, or month;
- The worker doesn’t hire, supervise, or pay assistants (unless employed as a foreman, manager, or supervisor);
- The worker must perform the job personally; and
- The worker receives training from the employer, or the worker must follow the employer’s instructions.

A worker is self-employed when he or she meets the majority of these conditions:

- Advertises his or her services to the general public;
- May be liable for damages if he or she quits before completing the job;
- Makes a profit or suffers a loss;
- Pays his or her own expenses and provides the equipment and work place; and
- Works for a number of persons or firms at the same time.

Determinations involving the common law control test can be complicated. CWICs should always refer beneficiaries to the local Social Security office for these determinations.

A reader-friendly summary of the rules governing employment determinations can be found in the Social Security Handbook here:
Types of Self-Employment

Part of the process of determining when a beneficiary is self-employed involves deciding what type of self-employment the individual is engaged in or plans to be engaged in. These classifications are important because the Social Security Administration may treat different forms of self-employment in different ways. Determining which form of self-employment a beneficiary is participating in can be very complicated. When in doubt, CWICs should refer the case to the local Social Security field office for assistance. The most prevalent types of self-employment are described below, but CWICs need to understand that many different situations may occur that Social Security may investigate on a case-by-case basis before making a determination.

Small Business Ownership

This is perhaps the most common form of self-employment and is the easiest to identify. Small business ownership occurs when a beneficiary owns all or part of a business or micro-enterprise and derives earned income by performing services for that business. Small businesses may assume many forms and owners can organize them under many different structures including sole proprietorship, partnership, limited liability companies (LLCs), and corporations. A beneficiary may be the only owner of a company or business, or may be one of a number of owners. Social Security considers an individual who owns a share of a business to be self-employed only when he or she performs some form of work or service for that business. It’s possible to be an investor in a business but for Social Security to not consider that person self-employed or receiving earned income, depending on what role the person plays within the business. Some very complicated rules apply to businesses that are incorporated and are explained later on in this unit.

Independent Contractors

An independent contractor is a person, business, or corporation that provides goods or services to another entity under terms specified in a contract or within a verbal agreement. Unlike an employee, an independent contractor doesn’t work regularly for an employer but works
as and when required. Independent contractors usually receive pay on a freelance basis.

In the United States, any company or organization engaged in a trade or business that pays more than $600 to an independent contractor in one year is required to report this to the Internal Revenue Service (IRS) as well as to the contractor. Independent contractors don’t have income taxes withheld from their pay as regular employees do. Independent contractors are responsible for their own self-employment tax.

In determining whether an individual is an employee or an independent contractor, Social Security applies the common control rule as previously described. When there is doubt about whether or not a beneficiary is working as an independent contractor, always refer the person to the local field office for a determination. These determinations can be very complex, and CWICs aren’t authorized to perform them.

**Statutory Employees**

Statutory employees include workers from four occupational groups who perform services under certain prescribed circumstances. These workers can’t qualify as employees under the common-law rules, but their work conditions are so similar to those who do that Congress provided for their coverage as statutory employees, rather than as self-employed persons. Statutory employees include:

- Agent or commission drivers who deliver food or beverages (other than milk) or pick up and deliver laundry or dry cleaning for someone else;
- Full-time life insurance salespeople who sell primarily for one company;
- Home workers who work by the guidelines of the person to whom they are providing services; and
- Traveling or city salespeople who work full time for one company or person.

These workers are employees for Social Security coverage purposes when:

- They have no substantial investment in facilities to do the work (other than transportation);
• They perform services in a continuing work relationship; and
• The service contract contemplates that they will perform substantially all of the services personally.

For more information about statutory employees, refer to **POMS RS 02101.300 - Statutory Employees**, which can be found online (https://secure.ssa.gov/apps10/poms.nsf/lnx/0302101300).

**Statutory Non-Employees**

When workers don’t meet the qualifications of an employee under the common law control test, Social Security will likely consider them to be self-employed as independent contractors. However, under IRS statute, Social Security does NOT consider workers in the following three occupations to be employees if they meet certain qualifications:

• Companion sitters;
• Direct sellers; and
• Real estate agents.

Section 3506 and 3508 of the Internal Revenue Code provide that these workers are “statutory non-employees.” This means the IRS treats them as self-employed for all federal tax purposes, including income and employment taxes, if a) substantially all payments for their services as direct sellers or real estate agents are directly related to sales or other output, rather than to the number of hours worked, and b) they perform their services under a written contract providing that the IRS will not treat them as employees for federal tax purposes.

For more information about how Social Security views real estate agents and other similar salespeople, refer to **RS 02101.200 Real Estate Agents and Salespeople** (https://secure.ssa.gov/apps10/poms.nsf/lnx/0302101200) and **RS 01802.232 Real Estate Agents and Direct Sellers** (https://secure.ssa.gov/apps10/poms.nsf/lnx/0301802232). Again, CWICs don’t make these determinations, but should refer beneficiaries to the local field office.

For more information, refer to the VCU NTDC resource documents titled “**Determining when a Beneficiary is an Employee or Self-Employed,**” which is available online (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=166)
Unusual Self-Employment Situations

Certain types of activities can be difficult for Social Security to classify as self-employment, wage employment, or hobbies. The situations CWICs encounter the most include the following:

Ministers and Members of the Clergy

Social Security typically considers services performed by ministers or other members of the clergy to be self-employment for Social Security coverage purposes, unless the minister has applied for and received an exemption from SECA (Self-Employment Contributions Act) taxes. However, ministers do receive an IRS Form W-2 (Wage and Tax Statement) from the church, order, or other entity for which they perform services. The Form W-2 shouldn’t show Social Security and Medicare wages or taxes because the beneficiary would pay these directly; the church wouldn’t withhold them. Ministers can receive a variety of things in exchange for ministerial duties, some of which count as earned income while others won’t. Gross income for a minister includes the following items:

- Salary;
- Fees and honoraria for officiating at weddings, christenings, funerals, and other services in the exercise of the ministry;
- Rental allowance for a parsonage or value of a parsonage furnished to the minister;
- Value of meals part of the compensation package; and
- Travel and automobile allowances, although the minister can deduct these same items as business expenses he or she incurred in the performance of ministerial duties.

A minister excludes the following items from gross income:

- Pensions and retirement pay;
- Parsonage or housing allowances when the employer includes it in retirement pay after the minister retires, or any other retirement benefit the minister received after retirement pursuant to a church plan as defined in Section 414(e) of the Internal Revenue Code, Social Security must exclude when
computing NESE. For example, if a minister retires from Church A and the rental value of a parsonage or any other allowance is included in his or her retirement pay, Social Security must exclude the parsonage allowance when determining NESE. However, if this same retired minister goes to work for Church B and it pays him or her a parsonage allowance, Social Security must include this new income when computing NESE.

- Gifts, unless they are part of the minister’s compensation.

CWICs must be careful when counseling beneficiaries who say they are members of the clergy, because there is so much variance in what this actually means. In addition, even when a beneficiary does meet Social Security’s definition of a clergy member, there are some cases in which an ordained minister is clearly an employee of the church or religious organization. For example, this is often the case for individuals who serve as youth ministers or music ministers for churches or religious groups. There are even special rules for certain members of the clergy, such as individuals who have taken a vow of poverty or clergy who are in the U.S. armed forces. Whenever there is any doubt about the employment status of a minister or member of the clergy, refer the case to the local Social Security field office for a formal determination.

**Directors of Non-Profit Organizations**

Beneficiaries sometimes want to start and manage a non-profit organization that they believe is a form of self-employment. In fact, Social Security doesn’t consider an executive director or other paid manager of a non-profit corporation that has federal tax exemption status under 501(c) (3) of the IRS code as self-employed. A non-profit organization isn’t “owned” by any person or entity in the way a business is owned, but rather is governed by a volunteer board of directors. The executive director of a non-profit organization is an employee of the organization who reports to the board of directors.

**Artists and Authors**

Social Security applies the same concepts described earlier when determining whether income derived from selling pieces of art or earning royalties from published written work constitutes self-employment income. Beneficiaries begin some endeavors as hobbies with no intention of ever making a profit and as such, generally don’t constitute engaging
in trade or business. For example, if a beneficiary receives a royalty payment based on products he or she made originally as part of a hobby, Social Security won’t consider the payments as “earned” for the period the individual was doing the activity as a hobby. However, if the beneficiary continues to provide the same services or products with the intention of making a profit, Social Security might consider any income he or she derived as self-employment income. In other cases, a beneficiary is clearly in the business of producing and selling art or literature, in which case any net earnings from self-employment derived from the business both the IRS and Social Security would count as earned income. Again, CWICs aren’t authorized to make determinations of this type. When any doubt exists, you should refer the beneficiary to the local Social Security field office for a formal determination.

**Farmers**

Social Security considers beneficiaries who derive income from farming to be self-employed unless they are working as an employee of someone else who owns a farm. The rules governing how both the IRS and Social Security count farm income are terribly complex and depend on the unique circumstances of the individual. CWICs who encounter a self-employed farmer should contact their technical assistance liaison with the VCU NTDC for help.

**Understanding Net Earnings from Self Employment (NESE)**

Before a CWIC can understand how self-employment income affects Social Security disability benefits, you must understand how Social Security views income generated from self-employment. For people who are self-employed, Social Security doesn’t count gross profits the business generated, but rather “net earnings from self-employment” (NESE). This is completely different from the way Social Security treats earned income from wage employment in which Social Security counts gross wages. The terms “gross” and “net,” and what they mean for someone who is self-employed and receiving Social Security disability benefits, can be confusing. Here is a brief explanation of the various terms:
• Gross income is the total amount of money that a business takes in from sales of products or services. This is also called “gross sales” or sometimes “gross receipts.”

• Net income is the amount of profit that the business makes. Profit is the gross sales minus any legitimate expenses that the business incurred. It’s this figure that a business owner reports to the IRS from which it assesses business taxes,

• Net earnings from self-employment (NESE) is the net income or net profit from a business less half of the self-employment taxes the beneficiary pays. More detail on how NESE is derived is provided in the next section.

**Turning Net Income into NESE**

The difference between net income from a business and NESE is the deduction of the extra Social Security tax that self-employed people pay. For people in wage employment, employers pay half of the Social Security tax on an employee’s behalf, but self-employed individuals must pay the whole sum by themselves. When determining NESE, Social Security gives self-employed individuals credit for paying the employer’s 7.65 percent share of the Social Security and Medicare taxes in addition to the 7.65 percent share they would normally pay as an employee.

When Social Security is trying to determine NESE for a current calendar year, it will take the estimated profit the beneficiary expects and will multiply that estimated net profit of the business by .9235. Social Security determines that factor by subtracting the percentage of extra taxes the beneficiary paid on each dollar of net earnings (.0765) from 1. When Social Security personnel are determining actual NESE for a calendar year that has concluded, they must perform the following steps:

1. Add the gross earnings from all trades or businesses carried on by the self-employed person.
2. Include the beneficiary’s distributive share of income from a partnership of which he or she is a general partner.
3. Exclude any types of income so specified by the Act or the Internal Revenue Code (IRC).
4. Subtract any ordinary and necessary expenses incurred in carrying on the business. In computing NESE, subtract
from total receipts all of the business expenses, which are deductible under the IRC.

5. Multiply the result by .9235 (i.e., 100% − 7.65% = 92.35% or 0.9235) to derive the NESE, beginning with taxable years after December 31, 1989.

**Example of turning net income into NESE:**

Jeanne estimates that she will have $2,000 in net profit. Jeanne operated her business beginning in November.

Social Security would average the net profit in this estimate over the months worked: $2,000 divided by 2 equals $1,000 in net profit per month the business was active.

To determine Jeanne’s estimated NESE for those months, multiply $1,000 by .9235.

\[ 1000 \times .9235 = 923.50 \text{ in NESE per month.} \]

Social Security only deducts the employer’s share of the self-employment tax to determine NESE when the beneficiary actually paid that tax. If the beneficiary paid no Social Security tax (either he or she didn’t owe any or because he or she didn’t file taxes), the deduction doesn’t apply. In addition, NESE may include in-kind income (e.g., food, clothing, shelter, a car, etc.). Social Security values in-kind income from NESE at its current market value.

Once Social Security determines the NESE for a given month, the agency uses that number as the starting point for SGA decisions and when determining how much SSI will be due. Social Security determines countable income by taking NESE and deducting any allowable work incentives. Social Security calculates NESE in exactly the same manner for both SSI recipients and Title II disability beneficiaries. Keep in mind, however, that the countable NESE would affect SSI and Title II cash benefits in different ways - just as is the case in wage employment. Detailed explanations of how these programs treat NESE is provided later in this unit.

**A Warning about “Owner’s Draw”**

When someone takes money out of his or her business, it’s called an “owner’s draw.” Owner’s draw isn’t a “salary” in the way this word usually applies but can include money, assets, or services the owner
takes out of the business. A common misconception is that Social Security only counts what a beneficiary actually takes out of the business as earned income. Unfortunately, this isn’t true.

Remember that Social Security is interested in the “net earnings from self-employment” or NESE. A business owner may choose to keep the profits of a business in the business account, or may take some or all of it out as an owner’s draw. The amount of owner’s draw a beneficiary takes is irrelevant to Social Security. Social Security uses NESE when making SGA determinations for beneficiaries of the Title II disability programs and when determining how much in SSI is due.

In the SSI program, Social Security refers to “owner’s draw” as “Withdrawals for Personal Use.” Because SSI is a means-tested program, if a beneficiary takes in-kind items or cash out of the business for personal use, Social Security could count it as income, which could cause a reduction in SSI cash payment, or possibly even cause ineligibility for SSI. When an individual alleges or when Social Security discovers that a beneficiary has withdrawn cash or in-kind items from a business for personal use, Social Security will ask the individual whether he or she properly accounted for the withdrawals in determining NESE. That is, did the beneficiary deduct them on his or her federal income tax return in determining the cost of goods sold or the cost of expenses incurred, or did he or she deduct them on his or her business records? If the individual alleges that he or she properly accounted for the funds, Social Security will accept this allegation and will NOT count this income against the individual again. If the individual did NOT properly account for the withdrawals, Social Security will proceed in the following manner:

1. Social Security will ask the individual to estimate the value of the cash or in-kind withdrawals. Social Security will deduct that amount from the cost of goods sold or the cost of expenses incurred on the profit and loss statement to arrive at the proper NESE.

2. If the individual can’t or won’t provide the profit and loss statement, but alleges an amount of NESE, Social Security will add the value of the withdrawals to the individual’s allegation of NESE.

3. If an individual alleges withdrawals for personal use but can’t or won’t estimate the value of the withdrawals, or if
the individual’s personal expenses exceed the stated NESE and no other income is available, Social Security will develop for unstated income.

CWICs should be aware that when an individual diverts money from a business to personal use without accounting for it through the business financial records, it’s against IRS rules for both small business and individual income reporting. No one should ever encourage beneficiaries to do this under any circumstances. Beneficiaries should deposit all income attributable to the business into the business account (not a personal bank account), and they must reflect this in the profit and loss statements for the business.

**Business Structures May Affect How Social Security Counts NESE**

Social Security treats different business structures in different ways when determining how much income to attribute to a beneficiary when conducting SGA determinations and determining how much in SSI is due. Business structure can also affect how the SSI program looks at the business assets when making resource determinations. The structure of a business matters, and it’s an important issue about which to counsel beneficiaries.

The five types of business structures are summarized below:

1. **Sole Proprietorship:** The easiest way to form a business is as a sole proprietor, and most small businesses have this structure. The business owner and the business are essentially the same. There is no need for legal documents, and there are no filing requirements other than the IRS Schedule C in the individual tax returns. A sole proprietor doesn’t even need a federal employer ID number, but can do business under the individual owner’s Social Security number.

2. **Partnership:** Partnerships exist when more than one person is involved in the ownership of the business. The partners share in income and expenses based on their percentage of ownership share in the partnership.
3. **Limited Liability Company (LLC, PLLC):** An LLC is the newest form of business ownership. It’s a registered unincorporated entity. It gives the same legal protection as a corporation, but without as much of the reporting and taxing requirements. An LLC can function like a sole proprietorship, partnership, or Sub S Corporation. Each state has certain requirements for setting up and maintaining an LLC.

4. **Sub S Corporation:** A Sub S Corporation is treated like a partnership for tax purposes, but creates a separate legal entity. The ownership is in the form of shares, so ownership can be transferred more easily. Businesses form a Sub S Corporation with the aid of an attorney or accountant.

5. **C Corporation:** A “C Corporation” is a standard corporation, and most large businesses use this structure. C Corporations provide good liability protection for the owner(s); however, the IRS sees a C Corporation as a separate entity and taxes it as such. This can result in double taxation. The corporation can pay taxes on income, then the owners pay taxes on distributions they receive. The ownership is in the form of shares. Businesses form a C Corporation with the aid of an attorney or accountant.

**Officers and Directors of Corporations**

Generally, Social Security considers an officer of a corporation to be an employee of the corporation. Social Security deems a corporate officer to be in “employment” even if he or she performs no services for the corporation, as long as he or she receives remuneration for holding corporate office. However, an officer of a corporation who as such doesn’t perform any services, or performs only minor services, and who neither receives nor is entitled to receive, directly or indirectly, any remuneration for serving as an officer Social Security doesn’t consider to be an employee of the corporation.

Although a corporate officer is generally an employee, payments made to the officer don’t constitute “wages” unless such payments are for performing services for the corporation or for holding corporate office.
Payments by a corporation to an officer for reasons other than the holding of a corporate office aren’t wages. Examples of such payments would include payment of dividends, repayment of loans, or fees for services performed in other capacities of a non-employment nature. Corporations often make payments of this type to “honorary” or inactive corporate officers.

The board of directors is the governing body of the corporation and therefore isn’t subject to control by the corporation. Therefore, a director who attends and participates in board meetings wouldn’t meet the common law test for an employee, but Social Security would deem the director to be in self-employment. A director who does work for the corporation, other than attending and participating in the meetings of the board of directors, may be an employee with respect to such work if it’s non-directorial in nature.

CWICs need to recognize that beneficiaries who are “officers” of relatively small companies that have been incorporated may think they are self-employed when, in fact, Social Security considers them to be employees. It’s good practice to check with the local Social Security field office whenever dealing with a beneficiary who is a corporate officer to verify employment status before offering advice. Remember that the difference between being an employee and being self-employed can have a significant effect on benefits — particularly in the SSI program. For more information, refer to POMS RS 02101.016 Officer or Director of a Corporation, which can be found online (https://secure.ssa.gov/apps10/poms.nsf/lnx/0302101016).

A Warning about Businesses Structured as Corporations

Business structure does matter, and in most cases, forming a corporation isn’t the best way to proceed for a variety of reasons. Accountants who aren’t accustomed to working with beneficiaries of Social Security disability programs often recommend incorporation because it offers certain tax advantages and because they want to make sure the business owner is protected from personal liability claims that result from accident or injury claims that occur in the business. If a beneficiary operates a business as a sole proprietorship or a simple partnership, for example, people with liability claims against the can personally sue him or her—this means the beneficiary’s personal assets can be at risk.
There is another, more effective way of dealing with these liability issues in most cases — that is, to file as a Limited Liability Company or LLC instead of a corporation. The LLC structure offers business owners the liability protection they need without some of the negative financial consequences of forming a corporation. The LLC structure is also very flexible. Business owners can design LLCs to act like sole proprietorships, partnerships, or even corporations in some instances. Besides, filing an LLC is usually far cheaper and faster than forming a corporation.

A full explanation of the various structures a business can take and how Social Security treats each structure would consume far more space than is available in this unit. In the overwhelming majority of cases, forming a corporation will most often be detrimental to a Social Security disability beneficiary, particularly SSI recipients. While corporations may offer certain tax advantages, the disadvantages of corporations in terms of the negative effect on benefit eligibility can far outweigh any benefit that incorporation might provide. It’s critically important that beneficiaries meet with a certified CWIC experienced in self-employment cases before they pay an accountant to incorporate a small business.

**NOTE:** Many self-employed beneficiaries use the services of a CPA, accountant, or bookkeeper to keep their books and prepare their tax returns. These professionals should have some working knowledge of how self-employment affects beneficiaries of the Social Security disability programs, but most will NOT have this knowledge or expertise. CWICs are encouraged to work closely with beneficiaries who are pursuing self-employment to help accounting and tax professionals understand the unique aspects of serving Social Security disability beneficiaries.

**Self-Employment and Title II Disability Benefits**

Title II disability beneficiaries who are self-employed utilize the same work incentives as beneficiaries who are in wage employment with a few notable differences. This section will highlight the differences in the way Social Security treats NESE as compared to gross wages.
The Trial Work Period and Self-Employment

Work activity in self-employment constitutes “services” (i.e., a TWP month) when NESE in a calendar month is more than the current TWP guideline, or if the self-employed person spends more than 80 hours in that month engaged in self-employment activity. This can create some problems, because many self-employed individuals don’t keep their business accounts on a calendar month basis, but rather just report profit to the IRS on an annual basis. When working with beneficiaries who are planning to become self-employed, CWICs need to stress how important it is to track profits on a calendar-month basis. If month-by-month profit and loss statements are unavailable and the self-employed individual can’t recreate them, Social Security has no choice but to determine if the beneficiary used TWP months by dividing the NESE earnings for the particular work period by the months in which the beneficiary alleges he or she was engaged in self-employment. Averaging NESE in this manner, over a period of months may not always be in the best interests of the beneficiary and may cause the beneficiary to use more TWP months than he or she would if he or she used a month-by-month breakdown. Again, CWICs need to advise beneficiaries to track business income and expenses on a monthly basis to ensure that Social Security makes accurate TWP determinations.

Even if the NESE for a calendar month is less than the current TWP guideline, the beneficiary may use a service month if he or she spent more than a specified number of hours in that month performing the work activity she or he would normally undertake for the business’ profit. This means that under the current rules, it’s possible for a beneficiary to have NESE under the current TWP guideline and still use a service month. This isn’t the case in wage employment, and it represents a significant difference between how Social Security looks at wages and NESE.

Hours in a Business

A self-employed individual uses a TWP month if the Net Earnings from Self-Employment (NESE) is over the TWP amount, OR if the individual works more than 80 hours in the business. Either factor will cause Social Security to count that month toward the nine months of the TWP. Beneficiaries should keep track of the hours worked in the business. Hours that count are hours they spent on the ongoing business duties for pay or profit. The beneficiary shouldn’t count hours he or she spent simply planning the business.
Special Work Incentives for Self-Employed Beneficiaries

Social Security recognizes that having the beneficiary’s business expenses paid for by someone else or receiving free help operating the business, rather than using money from the business to buy the goods or services, artificially inflates the beneficiary’s Net Earnings from Self-Employment (NESE). This means that the NESE may not accurately reflect the person’s actual earning capacity. When Social Security makes SGA determinations, they are only concerned with the beneficiary’s OWN earnings ability, not help provided by others. Social Security identifies two very separate and distinct work incentives that may be applicable in self-employment cases: “unincurred business expenses” and “unpaid help.”

Unincurred Business Expenses

In determining countable income from self-employment, Social Security deducts from the individual’s NESE any business expenses that the beneficiary incurred and that another person or agency paid for. Social Security makes this deduction even though the beneficiary incurred no actual expense. The item or service must meet the IRS definition of legitimate business expense, the value of which is determined by a variety of methods.

There are many kinds of unincurred business expenses. For example, a local organization may pay for start-up equipment, or, more commonly, a state VR agency may purchase equipment or pay for initial operating costs. A family member or friend could give equipment or free rent to the beneficiary, etc. Social Security determines the value of these items and deducts the value from NESE when determining if someone is performing SGA.

Unpaid Help

Another potential deduction occurs when someone receives free help operating the business. Social Security can deduct the amount of wages the business would otherwise have paid the person if the business had to purchase the services.

Example of how unpaid help affects NESE and SGA:

Lou is a lawyer who has just passed the bar. Her mother offers to help her in the office and drive her van to help her start her business. A neighbor offers to do some typing at
no cost. Lou’s parents give her 200 square feet of accessible office space at no cost, space that her parents could rent for approximately $5 per square foot. Imagine Lou has $4,000 in NESE in the first month of her business. She has already used her TWP in a paralegal job while she was in law school. Social Security looks at her NESE to determine if she is performing SGA.

Lou’s mother works 40 hours per week as an uncompensated assistant. In the market where Lou lives, that work would be worth at least $10 per hour. The neighbor offers up to 10 hours a week in uncompensated work, which Lou accepts. Typists receive $10 per hour in the community. Thus, Lou receives 50 hours per week at $10 per hour, or approximately $2,150 in uncompensated help. Subtracting this value from her monthly NESE leaves $1,850.

The office space Lou uses is worth $1,000 per month. The rent is an unincurred business expense, which Social Security may also deduct from her NESE.

Using the unpaid help and unincurred business expense deductions allows Social Security to adjust Lou’s self-employment income from $4,000 to countable income of $850.00. In 2020, the SGA guideline is $1,260 for individuals who aren’t blind. Because of subsidy for self-employed persons, Social Security would NOT consider Lou to be performing SGA.

When examining unincurred business expenses or unpaid help, it’s valuable to think through what the person needs, what the business has purchased, and what the beneficiary has received through family connections or services such as the State VR agency. It’s essential to keep records of any items or equipment provided to a business for both tax purposes and for SGA determination purposes, because reconstructing these deductions from memory may be difficult.

**How IRWEs Apply in Self-Employment Situations**

The rules for deducting IRWE are the same for self-employed individuals as for employees in wage employment. The big difference for
beneficiaries who are self-employed is that many expenses that would qualify as IRWEs also meet the IRS definition of allowable business expenses. When this is the case, it’s much more advantageous for the beneficiary to deduct the expense when determining net profit since this decreases taxable income AND decreases the NESE for Social Security purposes. By running the expense through the business accounts, it also saves the beneficiary the time and effort of claiming an IRWE. It’s important to note that individuals may not deduct the same expense as both an IRS deduction and as an Impairment Related Work Expense (IRWE) when Social Security is determining countable NESE. The basic rule of thumb is that if the expense is an allowable deduction for IRS purposes, it should be deducted in this manner. If the expense in question does NOT meet the IRS definition of an allowable business expense, then the CWIC should explore the option of claiming the expense as an IRWE. When in doubt about whether or not an expense would qualify as a business deduction, CWICs are advised to refer the beneficiary to a qualified tax professional.

**Example of business expense that is not an IRWE:**

Lou purchased Dragon Naturally Speaking, a voice input software, for her computer. She was able to deduct this cost as a business expense. Although the cost meets all of the requirements for an IRWE, she may not deduct that cost as an IRWE, because she already used it to reduce her NESE.

CWICs should understand that there might be certain items that would meet the IRWE requirements but may not qualify as an allowable business expense for IRS purposes. Beneficiaries should seek the services of a qualified tax professional whenever questions arise about what Social Security does and doesn’t allow as a business expense. To learn more about special tax rules for people with disabilities refer to IRS Publication 907 – Tax Highlights for Persons with Disabilities (http://www.irs.gov/pub/irs-pdf/p907.pdf).

**SGA Determinations for Self-Employed Beneficiaries**

Determining if a self-employed individual is performing SGA is a little more complex than making the same determination for employees. First, Social Security uses a slightly different form to collect information: Social Security 820 - Work Activity Report-Self-Employed. The information
Social Security seeks is also different because individuals who are self-employed have more control of the income they report to the IRS than employees usually have. Second, Social Security uses two different approaches when making SGA determinations for self-employment beneficiaries — one approach for individuals who have been entitled to Social Security disability benefits for 24 months or more and haven’t ceased, and a different approach for individuals who have been entitled to benefits for less than 24 months or who have ceased. The following sections explain the differences between these two approaches.

**Countable Income Test for SGA for Self-Employed Beneficiaries**

If a Social Security disability beneficiary is self-employed and has received cash benefits for at least 24 months, the Social Security Administration will use the countable income test to determine if the individual’s disability has ceased due to SGA.

For the purposes of the exemption of work activity provision, Social Security will consider a beneficiary to have received Title II disability cash benefits for 24 months beginning with the first day of the first month following the 24th month for which he or she received Title II disability benefits that he or she was due. The 24 months don’t have to be consecutive. For EXR cases, the beneficiary will meet the 24-month requirement when the individual completes the 24-month initial reinstatement period (IRP). Any months for which the beneficiary was entitled to Title II disability benefits but didn’t actually receive a Title II disability cash benefit Social Security won’t count for the 24-month requirement.

When the countable income test applies, Social Security will compare the self-employed beneficiary’s countable income (NESE less allowable work incentives) to the earnings guidelines to determine if the beneficiary has engaged in SGA. If the monthly countable income averages more than the applicable SGA guideline for the month(s) in which the individual worked, Social Security will determine that the individual has engaged in SGA unless there is evidence that shows the individual didn’t render significant services in the month(s). If the average monthly countable income is equal to or less than the applicable SGA guideline for the month(s) in which the individual worked, or if there is evidence that shows the individual didn’t render significant services in the month(s), Social Security will generally determine that the individual hasn’t engaged in SGA.
SGA Test for Self-Employment When Countable Income Doesn’t Apply

Under some circumstances Social Security won’t use the countable income test, but rather will apply a more complex three-test approach to determine if an individual has engaged in SGA. Social Security uses the three tests when:

- Determining initial eligibility for disability benefits;
- Determining whether work in self-employment performed by a Title II disability beneficiary before he or she has received Title II disability benefits for at least 24 months is SGA;
- Determining whether work a beneficiary performed in or after the EPE or re-entitlement period is SGA after Social Security has determined an SGA cessation; and
- Determining SGA during the initial reinstatement period (IRP) for expedited reinstatement (EXR) cases.

The three tests are as follows:

1. **Significant Services and Substantial Income:** The individual’s work activity is SGA if he or she renders services that are significant to the operation of the business, and if he or she receives from it a substantial income; or

2. **Comparability of Work Activity:** The individual’s work activity is SGA if, in terms of all relevant factors such as hours, skills, energy output, efficiency, duties, and responsibilities, it’s comparable to that of unimpaired individuals in the same community engaged in the same or similar businesses as their means of livelihood; or

3. **Worth of Work Activity:** The individual’s work activity is SGA if, although not comparable to that of unimpaired individuals, it is, nevertheless, clearly worth more than the applicable SGA guideline when Social Security considers it in terms of its effect on the business, or when Social Security compares it to the salary an owner would pay to an employee for such duties in that business setting.
Social Security applies these tests in the following manner:

**Test One: Significant Services AND Substantial Income**

The first test is called “Significant Services and Substantial Income.” Significant services mean that the beneficiary earned that money through his or her work effort. One-person businesses such as self-employed carpenters, gardeners, handymen, nurses, bookkeepers, consultants, and people in numerous other business operations may engage in their trade or profession by themselves, without employees, partners, or other assistants. The services of an individual in a one-person business are necessarily “significant.” The receipt of substantial income by the operator of a one-person business will typically result in a finding of SGA.

In a business involving the services of more than one individual, Social Security will find a sole owner or partner to be rendering significant services if he or she:

- Contributes more than half the total time required for management of the business; or
- Renders management services for more than 45 hours a month regardless of the total management time required by the business.

Where the services of a sole owner or partner are significant under either of the above tests, Social Security will find the individual engaged in SGA if he or she receives a substantial income from the business. Social Security will determine a self-employed individual to have a substantial income from a business if:

- “Countable income” (NESE less any applicable work incentives) from the business averages more than the appropriate SGA Earnings Guideline, or
- “Countable income” (NESE less applicable work incentives) from the business doesn’t average more than the amount referred to above, but the livelihood that he or she derives from the business is:
  a. Comparable to that which he or she had before becoming seriously impaired, or
b. Comparable to that of unimpaired self-employed individuals in his or her community engaged in the same or similar businesses as their means of livelihood.

If the self-employed person’s average monthly “countable income” doesn’t exceed the applicable SGA guideline, Social Security will consider whether the person’s livelihood from the business is comparable to:

- That which he or she had before becoming seriously impaired, or
- That of unimpaired self-employed persons in the community engaged in the same or similar businesses as their means of livelihood.

The experience of the local Social Security field office is of particular value in determining whether the individual is deriving, or can be expected to derive, a substantial income from a business. Social Security personnel should include in their determination an account of all the factors they consider, so that it will be clear when Social Security isn’t to take an earnings report at face value. It’s especially important that Social Security give a detailed explanation why an apparently substantial business is reported as yielding a less-than-substantial income. On the other hand, a description of special conditions affecting an individual’s business may make it clear why the beneficiary can’t derive the income ordinarily obtained from an enterprise of that type and scope.

- Among relevant items Social Security should consider are the type of business, amount of gross sales, the markup on products sold, and expenses such as rent, utilities, transportation, labor, costs, profit shares to employees and partners, etc.
- When the business has been in existence for some time, Social Security personnel should obtain data regarding operations in the past (e.g., income tax returns) for the file.
- The impressions of the local Social Security personnel, based on knowledge of local conditions obtained in the investigation of earnings credits claimed by self-employed individuals, will be particularly helpful in determining the validity of reported income and expenses.

A business from which the individual previously derived a substantial net income Social Security may now expect to yield considerably less income as a result of the curtailment of the individual’s work due to the disability.
Development should show whether the individual has been obliged to cut down the size of the business, operate the business fewer hours, hire additional labor to replace the individual’s own labor, accept the unpaid help of family members or others, or enter into a partnership arrangement so that the duties and income of the business will now be shared with others.

If the business was the individual’s sole means of livelihood for a number of years before he or she became seriously impaired, and the individual continues to receive a comparable livelihood from it after becoming seriously impaired, Social Security will generally consider his or her income to be substantial. However, in some cases, chronic illness or other special circumstances existing for some time prior to the individual’s becoming (or allegedly becoming) disabled may indicate that Social Security can’t fairly consider his or her financial situation in that period an indication of the individual’s standard of livelihood. Under such circumstances, the community standard of livelihood would be a more pertinent basis for determining whether current and expected income from the business is substantial.

In some businesses, particularly farming, the operator derives a livelihood despite the fact that cash income is small. Items that don’t lend themselves to precise monetary evaluation, such as homegrown food, may be a considerable part of the individual’s livelihood although not reportable for federal income or Social Security tax purposes, and, therefore, not reflected on the earnings record. In the case of a farmer, although a monetary evaluation of such commodities isn’t controlling, Social Security should consider the commodities determining whether the yield from the farm is comparable to personal or community standards of livelihood.

Meeting the community standard of livelihood will be a sufficient basis for finding substantial income, regardless of the individual’s economic circumstances prior to becoming (or allegedly becoming) disabled. However, in determining the community standard for similar business, Social Security excludes from consideration individuals who are, for various reasons, considered unrepresentative (e.g., where chronic illness accounts for a low level of income).

Social Security may question the self-employed beneficiary concerning the source and amount of his or her livelihood over a number of years (generally not less than five years) prior to becoming (or allegedly...
becoming disabled. Where the individual doesn’t meet his or her personal standard of livelihood or the information he or she furnishes is inconclusive as to his or her personal standard of livelihood, Social Security should obtain evidence regarding the community standard of livelihood for businesses of a similar nature. In some cases, the local field office’s own observations and knowledge will be sufficient. In others, Social Security will need evidence from the local Chamber of Commerce or other informed sources.

**Tests Two and Three: Comparability of Work and Worth of Work Tests**

If Social Security clearly establishes that the self-employed beneficiary isn’t engaging in SGA on the basis of significant services and substantial income under test one as described above, the agency will consider the second and third tests of the general evaluation criteria. Under these tests, Social Security will determine the individual to be engaged in SGA if evidence demonstrates that:

- The individual’s work activity, in terms of all relevant factors such as hours, skills, energy output, efficiency, duties, and responsibilities is comparable to that of unimpaired individuals in the same community engaged in the same or similar businesses as their means of livelihood;

- The individual’s work activity, although not comparable to that of unimpaired individuals as indicated above, is, nevertheless, clearly worth more than the applicable SGA guideline when considered in terms of its value to the business, or when compared to the salary an owner would pay to an employee for such duties in that business setting; or

- When the beneficiary operates a business at a level comparable to that of unimpaired individuals in the community who make their livelihood from the same or similar kind of business, Social Security may determine that the beneficiary is engaging in SGA. To establish comparability of work activity, Social Security must show that the beneficiary is performing at a level comparable to that of unimpaired persons considering the following factors: hours, skills, energy output, efficiency, duties, and responsibilities. The lack of conclusive evidence as to the comparability of the required factors will result in Social Security
finding that the work performed isn’t SGA under the comparability test.

An important part of the comparison is the selection of the group of unimpaired persons and the type of self-employment must be the same. In addition, the unimpaired persons must maintain on the basis of their activity a standard of living regarded as adequate for a particular community. Well-established businesses are generally the most reasonable choice for comparison.

Development of comparability of work must be specific. Businesses must describe in detail each factor cited above, showing its contribution to the business operation. Social Security considers general descriptions as inconclusive evidence for the point-by-point comparison the evaluator is required to make. Social Security instructions clearly state that if only a general description is possible or available the agency should resolve any doubt as to the comparability of the factors in favor of the beneficiary.

Evidence of the beneficiary’s activities accompanied by a statement that the work is comparable to the work of unimpaired persons is insufficient for a sound SGA decision. If necessary, Social Security should obtain a description through a personal interview with an unimpaired self-employed individual from the selected group. It may be necessary to have a more comprehensive description of the impaired individual’s activity than that which the impaired person can provide. Social Security personnel are instructed to make contact with people having first-hand knowledge of the beneficiary’s work situation obtained through actual participation or observation.

The degree to which evidence of comparability or worth of services should contain data supplied by outside authorities will depend on the individual situation. In many instances, the familiarity of the local field office with local conditions will make it unnecessary to document the file in great detail. For example, it might be evident in a poor farming area that management services on a small farm yielding a less-than-subsistence income wouldn’t be comparable to the full range of physical and mental activities performed by an able-bodied farm operator, nor would the services be clearly worth more than the applicable SGA guideline. On the other hand, where there is any doubt as to the comparability or worth of services, Social Security should obtain evidence in appropriate detail and supplement it as required by opinions from authoritative sources in the community.
Examples of determining SGA for sole proprietors:

**Test 1:** Myrtle has a small accounting business. Her average NESE is $2,000 per month for the period she worked this year. She has deductions for IRWE, and unpaid help of $400. Myrtle is a sole proprietor and thus her work is significant to the business. Myrtle has substantial income, and is thus performing SGA.

**Test 2:** Fred is a plumber. He has NESE of $500 a month. Fred performs plumbing full-time, however, and plumbers in his area make $5,000 per month. Fred does the plumbing himself and does as much work as other plumbers who work in his community. Social Security determines that Fred’s work is comparable to SGA-level work. Social Security decides that Fred is performing SGA.

**Test 3:** In 2020, Octavia types and makes photocopies for small businesses in her community. Because of her disability, Octavia takes fewer jobs than other services. Even so, considering the effort and time that Octavia spends and the number of jobs she completes, her work should be worth $1,500 a month, instead of the $200 per month she reports. Octavia isn’t blind, and the applicable SGA guideline is $1,260. Social Security decides Octavia is performing SGA.

**NOTE:** The comparability of work, and worth of work tests never apply to beneficiaries who meet the definition of statutory blindness. For blind individuals, only the Significant Services and Substantial Income tests are relevant.

**Use of Averaging in Self-Employment Cases**

Because self-employment income may fluctuate widely due to transitory business conditions, changes in the nature and size of the business, improved methods of operations, or other factors, the self-employed beneficiary is far less likely than an employee to have a uniform monthly income, which Social Security can readily compare to the SGA guidelines. Because of this variance, Social Security averages the individual’s countable income by figuring total countable income over a
representative period and dividing by the number of months in that period. As in the case of employees, Social Security generally averages income over the entire period of work requiring evaluation, which may be up to a full calendar year. For some beneficiaries that period could be an entire calendar year, while for others it could consist of a just a few months. Social Security will average separately the distinct periods of work involved when there is a regulatory change in the SGA earnings level or there is a significant change in work patterns or income.

**SGA Determinations When Multiple Work Efforts Exist**

Sometimes beneficiaries are engaged in self-employment and also hold wage employment jobs at the same time. Still other beneficiaries may operate more than one small business simultaneously. When more than one work effort exists at the same time, Social Security considers each separately during an SGA determination. If Social Security finds any single endeavor to represent SGA, the agency decides the case on that basis. If no single work effort equals SGA, then Social Security combines the income from all work efforts. Any self-employment loss would never reduce total earnings. Social Security would simply represent the self-employment income as zero.

**Final Words about Self-Employment and SGA Determinations**

It’s much more likely that Social Security will make accurate and correct SGA determinations for self-employed beneficiaries if they keep complete accounting records. Benefit implications relate to the manner in which financial records are kept as well as the accuracy of month-by-month accounts. Because SGA determinations in self-employment situations can be so complex, beneficiaries are advised to seek assistance from qualified accountants or bookkeepers in maintaining their financial records.

**SSI Net Earnings from Self-Employment (NESE)**

The SSI program treats income from self-employment very differently from wages in some important ways. First, the POMS instructs Social Security personnel to estimate NESE for the current taxable year during an initial claim, redetermination, or review of income when an individual
alleges he or she is (or has been) engaged in self-employment during the current taxable year. Social Security personnel must advise the individual:

- How they determined his or her estimated NESE and its effect on eligibility or payment amount;
- To promptly contact the field office if any change occurs that could affect the amount of his or her estimated NESE;
- To maintain business records until a federal income tax return is available, so he or she can report any changes promptly; and
- To provide a copy of his or her federal income tax return when it becomes available.

If the beneficiary is engaged in a new business, Social Security generally bases the estimate on the individual’s allegation about what profits he or she expects to generate by the end of the calendar year. Depending on how much (or how little) the expected profit will be, Social Security will compute NESE by subtracting the employer’s share of the self-employment tax by using the multiplier of .9235. If the beneficiary has engaged in a new business for a partial year, Social Security will obtain the individual’s profit and loss statement or other business records for his or her taxable year to date, will ascertain his or her net profit to date, and will project that net profit for the entire taxable year to adjust the SSI cash payment moving forward. Social Security personnel will NOT use this method of estimating NESE for businesses that are seasonal or have unusual income peaks at certain times of the year. Social Security does this to avoid underpayments caused by overestimating NESE and reducing the SSI cash payment too much. After the initial year of business operations, Social Security will take the actual annual NESE from the initial year of operations and divide it equally among the number of months in the taxable year (12). It divides it over 12 months even if the business:

- Is seasonal;
- Starts during the year;
- Ceases operation before the end of the taxable year; or
- Ceases operation prior to initial application for SSI.

A period of less than 12 months may be a taxable year if:
• The basis for computing and reporting income changes (e.g., fiscal to calendar year); or

• The taxpayer dies (the taxable year ends on the date of death, and Social Security computes net earnings as of the date of death); or

• The Commissioner of IRS closes the taxable year.

**NOTE:** An individual’s taxable year doesn’t end when the beneficiary goes out of business. Once Social Security has determined how much NESE to attribute to each month in the calendar year, it retroactively applies this income to determine how much in SSI cash payments were due. Social Security will adjust the SSI check retroactively for the entire calendar year. In most cases, if the business generated more profit than the beneficiary expected, it will mean that Social Security overpaid the SSI recipient. After that first year of self-employment, Social Security will generally use the NESE from the prior year as an estimate of monthly countable income for the current taxable year, unless the beneficiary alleges his or her NESE for the current year will vary from NESE for past years and gives a satisfactory explanation for the variation.

**Example of NESE for a self-employed beneficiary:**

Martika is self-employed in a sole proprietorship. Martika started her business in December 2020 and made $1,200 in NESE after all business deductions including deductions for the extra Social Security taxes she pays as a self-employed individual. Although Martika didn’t start her business until December 2020, Social Security will consider Martika’s earnings to be $100 per month throughout the 2020 calendar year.

**Example of NESE for a self-employed beneficiary:**

Torrey operates a small business doing interior design. He began his business in March and made a profit of $2,600 during the first six months of the year. Unfortunately he accepted a big job in the second half of the year that lost money. When he filed his taxes for the year, his NESE
represented a loss of $200. Torrey submitted his tax returns to Social Security, and the agency did NOT reduce his SSI check for the past 12 months because he incurred a business loss. In the coming year, however, Torrey estimates his NESE to be $3,000. For the coming 12 months, Social Security will count an average of $250 in countable NESE ($3,000 divided by 12). Torrey plans to watch his profits on a month-by-month basis and adjust his estimate of projected NESE if actual profits are significantly higher or lower than his projection.

If the business lost money in the calendar year as Social Security verifies by the tax returns, the agency divides any verified net loss for a taxable year evenly over the months in the taxable year. Social Security will subtract each monthly net loss amount from the individual’s other earned income (NESE or wages) in the same month, if any exists. Social Security doesn’t take into account an estimated net loss when estimating NESE for the current taxable year, because Social Security can only use a net loss to offset other earnings after Social Security has verified it. Social Security can only use verified losses to offset other forms of earned income.

**Application of SSI Work Incentives for Individuals who are Self-Employed**

There really are very few differences in the way the SSI work incentives apply in wage employment and self-employment cases. The Student Earned Income Exclusion (SEIE) and Blind Work Expenses (BWE) apply in the exact same fashion regardless of whether the beneficiary is wage-employed or self-employed. CWICs simply apply the deduction in the SSI calculation chart in the appropriate place to arrive at countable NESE.

As previously explained, the rules for deducting IRWE are the same for self-employed SSI recipients as for employees. The big difference for beneficiaries who are self-employed is that many expenses that would qualify as IRWEs also meet the IRS definition of allowable business expenses. When this is the case, it’s much more advantageous for the beneficiary to deduct the expense when determining net profit because this decreases taxable income AND decreases the NESE for Social Security purposes. By running the expense through the business account, it also saves the beneficiary the time and effort of claiming an IRWE. It’s important to note that individuals may not deduct the same
expense as both an IRS deduction and as an Impairment Related Work Expense (IRWE). The basic rule of thumb is that if the expense is an allowable deduction for IRS purposes, the beneficiary should deduct it in this manner. If the expense in question does NOT meet the IRS definition of an allowable business expense, then the CWIC should explore the option of claiming the expense as an IRWE.

**Self-Employment and Medicaid**

SSI applies the 1619(b) extended Medicaid provisions in exactly the same manner for self-employed individuals as for persons who are in wage employment. Once countable NESE exceeds the break-even point, the SSI recipient will stop receiving a cash payment, and Social Security will assess eligibility for continued Medicaid under 1619(b). The same eligibility criteria apply as in wage employment:

- Annual countable NESE must remain below the state threshold (work incentives apply to reduce countable income during 1619(b) determinations) unless Social Security can apply an individualized threshold amount.

- The individual must still be disabled per Social Security’s definition.

- The individual must meet all other SSI eligibility requirements other than earnings (unearned income and resource limits).

CWICs must be aware that state Medicaid agencies aren’t accustomed to dealing with beneficiaries who are self-employed and sometimes misapply the rules governing how Social Security determines NESE and applies it during Medicaid eligibility determinations. It may be necessary to print the POMS citations describing how NESE is determined in the SSI program to facilitate proper Medicaid determinations.

**Important Considerations for SSI Recipients who are Self-Employed**

During the initial tax year when a beneficiary first begins self-employment, it may be impossible to determine what NESE will be and how much to report to Social Security. This makes CWICs uncomfortable because they are accustomed to advising beneficiaries to report earned income in advance or at least shortly after employment begins. While it’s required that an SSI recipient inform Social Security when he or she is
embarking on small business ownership in the initial months of self-employment, there really isn’t much one can do by way of reporting income. In self-employment, an individual may have profits one month and incur losses the next month. In some cases, there may be no way of knowing whether there will be countable NESE until the entire tax year has ended and the beneficiary reports results on tax returns.

The best course of action is for the beneficiary to inform Social Security that he or she has started a small business as soon as operations begin. SSI recipients should initially provide a very conservative estimate of expected profits to Social Security. If they don’t expect profits, it’s imperative that they report this to Social Security to avoid unnecessary reduction of SSI cash payments. CWICs should advise SSI recipients to watch their profit and loss statements on a month-by-month basis to see if the business generates a profit. If the business generates a profit that isn’t offset by losses in previous months, the SSI recipient should report it to Social Security so that the agency can adjust SSI cash payments accordingly. CWICs must clearly explain how this estimation process works to SSI recipients who engage in self-employment and should help these individuals minimize the risk of overpayments if the business profit exceeds initial projections.

After the initial tax year of self-employment, Social Security uses projected estimates of annual NESE at the start of each calendar year to calculate the monthly SSI payment for the coming 12 months. Social Security bases this projection on the NESE the beneficiary earned for the prior year using completed tax returns and may adjust the projection based on what the beneficiary expects profits to be for the coming year. Providing Social Security with inaccurate projections can have serious implications for SSI recipients. If the annual NESE projection is too high, the SSI monthly payment will be unnecessarily low, and underpayment of benefits will result. If the annual NESE projection is too low, the monthly SSI check will be too high, and overpayment will result.

The solution to this problem is to work closely with SSI recipients when developing projections of NESE and to track the actual profits the business generates on a month-by-month basis. By the mid-point of the year, if the profits appear to be off, CWICs should help the beneficiary develop a revised NESE projection that he or she should reported to Social Security. The beneficiary should continue to monitor profits for the remainder of the year and then submit completed tax returns as quickly
after the tax year ends as possible. The objective is to avoid any substantial over or underpayment of SSI benefits.

**Small Business Ownership and Resource Determinations for SSI Recipients**

In many instances, owning a business with assets, property, equipment, or cash in business accounts won’t cause ineligibility for SSI or Medicaid, but it all depends on how the owner structures the business. Remember that individual SSI recipients may not have more than $2,000 in countable resources to stay eligible for benefits, while eligible couples have a combined resource limit of $3,000. However, for businesses structured as sole proprietorships or simple partnerships, Social Security specifically excludes assets held by the business as countable resources under a special provision called “Property Essential for Self-Support” or PESS.

The PESS provision allows the exclusion of certain property held by SSI recipients during resource determinations, regardless of its value or rate of return. PESS exclusions apply to:

- Property used in a trade or business (effective May 1, 1990);
- Property that represents government authority to engage in an income-producing activity;
- Property used by an individual as an employee for work (effective May 1, 1990); and
- Property required by an employer for work (before May 1, 1990).

The POMS citations describing application of PESS can be found online (https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130500).

**Self-Employment and PASS**

CWICs can assist beneficiaries pursuing a self-employment goal by developing a Plan to Achieve Self-Support (PASS). Because establishing a small business may require start-up funding, developing a PASS can be a valuable method for generating this start-up capital. CWICs should always check to see if PASS is a possibility for any beneficiary who indicates an interest in becoming self-employed.
Business Plans and PASS

A PASS with a self-employment goal must include a detailed business plan that follows a very specific format. CWICs can find these requirements for a business plan in the POMS online (https://secure.ssa.gov/apps10/poms.nsf/lnx/0500870026)

Social Security won’t deny a PASS because the business plan doesn’t cover required elements. If the individual is willing to work on the business plan, PASS Specialists will provide assistance or direction as needed. For example, in some cases, this may involve asking a few questions that the individual may know or quickly determine. If appropriate, PASS Specialists will refer the individual to a third party who can help the person develop a detailed business plan. Such sources include the U.S. Small Business Administration and its sponsored organizations, the Service Corps of Retired Executives (SCORE) and Small Business Development Centers (SBDCs), State VR agencies, local Chambers of Commerce, local banks, and appropriate staff at local colleges and universities. Social Security may allow costs associated with developing a business plan (if any) to be included in the PASS as an allowable expense.

Start-up Costs

Start-up costs refer to the expenses associated with opening a business. PASS expenses are limited to the start-up costs for the particular work goal. For someone opening a business, the start-up costs include the expenses to start the business through the first 18 months, or longer if needed, of the business’ operation. The use of an item as a business expense in determining net earnings from self-employment doesn’t preclude its use as a PASS expense during the calendar years (or fiscal years) that encompass the start-up period of a business.

Social Security gives a business a minimum start-up period of 18 months unless the individual indicates that he or she will need less time to sustain business operations. A business owner must justify a request for a start-up period of a longer duration than 18 months.

Self-Employment Combined with Wage Employment

Some beneficiaries participate in both wage employment and self-employment simultaneously. Social Security has very specific rules about how to count income in these cases.
For Title II beneficiaries, SSA determines countable income for the wage employment and the countable income for the self-employment separately and adds the two forms of income together when making SGA determinations. Beneficiaries can’t use losses from self-employment to offset SGA-level earnings in wage employment (See DI 10505.015 Averaging Countable Earnings).

In the SSI program, Social Security divides any verified net losses from self-employment over the taxable year in the same way as net earnings. The agency deducts the average monthly net loss only from other earned income of the individual or spouse in that month to determine gross income. It would then deduct work incentives from that amount when determining how much the Social Security payment should be (See SI 00820.210 How to Determine Net Earnings from Self-Employment found online at https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820210)

Self-Employment and the CWIC

Self-employment cases can be challenging for CWICs because they combine the complex effects of self-employment earnings and small business ownership on public benefits with the intricacies of private sector business planning and management. This combination sometimes confuses CWICs about their role in working with beneficiaries who are considering self-employment, or who already operate small businesses. The charts on the following pages are designed to clarify CWIC roles and responsibilities, as well as the limitations within each of the two critical areas specific to self-employment: the business domain and the benefits domain. First, let’s start by explaining how CWICs initiate WIPA services with beneficiaries who plan to pursue self-employment.

Counseling Beneficiaries with Self-Employment Goals – Starting the Process

When a beneficiary expresses interest in self-employment, or is already engaged in some form of self-employment, the first step a CWIC must take is to determine where the beneficiary is in the process of establishing a small business:

- Initial stages of considering self-employment;
• Business concept development stage;
• Business planning stage;
• Business start-up stage; or
• Business operations stage.

Where the beneficiary is in the self-employment process determines what services the CWIC provides and defines the timeline for service delivery. It’s much easier to counsel beneficiaries who are in the very early stages of planning a business before they make missteps that will require correction. The CWIC’s role at this initial stage will involve:

• Helping the beneficiary decide if self-employment is the best option;
• Working with the beneficiary to determine if the activity he or she plans to pursue would be considered self-employment, wage employment, or a hobby;
• Advising the beneficiary on sources of support in refining a business concept or testing the concept for feasibility;
• Referring the beneficiary to sources of assistance for developing a written business plan; and
• Offering general advice on how self-employment income will affect disability benefits and how the beneficiary may use work incentives to finance a business start-up.

Some individuals who want to become self-employed don’t understand what this goal truly entails. Before the CWIC spends a great deal of time and energy connecting the beneficiary with sources of assistance for feasibility analysis and business plan development, it’s wise to explore how well the beneficiary has thought through the implications of pursuing self-employment. At the end of this unit, there’s a handout for use in any initial discussion about self-employment. The handout (titled “So, You Want to be Self-Employed”) lists the major areas the beneficiary needs to consider before entering into self-employment and helps the CWIC determine how well the beneficiary has thought through the process, while highlighting the areas that need more work. CWICs should cover the following items in this conversation:

• Business feasibility;
• Capitalizing business start-up;
• Developing a written business plan;
• Business structure;
• Accounting and financial record keeping;
• Tax implications of self-employment;
• Licenses, permits or other legal requirements;
• Accommodations needed to operate the business successfully; and
• How self-employment will affect Social Security disability benefits and other public benefits.

Once the beneficiary has explored all of the areas listed above, the next step is to begin business feasibility assessment and business plan development. This is where the CWIC begins to enter unfamiliar territory, as these are clearly business functions, with which most CWICs have very little experience. The following chart provides some direction on activities within the business domain in which CWICs should participate as well as boundaries or limits CWICs have in this domain.

**The Business Domain**

**CWICs should:**

• Research local resources available to help beneficiaries with business planning, feasibility studies, financing, accounting systems and bookkeeping, tax planning/preparation, and setting up corporations/LLC, etc.

• Provide specific information and referral services to help beneficiaries connect with local sources of business expertise and assistance.

• Help beneficiaries understand the business plan requirements inherent in the PASS program — reviewing business plans and providing general feedback about whether or not they meet PASS requirements.

• Advise beneficiaries about the effect of various business structures (corporations, LLC, sole proprietorship, etc.) on public benefits.
• Advise beneficiaries on the effect of accounting methods (accrual vs. cash) on public benefits.

• Help beneficiaries understand how to include work incentive payments in their business financial statements.

**CWICs should NOT:**

• Help beneficiaries decide what type of business they should pursue.

• Determine whether or not a beneficiary is capable of starting and managing a business.

• Provide direct assistance with writing, editing, or critiquing business plans.

• Share information with beneficiaries on any legal or tax issues related to business establishment or management.

• Give advice to beneficiaries on sources of business financing beyond work incentives related to public benefits. CWICs don’t assist with preparing financing requests or loan applications.

• Perform feasibility studies or assessments. CWICs aren’t qualified to evaluate the viability of a business concept.

• Prepare financial statements for the business such as break-even analysis, cash flow analysis, or income/expense statements.

• Provide business analysis, consultation, and problem solving services to increase profitability.

The following is an explanation of the CWIC’s role in some of the most common areas related to the business domain:

**The Business Concept and Business Feasibility**

It’s not uncommon for a beneficiary to pitch a business concept that may seem a bit unrealistic to the CWIC. In many cases, the beneficiary will be very excited about the idea and utterly convinced that it will result in a highly profitable business. CWICs may feel tempted to debate with the individual about the feasibility of the business concept, but the CWIC role in this area is very limited. When discussing business feasibility with beneficiaries, CWICs should keep the following boundaries in mind:
• It’s NOT the CWIC’s job to tell a beneficiary that a business concept is unrealistic, unfeasible, etc.

• It’s the CWIC’s job to know when a business concept may need more refinement or research before the beneficiary can write a business plan or before successful start-up is likely.

• It’s the CWIC’s job to know where a beneficiary can go for help with developing a solid business concept and to make referrals to these entities.

• No matter what the CWIC may think of the business concept, he or she is responsible for providing specific information about how self-employment income as projected by the beneficiary and business support team will affect benefits and how work incentives may apply.

The Business Structure Decision

First and foremost, it’s important for CWICs to explain to beneficiaries preparing for self-employment that business structure does have an effect on how Social Security will treat the NESE and also how it may affect resource determinations for SSI recipients. If the beneficiary hasn’t yet determined what business structure is best, the CWIC should provide counseling on how Social Security treats different types of structures and how the various structures may affect that individual’s benefits.

Many accountants will recommend incorporation, because this is often most advantageous for individuals who aren’t on disability benefits. CWICs need to warn beneficiaries about this possibility and should be specific about why this course of action wouldn’t be most advantageous. The CWIC should provide written material on this subject to the beneficiary for sharing with the accountant and should offer to answer questions the accountant might have about how Social Security benefits are affected by business structure. CWICs should be familiar with knowledgeable sources for assistance in making business structure decisions (SBA, SCORE, etc.) and should make direct referrals to these sources when necessary.

If the beneficiary has already established a business structure by the time he or she makes contact with the CWIC, you’ll need to discuss how Social Security will treat income from the business based on chosen business
structure, and identify potential options for changing business structure, if warranted. Once a business is operational, an owner can change the business structure, although it may cause some inconvenience and incur expense.

**Business Plan Development**

First, determine whether or not a formal written business plan is necessary. In most cases, it will be, but in some cases, it won’t. If the business is a sole proprietorship with no need for capitalization, there may be no need to develop a detailed plan. In most cases, a business plan is necessary under the following circumstances:

- If the beneficiary is pursuing a PASS;
- If the State VR Agency or EN is providing funding for the business;
- If the beneficiary is seeking a business loan; or
- If other funding sources require it.

If the beneficiary does need to develop a business plan, the CWIC needs to be familiar with the agencies or individuals in the local area that provide assistance and support in this area. CWICs are responsible for referring beneficiaries to local resources to assist with the business planning process. They should also review general information about how Social Security treats self-employment earnings.

**What CWICs Need to Know about Business Financials**

It’s NOT the CWIC’s job to develop financial projections, determine profit estimates, or make cash flow projections. However, Social Security does expect CWICs to assist with advising the beneficiary and his or her supports (family, accountant, business planning team) on the effect of financial projections or business profits on benefits. When working with small businesses, CWICs are primarily interested in the bottom line — the net profit of the business. The net profit figure is the starting point for specific counseling on NESE and use of applicable work incentives. In most cases, the CWIC will need to know how to read a simple Profit & Loss Statement (P&L). This is a common financial report used to project business profit (or loss), which is generally prepared in a spreadsheet format. Typically, the business income (sales, returns, etc.) is listed across the top with individual business expenses listed by category.
underneath. The expenses are subtracted from the income to calculate net profit or loss. There are some specific things CWICs need to know about P&Ls and how to account for work incentives such as:

- Don’t include in P&L statements any PASS expenses that are also IRS allowable business expenses. Exclude from the P&L any PASS expenses that would NOT meet IRS rules for business expenses. Do NOT list PASS income in the P&L, as it’s not a form of income, but rather the “owner’s investment.” For tax purposes, Social Security would consider the income that beneficiaries use to fund a PASS attributable to the individual rather than the business. Any tax liability would be the responsibility of the individual beneficiary as indicated by the individual’s tax returns.

- Don’t include in the P&L statements any IRWEs/BWEs that are also IRS allowable business expenses. CWICs should note that beneficiaries can’t claim IRWEs/BWEs included as business expenses when reducing countable NESE during SGA determinations or when Social Security is adjusting the SSI check. That is because Social Security has already accounted for the expenses when determining the amount of profit. To claim these expenses a second time would constitute “double dipping,” and Social Security doesn’t permit it.

- Beneficiaries should NOT include in the P&L statements any expense purchased by other sources (VR, WIA, etc.). However, if the business owner directly receives funds from other sources (VR, WIA, etc.), both the funds and the expenses are included in the P&L.

**NOTE:** Under certain circumstances the beneficiary may exclude from income reported to the IRS, any items or cash the beneficiary received to pay for rehabilitation needs. In IRS Publication 525, there is an exemption on Page 27 under the section on “Welfare and Other Public Assistance Benefits” that reads:

“If you have a disability, you must include in income compensation you receive for services you perform unless the compensation is otherwise excluded. However, you don’t include in income the value of goods, services and cash you receive, not in return for your
services, but for training and rehabilitation because of your
disability. Excludable amounts include payments for transportation
and attendant care, such as interpreter services for the deaf, reader
services for the blind, and services to help mentally retarded
persons do their work.”

**CWIC Role in Accounting and Financial Record Keeping**

CWICs have a very limited role in accounting or other financial record
keeping. Keep the following parameters in mind when counseling self-
employed beneficiaries:

- CWICs aren’t accountants. Don’t advise beneficiaries on specific
  accounting techniques or strategies.

- CWICs may be called upon to advise accountants or bookkeepers
  about various things including:
  - Recordkeeping for Social Security
  - Effect of self-employment income on benefits
  - Effect of accounting on work incentives usage or vice versa
  - Business structures (many accountants recommend
    incorporation for tax reasons, which may be
disadvantageous to the beneficiary)

- Some accountants do have knowledge of Social Security
  benefits. When that’s the case, the CWIC should be ready to
  provide resources or referral information as necessary.

- CWICs should inform self-employed beneficiaries of all
  information that they should gathered and retain. Most of the
  information Social Security needs is the same information the
  IRS requires. Social Security (or other benefits programs) may
  require additional information.

**The Benefits Domain**

This is the area where CWICs have a great many responsibilities. Social
Security expects CWICs to have a solid understanding of how self-
employment income affects Social Security cash benefits and
Medicaid/Medicare, as well as other federal, state, and local benefits.
There is no difference between wage employment and self-employment in terms of the CWIC’s work incentives counseling responsibility.

**CWICs should:**

- Explain the effects of self-employment income and business ownership on SSI, Social Security disability benefits, Medicaid, Medicare, and all other public assistance programs.
- Prepare a detailed, written Benefits Summary & Analysis report to spell out how self-employment will affect benefits.
- Provide specific advice about use of work incentives in self-employment, based upon the unique needs of the individual.
- Teach beneficiaries how they may use work incentives to help fund self-employment.
- Provide specific advice about, and assistance with the use of a PASS in establishing a business.
- Facilitate the development of a PASS to include coordinating with Social Security PASS specialists to facilitate approval of the plan.
- Act as an intermediary with business advisors to help them understand how Social Security may apply work incentives to help establish a business.
- Act as an intermediary with accounting or bookkeeping professionals to help them understand specific accounting needs related to Social Security benefits.
- Follow up periodically with beneficiaries pursuing self-employment with active PASSes to see that everything is going as planned.

**CWICs should NOT:**

- Attempt to talk beneficiaries out of pursuing self-employment due to the complex inter-relationship between business ownership and public benefits.
- Simply refer the beneficiary to local SBDC or SBA without fulfilling the responsibility for assisting with the Benefits Summary & Analysis.
• Try to develop, edit, revise, or in any way oversee or manage the writing of the business plan. CWICs are simply NOT trained to assist with this process.

• Write the entire PASS in isolation of the beneficiary. The PASS belongs to the individual with the disability — not the CWIC. Substantial involvement from the beneficiary is necessary if the PASS is to be successful.

• Take responsibility for setting up business accounts, reporting estimated earnings to Social Security, or keeping track of PASS expenditures. The CWIC’s role is to teach the beneficiary to do these things.

• Provide WIPA services to individuals who are withholding information about income and resources from Social Security or misrepresenting net earnings from self-employment to any agency administering public benefits programs.

**Reporting Self-Employment Income to Social Security**

CWICs should invest time and energy into teaching self-employed beneficiaries what income they need to report to Social Security and how exactly to perform this reporting. The overwhelming majority of benefits problems CWICs deal with on self-employment cases are directly related to failure to report or reporting inaccurate information. Beneficiaries can make problems for themselves by not keeping their books on a regular basis and not preparing their taxes in a timely fashion. Remember, it’s NESE that Social Security cares about, not gross income or even gross profit from the tax returns, and certainly NOT “owner’s draw.” Social Security may further reduce countable NESE by applying work incentives. To report NESE accurately, the beneficiary must retain receipts and track income and expenses in an organized fashion.

Here are some practical tips on reporting self-employment income that CWICs should share with beneficiaries.

**Reporting Tips for Title II Disability Beneficiaries**

• **Beneficiaries should keep business financials on a calendar month basis during the TWP.** The beneficiary
should track profit and should know when profits have exceeded the applicable TWP guideline. Sending in month-by-month P&L statements will work for this reporting.

- **Beneficiaries should track all hours spent operating the business on a calendar month basis.** Beneficiaries must be aware that they may be using TWP months even if the business loses money if they spend more than 80 hours running or working in the business in a calendar month.

- **Even after the TWP ends, monthly financial statements are still the preferred way for beneficiaries to track their profits or losses for the purposes of SGA determinations.** Beneficiaries should be closely monitoring profits on a monthly basis and comparing countable NESE with the applicable SGA guideline. If countable monthly NESE begins to exceed the current SGA guideline, it’s advisable to submit the profit and loss statements to Social Security and request that the agency conduct a work CDR. If the beneficiary waits until the tax year ends before reporting profits to Social Security, it’s possible that a large overpayment could occur. Even if the business loses money, it’s essential that the beneficiary gets his or her taxes prepared promptly and submitted to Social Security for review.

- **NEVER report gross sales or gross receipts from the business to Social Security.** Beneficiaries must retain all documentation of work incentives and should submit the Work Activity Report for self-employment (SSA Form 820) with the monthly profit and loss statements. Beneficiaries should also submit completed tax returns to Social Security each year as soon as they prepare them.

**Reporting Tips for SSI Recipients**

- **SSI recipients are required to notify Social Security when they initiate self-employment, even if they don’t generate profits.**

- **Because Social Security may adjust the SSI payment by estimated profits in the initial year of business operations, it’s essential to supply an accurate initial estimate to Social Security.** Recipients should be conservative in their estimate to avoid Social Security reducing the cash payment.
reduced too much. Recipients should carefully monitor profits on a month-to-month basis and adjust the estimate based upon actual countable NESE that they produce.

- **After the initial year of operations, watch out for using projected NESE.** Social Security will estimate annual income based on these projections and will adjust the SSI payment accordingly. If the projections are inaccurate, overpayments or underpayments will occur.

- **When the beneficiary uses estimates to adjust the SSI cash payment, he or she must diligently and carefully track actual NESE and adjust the projections quarterly as needed.**

**Common Mistakes Beneficiaries Make in Reporting NESE**

- **GROSS income isn’t what Social Security counts** — it’s countable NESE. Beneficiaries should never report gross income to Social Security when they are self-employed.

- **Social Security doesn’t count PASS funds as income to the business.** The agency counts them as owner investment and aren’t reportable to the IRS as part of the business tax returns.

- **Neither Social Security nor the IRS permits beneficiaries to claim personal expenses as business expenses.** The beneficiary must have a legitimate business purpose for the beneficiary to deduct the expense legally. When in doubt, beneficiaries should get the advice of a qualified tax professional.

- **Mixing business and personal funds is a VERY common problem for self-employed beneficiaries.** They must keep funds separate to meet both Social Security and IRS requirements.

**Final Words on Supporting Beneficiaries to Achieve Self-Employment Goals**

There are some significant differences in the way that Social Security treats income derived from self-employment as opposed to wage employment, and Social Security expects CWICs to have a complete
understanding of these differences. While self-employment cases may be rather complicated and may be a bit intimidating for new WIPA personnel, CWICs can’t avoid them, and you must pursue them with the same diligence as wage employment cases. The intent of this unit is to serve as a starting point for developing competence in the provision of high-quality WIPA services to beneficiaries who wish to become self-employed. Undoubtedly, there will be cases that require additional research and extended support from the VCU NTDC personnel. CWICs should seek such support whenever questions arise.

**Conducting Independent Research**

**POMS References**

- DI 10510.000 - Evaluation and Development of Self-Employment
- DI 10510.001 - SGA Evaluation and Development of Self-Employment
- DI 10510.010 - SGA Criteria in Self-Employment
- DI 10510.012 - Determining Countable Income
- DI 10510.015 - Test One of General Evaluation Criteria: Significant Services and Substantial Income
- DI 10510.025 - Documenting Self-Employment Cases
- DI 10510.030 - Completion of SSA-820-F4 (Work Activity Report — Self-Employed Person)
- DI 10510.035 - SSA-820-F4 Identification Items
- DI 10510.040 - SSA-820-F4 — Work Activity Report — Self Employed Person
- SI 00820.200 - Net Earnings from Self-Employment (NESE)
- SI 00820.210 - How to Determine Net Earnings from Self-Employment (NESE)
- SI 00820.220 - How to Verify Net Earnings from Self-Employment (NESE)
Additional Resources

The following resources are included in this section:

- Handout for beneficiaries titled “So, you want to be self-employed”
So, you want to be self-employed. Have you thought about...

**Business feasibility?**
How do you know that your business idea will work? Have you done any test marketing, or have you talked to knowledgeable people about whether or not your business idea has a reasonable chance for success?

**Capitalizing business start-up?**
Do you know how much it will cost to start your business? Do you have any ideas about how to get the money you think you will need?

**Developing a written business plan?**
If you plan to apply for a loan, submit a Plan to Achieve Self-Support (PASS), or ask the State VR Agency for funds, you will probably need a formal written business plan. Can you develop this document yourself, or will you need help?

**Business structure?**
This refers to the legal structure your business will take such as a corporation, partnership, Limited Liability Company (LLC), or sole proprietorship. Business structure decisions are important because the structure of your business affects how Social Security looks at any income your business generates as well as how the IRS assesses taxes.

**Accounting and bookkeeping?**
Being self-employed requires that you keep track of business income and expenses. Do you plan to do your own bookkeeping and accounting? Will you use the services of a professional? Have you looked into the cost of accounting software or the services of a bookkeeper or accountant? Will you need training to perform your own accounting?

**Tax implications of self-employment?**
When you are self-employed, you still have to pay your Social Security tax (FICA), Medicare tax, and all other federal, state, and local taxes. Do you know what the requirements are in this area?
Licenses, permits, or other legal requirements?
Will your business require any licenses or permits so that you can operate legally in your community? Do you know what paperwork you need to file to meet the federal, state, or local tax requirements?

Accommodations you might need to operate your business successfully?
Have you thought about what services and supports you might need to accommodate your disability as you manage your business? If you need services or supports because of your disability, do you know where to go to get help arranging and paying for with these?

How self-employment will affect your Social Security disability benefits?
Profits from a business count when the Social Security Administration looks at your earned income. As you move forward with your small business plans, make sure you stay in touch with your local WIPA program for assistance with Social Security benefits issues.
Competency Unit 9 – Understanding Rights and Other Protections Afforded to Beneficiaries of Social Security Disability Benefits

Introduction

This unit discusses the possibilities for continued entitlement or re-entitlement when an individual Social Security no longer considers a person to be disabled per the agency’s definition. This may occur because of medical improvement or, for Title II disability beneficiaries, by performing SGA-level work. In either case, Social Security will no longer consider the individual to be disabled and will terminate benefits. This unit explores the various rights and other protections Social Security affords beneficiaries of the disability programs when it makes a determination that an individual is no longer disabled and thus, no longer eligible for disability benefits.

What is Termination?

Termination for Social Security purposes doesn’t just mean that the cash payments have stopped. Social Security may stop payments under certain circumstances even though a beneficiary remains eligible for disability benefits. Termination means that Social Security has terminated or closed the computer record that maintains payments. Once Social Security has terminated benefits, the agency requires a formal re-entitlement or re-instatement decision for payments to begin again. This is important to understand, because termination is more than just stopping payments. Termination is more than cessation, suspension, non-payment, or any other term Social Security uses to denote merely the loss of cash payment. It also means that no more benefits are payable based on that application, and that the “period of disability” has closed.

Prior to January 1, 2001, once Social Security had terminated a disability benefit, the only way someone could receive payments again was to
submit an entirely new application for benefits. Reapplication is often a lengthy process requiring a new medical determination of disability. Reapplication is subject to the Sequential Evaluation process discussed in Unit 1.

Reapplication under the Title II Disability Program

First and foremost, it’s critical for CWICs to understand that when Social Security terminates Title II disability benefits, no matter what the reason may be, a former beneficiary may always reapply for benefits if the disability subsequently prevents SGA-level employment. There’s a common misconception that Social Security offers disability benefits on a “one time per customer” basis. This is absolutely false! Reapplying for benefits remains an option indefinitely. There is no limit on the number of times an individual can establish a new period of entitlement. As long as the beneficiary meets ALL eligibility criteria, Social Security may establish entitlement for disability benefits.

As discussed in Unit 1 of this module, when people apply for Social Security Disability Insurance (SSDI) based on their own work, they serve a waiting period before benefits are payable. The waiting period is five full calendar months after the date the disability began, also called the Date of Onset. Once Social Security terminates SSDI benefits due to work, there is a five-year (60-month) period after the termination during which former beneficiaries can apply and Social Security can re-entitle them without the beneficiaries having to serve another five-month waiting period. Persons who apply and that Social Security re-entitles in this manner also receive a new set of work incentives as soon as Social Security awards their benefits. If the beneficiary applies more than five years after termination, the applicant must serve a new five-month waiting period before becoming entitled to benefits. Once the waiting period has passed, these individuals also receive new work incentives as soon as Social Security entitles them.

Childhood Disability Beneficiaries (CDB) and Reappplication

CDB beneficiaries never serve a five-month waiting period. Also, effective October 2004, Social Security may re-entitle CDB beneficiaries to benefits
on the same parental work record at any time if the reason Social Security terminated the prior entitlement was performance of SGA. Before making this change, Social Security imposed a seven-year limit during which CDBs could re-establish entitlement on the original parental work record. Once this seven-year limit expired, the individual could no longer access benefits on that parental record. Currently, there is no time limit on re-establishing entitlement as long as termination was due to engaging in SGA-level employment.

**Disabled Widow(er) Beneficiaries (DWB)**

Like SSDI applicants, a DWB applicant must serve a five-month waiting period when initially entitled to benefits. Social Security may not re-entitle Disabled Widow(er)s to DWB benefits more than seven years from the date that Social Security terminated the prior benefits. It’s likely, however, that at that point the individual will have reached 60. At that time, he or she could file for Widow(er)s Insurance Benefits (WIB) on the worker’s Social Security work history, and be entitled to the same (or a higher) benefit. In addition, the individual might qualify for SSDI on his or her own record if he or she had sufficient work in covered employment or self-employment in the intervening years.

**Expedited Reinstatement (EXR)**

**Introduction**

The Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999 created an important work incentive called Expedited Reinstatement (EXR). Expedited Reinstatement affords eligible individuals a quick way to re-establish entitlement for Social Security disability benefits after the agency terminated those benefits due to earned income and work activity. The former beneficiary must have the same or a related disability as the earlier entitlement, and the person must again be unable to perform SGA. EXR permits individuals to receive provisional payments while Social Security is processing the reinstatement request.

Prior to January 1, 2001, once Social Security terminated a Title II disability or SSI record, the only way someone could receive payments again was to submit an entirely new application for benefits. This is often a lengthy process requiring a new medical determination of disability. With the enactment of the EXR provisions, eligible individuals whom
Social Security terminated because of work received a valuable alternative to re-application. In October 2005, final federal regulations further expanded and clarified the EXR provisions.

**Expedited Reinstatement (EXR) Basics**

- EXR is available to former Social Security disability beneficiaries including those who received Social Security Disability Insurance (SSDI), Childhood Disability Benefits (CDB), or Disabled Widow(er)’s Benefits (DWB). It’s also available to people who received SSI payments based on disability or blindness.

- Social Security must've terminated the individual’s prior entitlement due to work activity, NOT medical recovery or any other reason. For Title II disability beneficiaries, this means Social Security determined the individual to have engaged in Substantial Gainful Activity. For SSI recipients it means that countable earned income or a combination of earned and unearned income was sufficient to cause the loss of cash benefits as well as 1619(b) extended Medicaid coverage.

- The individual must be unable to perform SGA due to the same disability (or a related disability) that entitled the beneficiary to payments previously.

- The EXR provision allows an individual to receive up to six months of provisional (temporary) cash benefits while Social Security conducts a medical review to determine whether the agency can reinstate the individual to benefits. The individual may also be eligible for Medicare or Medicaid coverage during the provisional benefit period.

- Social Security will pay provisional benefits and reinstate Medicare (if needed), beginning with the month the individual files the request for reinstatement if the individual doesn’t perform substantial gainful activity in that month. Social Security will pay provisional benefits and reinstate Medicare (if needed) beginning with the month after the individual files a request for reinstatement if the individual performs SGA in the month.

- There is an important deadline for Expedited Reinstatement. To receive EXR benefits under any of the Social Security disability programs, the beneficiary must request the benefits within 60
months of when Social Security terminated the prior benefit, unless Social Security can substantiate good cause. Thus, if a person’s disability causes the reduction or cessation of work more than five years after Social Security terminates the record, EXR won’t be available, and the beneficiary must file a new application for benefits.

**When EXR Applies**

**Title II Disability Beneficiaries (SSDI/CDB/DWB)**

To expedite the reinstatement of benefits, Social Security must’ve terminated the earlier record due to work activity. Former beneficiaries must’ve worked through all of the work incentives. That means they used their Trial Work Period (TWP) and Extended Period of Eligibility (EPE), engaged in SGA, used the Cessation Month/Grace Period, and have a terminated Social Security record.

Beneficiaries who are still in their EPE don’t need to request EXR, as Social Security hasn’t fully terminated them from benefits. Beneficiaries reinstated during the EPE don’t have to prove their disability again, unless it’s time for a regularly scheduled CDR. For Social Security to reinstate their benefits during the EPE, beneficiaries merely need to submit documentation that their countable wages have fallen below SGA or their employment has ended.

Individuals who are in their Extended Period of Medicare Coverage (EPMC) but whom Social Security terminated for cash benefits and are beyond their EPE may also request Expedited Reinstatement. Since the disability standard for Expedited Reinstatement is the same as the standard for people using the EPMC work incentive, a denial of EXR for medical improvement will terminate Medicare. Former beneficiaries should consider this risk when requesting EXR.

**Supplemental Security Income Recipients (SSI)**

To be eligible for EXR, SSI recipients must exhaust all of the SSI work incentives, including 1619(b). These individuals must earn wages in excess of the applicable threshold amount long enough that Social Security terminated the SSI record. For this to occur, an individual must not be eligible for SSI payments or Medicaid under 1619(b) within the 12-month suspension period.
Like Social Security Disability beneficiaries in their Extended Period of Eligibility, individuals who received SSI or 1619(b) within the prior 12 months don’t have to reapply or request EXR, as they aren’t fully terminated from benefits. These people only need to show Social Security that their income has dropped for reinstatement.

**IMPORTANT NOTE:** Effective October 16, 2016 a previously entitled individual may request EXR in the same month he or she stopped performing SGA. These revised rules also allow provisional benefits to begin the month after the request for EXR if the individual stops performing SGA in the month of the EXR request. Claimants “become unable” to perform SGA if, in the month of their EXR request, their work is SGA, but they stop performing SGA by the day they file their request. To meet the requirement of having become unable to perform SGA, they must also not perform SGA in the month following the EXR request. These new rules apply to Title II disability beneficiaries (SSDI, CDB, DWB) and Supplemental Security Income (SSI) recipients.

**Requesting EXR vs. Reapplying for Benefits**

Social Security’s Program Operations Manual System (POMS) specifically states that EXR and reapplication are mutually exclusive. CWICs may need to help some individuals understand how EXR and reapplication differ. CWICs may also need to help individuals explain some of their unique needs to Social Security when seeking information about which to request. This is an important decision that requires consideration and weight of the following factors:

**Waiting Periods**

One of the potential disadvantages of pursuing a new application over requesting EXR is that some disability benefits require that the beneficiary serve a waiting period before cash payments may begin. Social Security Disability Insurance (SSDI) and Disabled Widow(er) Beneficiaries (DWB) serve a waiting period before Social Security will pay benefits. This waiting period is five full calendar months after the date the disability began. Childhood Disability beneficiaries (CDBs) never serve the five-month waiting period.
Once Social Security terminates SSDI benefits due to work, there is a five-year (60-month) period after the termination during which former beneficiaries can apply and Social Security can re-entitle them without their having to serve another five-month waiting period. Persons who apply and whom Social Security re-entitles in this manner also receive a new set of work incentives as soon as Social Security benefits are awarded (i.e., TWP and EPE). Social Security may also re-entitle Disabled Widow(er)s without a waiting period within five years of termination. Social Security limits their re-entitlement, however, if more than seven years have passed since the agency terminated their benefits. In that case, however, the widow(er) over age 60 can apply for Widow(er)s Insurance Benefits (WIB) that Social Security doesn’t base on disability. There is no waiting period at all for WIB.

Individuals may re-apply for SSI at any time after termination. Keep in mind that termination due to earned income doesn’t occur until after a person has been ineligible for 1619(b) extended Medicaid for more than 12 months. If termination has occurred because of unearned income or resources, a beneficiary may move back into cash payment status without filing a new application if the beneficiary is eligible again within 12 months after Social Security suspended his or her benefits. If termination occurred because of earned income, it’s highly likely that re-application will result in an award of SSDI instead of or in addition to SSI, as the individual will now have earned work credits and may have achieved insured status. Keep in mind that SSI is always the benefit of last resort. Applicants are required to apply for all other benefits they might receive before Social Security awards SSI. Only Social Security staff can calculate whether or not a claimant has established eligibility for SSDI.

**Medical Disability Determinations during EXR and Reapplication**

To understand one of the unique advantages of EXR over reapplication, one needs to know a little about the disability determination process. Each state has a subcontracted agency called the Disability Determination Service (DDS) that makes disability decisions for Social Security. There is a difference between the way these agencies look at initial applications for disability benefits and the way they make decisions about continuing the benefits at periodic reviews.

- When initially applying for benefits, claimants must have disabilities that prevent them from performing substantial work. They must not only have severe disabilities, but Social Security
must expect these disabilities to last more than 12 months or end in the applicant’s death before then. To establish that a disability exists, Social Security looks closely at the applicant’s medical records. The burden of proof lies with the person filing the claim, not with Social Security. The individual must prove that the disability meets the severity listings that the DDS uses to make a decision.

- A listing is a description of the severity of a physical, psychiatric, or cognitive disability. Each state’s DDS uses these very specific descriptions to see if the applicant is entitled to benefits. This can be a hard standard to meet, especially if the person’s disability isn’t well documented.

- Once individuals are entitled to benefits, they must periodically prove their disabilities continue. For these reviews, the DDS uses a different standard from the one it uses for initial applications. Once people are entitled to benefits, the DDS doesn’t look for medical evidence proving that disabilities exist, because that has already been established. Instead, the person making the decision looks for evidence that the disability is better. If there is sufficient medical improvement, the person’s benefits are terminated. This is an easier test. The person isn’t proving that he has a disability, only that the disability still exists at the same level of severity.

Under EXR the DDS will establish that the individual’s current impairment(s) is the same as or related to the impairment(s) from the terminated entitlement. The DDS uses the disability determination process that it uses with Continuing Disability Reviews (CDRs). The DDS assumes that the disability is there. What it needs to establish is that the disability has the same or worse severity in order to pay benefits. This standard means that people may more easily return to the benefit rolls than they might be able to if they made a new application.

**Provisional Payments under EXR**

Some individuals may prefer to request EXR instead of reapplying, because EXR permits provisional payments, whereas reapplication doesn’t. A person may receive up to six months of provisional payments while the DDS reviews the applicant’s medical records. If the DDS determines that the beneficiary has medically improved and denies reinstatement, Social Security normally doesn’t reclaim provisional
payments, meaning there is usually is overpayment. There are some exceptions to this general rule which Social Security describes in the POMS at DI 13050.080 – Overpayments.

**Health Insurance Considerations for EXR and Reapplication**

During the time that Social Security makes provisional payments, SSDI, CDB, and DWB beneficiaries will receive Medicare, while SSI recipients will receive Medicaid health insurance coverage. If Social Security awards the reinstatement, the health coverage will continue with the payments. If Social Security denies the EXR, the health insurance will stop with the cash payment, but Social Security won’t assess overpayment. There is no provision for medical insurance during reapplication.

**WARNING:** There is one significant risk certain beneficiaries may incur when they apply for EXR. This risk is related to Medicare coverage. Under the Social Security disability program, a person may receive extended Medicare coverage for at least 93 months after the Trial Work Period ends. The person must still be disabled in order to receive this Medicare extension. If a beneficiary applies for EXR, and Social Security finds a medical improvement, he or she is no longer is disabled under Social Security law. That means his or her Medicare stops. If the person reappplies for benefits, instead of requesting EXR, neither a denial nor approval will affect Medicare entitlement under the Extended Period of Medicare Coverage.

**How Social Security Determines Provisional Payments under EXR**

For Title II beneficiaries, Social Security bases the provisional payment amount on the applicable percentage of the worker’s Primary Insurance Amount (the worker’s highest benefit), and is often similar to what the person was receiving before termination. For people who receive benefits based on their own work (SSDI), Social Security may re-compute the benefits to a higher amount if earnings of the prior termination are higher than the earnings used to calculate the initial benefit.

**Primary Insurance Amount (PIA):** The PIA is the result of a complex benefit calculation the Social Security
Administration uses to determine the amount of payments. It’s the amount in benefits that the worker would receive at full retirement age. Social Security calculates all benefits paid on this worker’s record from this PIA. For example, children receive part of the worker’s PIA. The child of a living worker receives up to 50 percent of the worker’s PIA, but a surviving child receives up to 75 percent of the worker’s PIA.

Cost of living adjustments (COLAs) between the last period of entitlement and the EXR request increase the provisional benefit amount for all beneficiaries. This includes the COLA increases in SSI Federal Benefit Rates, for SSI beneficiaries.

**Cost of Living Adjustments (COLA)s:** In recent years, Social Security has increased Social Security payments and SSI Federal Benefit Rates (FBRs) by a factor that adjusts for the increase in the cost of living. COLAs currently increase the payment amounts in January of each calendar year. When Social Security calculates the cost-of-living raises, it adds the COLA to the Primary Insurance Amount, and then figures out what beneficiaries receive based on that PIA.

Social Security bases the SSI benefit on financial need. It bases provisional benefit amounts on the individual’s countable income and the current FBR. Social Security doesn’t make state supplemental payments during the provisional benefit period.

**The difference in benefit amounts between re-application and reinstatement**

Many factors could affect the amount of the reinstated payments. Social Security personnel are best equipped to estimate the differences and assist the beneficiary in understanding which option will yield a higher payment. Because of a special disability Primary Insurance Amount (PIA) guarantee, however, an SSDI beneficiary would never receive a lower benefit than the benefit he or she received before Social Security terminated the first period of disability. Here is an example of how this works:
Example of the difference in benefit amounts between re-application and reinstatement:

Yanna received $900 a month in SSDI before she returned to work. Social Security terminated her benefit record four years ago. She has had a relapse of clinical depression and is deciding whether to reapply or request Expedited Reinstatement. Yanna checked with Social Security and found out that the benefit amount would be higher under the Expedited Reinstatement provisions, because she can access all of the COLAs since Social Security terminated her prior benefits.

For Yanna, there are several advantages to reinstatement instead of reapplication. First, Social Security would add the COLAs to her previous benefit, and her benefit would thus be higher. Second, Yanna is feeling a lot of stress about being re-entitled (a new disability determination). She wants Social Security to use the EXR standard (Medical Improvement Review Standard-MIRS) when deciding if she is disabled. She also wants to receive provisional payments. Yanna requests EXR.

Family Maximum

When Social Security calculates benefits, it must take into account the Family Maximum. This is a cap that limits how much the various family members of a worker may receive in total. Social Security pays his or her benefits first, and then whatever is left of the Family Maximum, Social Security divides among the entitled family members.

Workers receiving SSDI always receive their benefits without consideration of the Family Maximum. CDB and DWB beneficiaries, however, might receive a lower benefit because of the cap. For months of provisional benefits, individuals receive the former benefit without a reduction due to the family maximum. Once Social Security has approved the reinstatement, the family maximum could affect CDB or DWB payments, as well as the payments of other family members on the record. This could result in overpayments.
Retroactivity

Both with EXR and initial application, Social Security is able to pay retroactive Social Security disability benefits as much as 12 months prior to the date of application or request. If the agency denies an EXR request, the EXR request can then serve as a protective filing for a new initial claim. However, if Social Security denies an initial claim, it doesn’t protect EXR filing. This could be an important consideration if more than 12 months’ retroactivity is possible under both filing options.

SSI doesn’t have the same type of retroactivity built into it as Social Security Disability benefits do. In fact, the furthest an SSI request for EXR can go back is the date Social Security first knew of the request.

Whether an applicant is making a request for EXR or a new application for SSI, there is a short waiting period. The month in which individuals inform Social Security that they want to apply is the eligibility month. Payments aren’t possible until the next month. The benefit amount and work incentives would be the same with EXR or reapplication.

EXR and Work Incentives

The Initial Reinstatement Period (IRP)

An important aspect of EXR is that it allows the individual to obtain another Trial Work Period (TWP) and Extended Period of Eligibility (EPE), but not immediately. The individual must receive 24 months of EXR payments before Social Security entitles him or her to another TWP. These 24 months don’t have to be consecutive. If someone who requests EXR goes back to work above the SGA level, the 24-month clock stops ticking until he or she again stops performing SGA and Social Security entitles him or her to another EXR payment. Once the individual has received 24 months of EXR payments, he or she receives a new TWP and EPE, and all of the other work incentives Social Security confers on initial applicants for Social Security disability benefits.

Medicare Coverage and EXR

Another important benefit of EXR is that it may significantly increase eligibility to Medicare. If former Title II beneficiaries who were previously entitled to Medicare request EXR, they will receive Medicare beginning with the first month of provisional payments and throughout the Initial Reinstatement Period. Even though Social Security suspends payments and the 24-month clock stops ticking for months of SGA, Medicare
coverage would continue for those months as well. Once the individual has received 24 months of payments, he or she will have free Medicare Part A as long as he or she is entitled to benefits. If the beneficiary returns to work at a level that causes suspension, he or she may access a new Extended Period of Medicare Coverage (EPMC).

**Supplemental Security Income Beneficiaries (SSI)**

If the individual receives SSI, and not Social Security disability benefits, then the beneficiary can use SSI work incentives immediately after they are reinstated. Once someone receives SSI through EXR, he or she must receive benefits for 24 months before again requesting EXR. If the entitlement ends before the 24 months have passed, the beneficiary would have to reapply to get SSI payments again.

**Important Changes to the EXR Regulations**


Under the current regulations, Social Security no longer requires that the individual leave or reduce employment because of the person’s disability. Instead, the beneficiary may leave or reduce employment for any reason, but must be unable to perform SGA because of the same or related disability at the point the he or she requests. Other provisions in the final regulations include:

- The opportunity to file a second request for reinstatement if Social Security denies the previous request. Social Security won’t pay provisional benefits for the second request if it paid provisional benefits under the first request.

- Receiving Medicaid under section 1619(b) for a month uses one of the 24 months of the initial reinstatement period for SSI beneficiaries.

- Social Security will pay Childhood Disability and Disabled Widow(er) Beneficiaries provisional payments without consideration of the family maximum, the cap on total family benefits. If Social Security later reinstates provisional payments, however, the agency will consider the difference between the higher provisional payments and the adjusted reinstated payments an overpayment.
• A denial of EXR because an individual has medically improved will terminate Medicare entitlement under the Extended Period of Medicare Coverage. If this is a concern for a beneficiary, the individual may wish to file a new application rather than request EXR.

• Medical approval for EXR will generate a new Ticket to Work for beneficiaries, and will terminate any previously issued tickets for that individual.

• Requests for EXR made for Title II beneficiaries are effective the month that Social Security receives the request. If Social Security reinstates benefits, then Social Security will determine if any retroactive benefits are due. Retroactivity is possible for up to 12 months before the beneficiary made the request.

• EXR requests are effective for SSI the month after the beneficiary makes the request. There is no retroactivity for SSI entitlement. In addition, Social Security won’t pay provisional benefits for any month in which a suspension or terminating event occurs under the usual rules, such as if the beneficiary is incarcerated. Social Security may recover provisional benefits as overpayments if the beneficiary knew or should’ve known that the beneficiary wasn’t eligible for those payments.

• If a beneficiary performs SGA during the provisional benefit period, Social Security will terminate provisional benefits. The last month of provisional benefits payable is the first month of SGA. Provisional benefits don’t resume after termination due to SGA.

• In the SSDI program, Social Security will only make provisional payments to the SSDI beneficiary, and not to family members. Once Social Security reinstates the worker under EXR, the spouse or eligible children need only make a request to have Social Security reinstate benefits.

• Beneficiaries may appeal denied EXR requests. However, they may not appeal determinations Social Security makes regarding provisional benefits. The EXR request does provide protective writing for a new claim, which the beneficiary can pursue while following the EXR appeals process.
In addition effective April 17, 2017 the EXR regulations allow previously entitled beneficiaries to apply for EXR in the same month they stop performing SGA, and provides that provisional benefits to begin the month after the request for EXR if the beneficiary stops performing SGA in the month of the EXR request.

**Frequently Asked Questions about EXR**

**If a beneficiary requests EXR or re-applies for benefits and then returns to work at a substantial level shortly thereafter, how will this affect the EXR request or the status of my application?**

If the individual plans to return to work shortly after making the EXR request or filing for re-application, then there are special considerations. Work above SGA shortly after applying, either for SSI or Social Security disability benefits, may cause Social Security to reopen and deny the application. EXR would permit provisional payment for the few months that the individual is below SGA. Social Security would suspend the payments for months above SGA, but there would be no overpayment.

**What happens to provisional payments if the person owes Medicare Premiums?**

If a Social Security disability recipient owes back Medicare premiums, Social Security will deduct the premiums from provisional benefits.

**Will existing overpayments affect provisional benefits?**

Social Security won’t withhold overpayments from provisional benefits without the written consent of the individual. Once the agency reinstates the benefits, however, overpayment recovery follows normal rules.

**If beneficiaries had family members receiving benefits before Social Security terminated the benefits, will Social Security owe the family members provisional payments?**

Individuals who receive Social Security Disability Insurance based on their own work may have children or a spouse who previously received benefits on their record. These family members would receive benefits again once
Social Security makes the reinstatement decision. They won’t be eligible for provisional payments.

**What happens if someone was receiving CDB benefits previously, and married before or after Social Security terminated the benefits?**

When Social Security terminates CDB benefits due to marriage, individuals won’t be able to apply again on that parent’s record, unless the marriage was void or annulled. EXR wouldn’t be possible because Social Security would have terminated CDB benefits for reasons other than work activity.

**What happens to individuals who are eligible for both Social Security disability and SSI?**

People on SSI are required to apply for any other benefit for which they are eligible. If someone receiving SSI has earnings that drop below the Substantial Gainful Activity limit, he or she must apply or request EXR, which depends on the respective payment amounts. Social Security requires individuals who are entitled to SSI to procure whatever benefit will pay the earliest and the highest amount.

**Are there differences in EXR if the individual is blind?**

EXR applies to blind individuals the same way it applies to other beneficiaries, with some exceptions. For blind people over age 55, a special provision may let them come in and out of payment status, depending on earnings, without having to reapply. For those individuals, EXR isn’t possible. Also, when considering reapplication or EXR for blind individuals, remember that there are some differences in the work incentives. For Social Security disability beneficiaries, the financial limit that Social Security uses to consider work as substantial is significantly higher. SSI recipients can make additional deductions when considering gross income to determine what income is countable. These work incentives apply immediately if Social Security reinstates the person. Under reapplication, the limit for substantial work only applies after the Trial Work Period is complete.
If someone reapplied and Social Security denied him or her, may the person request EXR?

As stated earlier, it’s more difficult for a person to meet the medical disability standard for reapplication than the medical standard for EXR. A person could choose to reapply, and then Social Security could deny him or her. If that happens, he or she may request Expedited Reinstatement. The EXR request date won’t be retroactive to the application date.

If Social Security denies EXR, may former beneficiaries reapply?

Yes, and the EXR request date will protect retroactivity for the individual’s application date.

For more information about Expedited Reinstatement, refer to DI 28057.000 - Expedited Reinstatement Sub Chapter Table of Contents found online (https://secure.ssa.gov/apps10/poms.nsf/lnx/0428057000).

Continuation of Payments under Section 301

Section 301 provisions offer extended benefits to eligible individuals who would otherwise terminate from benefits due to medical recovery, not individuals who lose benefits due to work activity or other reasons.

Section 301 permits temporary payment of benefits for individuals working toward a vocational goal. In a sense, Social Security is making a short-term investment in the individual’s benefits, “betting” that completing the vocational plan or program would help the individual not need benefits in the future.

When Social Security conducts a medical CDR or an age-18 redetermination, it may find that the beneficiary no longer meets the medical requirements to receive disability benefits. If that happens, Social Security usually stops the individual’s benefits. Under certain specific conditions, however, Social Security may continue to provide cash disability payments and medical insurance (Medicare or Medicaid) to individuals who are participating in programs that may enable them to become self-supporting.
Because the statutory authority for these continued benefits first appeared in section 301 of the Social Security Disability Amendments of 1980, they often are called “section 301 payments.” The current statutory authority for them is in sections 225(b) and 631(a)(6)(A) of the Social Security Act.

**Important Section 301 Facts**

- Section 301 provisions only offer extended benefits to eligible individuals who would otherwise terminate from benefits due to medical recovery, not individuals who lose benefits due to work activity or other reasons.

- Section 301 allows continued benefit payments for any auxiliaries drawing off the insured worker (such as a spouse or dependent children).

- Section 301 payments are accompanied by continuation of Medicare or Medicaid health insurance as applicable.

- Section 301 provisions apply to SSI as well as the disability benefits authorized under Title II of the Social Security Act. This would include SSDI, CDB, and DWB.

- SSI recipients must continue to meet all SSI eligibility criteria such as the income and resource limits to retain Section 301 payments.

- All of the work incentives under the SSI program apply except for the 12-month suspension period and EXR.

- All of the work incentives apply under the Title II program except for the TWP and EPE.

- It is important to note that if the individual elects statutory benefit continuation during an appeal, Social Security will suspend Section 301 development.

**Eligibility Requirements for Section 301 Payments**

An individual receiving Title II or SSI benefits based on disability or blindness Social Security must’ve medically ceased or determined ineligible due to an age-18 redetermination, and meet all of the following requirements:
• The individual participates in an appropriate program of Vocational Rehabilitation (VR) services, employment services, or other support services;
• The individual began participating in the program before the month his or her disability or blindness ceased;
• The individual’s participation in the program continues through the 2-month grace period after cessation; and
• Social Security determined that the individual’s completion of the program, or continuation in the program for a specified period of time, would increase the likelihood that the individual won’t return to the disability or blindness benefit rolls.

**When Eligibility for Section 301 Payments Ends**

Section 301 eligibility ends when:

• An individual completes the appropriate program of vocational rehabilitation, employment services, or other support services.
• The beneficiary stops participating in the program or supports for whatever reason for more than 3 months.
• A Title II disability beneficiary performs SGA.
• An SSI beneficiary loses cash payments due to any reason other than work activity that fits the 1619(b) criteria.
• Social Security determines that continuing participation in the program [other than a primary or secondary school individual Educational Plan (IEP)*] would no longer increase the likelihood of returning to benefit

* If the beneficiary is a student aged 18-22 who is in primary or secondary school, Social Security assumes that participation in an IEP will improve the likelihood of a reduced dependency on benefits. For these students, Social Security does not require case-by-case likelihood determinations.

Section 301 payments terminate effective with the month after the earliest of the following:

• The month that the individual completes the program;
• The month that the individual stops participating in the program for any reason; or
• The month that Social Security determines the individual’s participation in the program will not or will no longer increase the likelihood that the individual won’t return to the disability benefit rolls.

Individuals who receive continued SSI payments under Section 301 must also continue to meet all of the non-disability-related standards for this program, including the income and resource limits. Under no circumstances will Social Security stop benefit payments earlier than the second month after the month in which the disability ceased, provided that the beneficiary meets all other requirements for entitlement to benefits.

Section 301 determinations can get very complex and the details would be outside of the normal work scope for CWICs. For more information, refer to the VCU NTDC resource document titled “Understanding Section 301” found online (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=37).

When Beneficiaries Disagree with Social Security

A Social Security applicant or beneficiary has the right to appeal any initial decision made about his or her benefits. Beneficiaries must make most requests within 60 days of the date he or she received the letter, or notice, of the decision. Social Security assumes beneficiaries will have received the letter within five days of the date Social Security sent it.

If an individual request an appeal past the 60-day appeal window, Social Security will take the request and determine whether or not there was a good reason, or “good cause,” for the person to be late.

Levels of Appeal

A person who disagrees with an initial determination or decision may request further review. This is called an appeal. The appeal consists of several levels of administrative review that the beneficiary must request within certain time periods and at the proper level. The levels of administrative review are reconsideration, administrative law judge (ALJ)
hearing, and Appeals Council (AC) review. The AC review ends the administrative review process. If an individual is still dissatisfied, he or she may request judicial review by filing an action in federal court.

If the individual doesn’t request review within the time period, he or she may lose the right of further review unless he or she can show good cause failing to make a timely request for review.

**Reconsideration**

In most cases, reconsideration is the first step in the administrative review process for individuals who disagree with the initial determination. Social Security provides the opportunity for an ALJ hearing as the first step in the administrative review process for those determinations involving a request for waiver of an adjustment or recovery of an overpayment.

The method of reconsideration for Title II consists of a case review and disability hearing. The method used depends on the issue involved. For non-medical issues, it’s a case review. For medical issues, it’s a case review for initial claims and a disability hearing, which is a face-to-face reconsideration, for all medical cessation cases.

**ALJ Hearing**

In general, with some exceptions, a hearing before an ALJ is the next level of appeal after Social Security has made a reconsideration determination.

**Appeals Council**

If the individual disagrees with either the ALJ decision or the dismissal of a hearing request, the individual may ask the AC to review the action. The AC may dismiss or deny the request for review, or it may grant the request and either issue a decision or remand the case to an ALJ. The AC may also review an ALJ decision (within 60 days of the hearing decision or dismissal) on its own motion. The AC has final review authority for Social Security.

**Federal Court Review**

The AC review completes the administrative review process. If an individual is still dissatisfied, he or she may request judicial review by filing a civil action in a federal district court.
Each of these appeal steps has required forms and time frames. CWICs may not represent beneficiaries in appeals against Social Security. However, you may assist beneficiaries in understanding their appeal rights, accessing the forms, and understanding what additional information may assist Social Security to make a decision if the beneficiary requests an appeal.

For more information refer to **POMS GN 03101.001 - Summary of Administrative Review Process** found online (https://secure.ssa.gov/apps10/poms.nsf/lnx/0203101001).

**Overpayments**

An overpayment occurs when Social Security pays the beneficiary more than he or she should’ve received. If this happens, Social Security will notify the beneficiary and the representative payee, if applicable. The notice explains why the overpayment occurred, the beneficiary’s repayment options, and his or her appeal and waiver rights.

**Options for Repaying**

If the beneficiary agrees that Social Security paid him or her too much and that the overpayment amount is correct, the beneficiary has several options for repaying it. If the Title II beneficiary is in current pay status, Social Security will withhold the full amount of the benefit each month, unless the beneficiary requests a lesser withholding amount and Social Security approves the request. Full withholding begins 30 days after Social Security notifies the beneficiary of the overpayment.

If the beneficiary receives SSI, generally Social Security will withhold 10 percent of the FBR each month to recover the overpayment. If the beneficiary can’t afford this, he or she may ask that Social Security take less from his or her monthly benefit. Beneficiaries may also request that they pay back the overpayment at a rate greater than 10 percent. Social Security won’t start deducting money from the SSI payments until at least 60 days after it notifies the beneficiary of the overpayment.

If the beneficiary no longer receives SSI, but does receive Social Security disability benefits, he or she can pay back the SSI overpayment by having Social Security withhold up to 10 percent of the monthly Social Security benefit.
Security benefit. If the beneficiary isn’t receiving benefits, their options to repay include:

- Sending a check to Social Security for the entire amount of the overpayment within 30 days; or
- Contacting Social Security to set up a plan to pay back the amount in monthly installments.

If the beneficiary isn’t receiving benefits and doesn’t pay back the amount by using one of the above options, Social Security can recover the overpayment from federal income tax refunds due to the beneficiary or from wages if the beneficiary is working. Social Security can also recover overpayments from future SSI or Social Security benefits. Social Security may also report the delinquency to credit bureaus.

**Appeal and Waiver Rights**

If the beneficiary doesn’t agree that Social Security overpaid him or her, or if he or she believes the amount is incorrect, the beneficiary can file an appeal by completing form SSA-561. He or she can obtain the form SSA-561 online or by calling or visiting the local Social Security office (https://www.ssa.gov/forms/ssa-561.pdf). The appeal must be in writing, and should explain:

- Why the beneficiary thinks Social Security hasn’t overpaid him or her; or
- Why he or she thinks the amount is incorrect.

The appeal request should also include any evidence the beneficiary has to support his or her argument. For example, if a beneficiary is appealing an overpayment related to work activity, and IRWE weren’t considered as part of the determination, the beneficiary should present IRWE receipts.

Beneficiaries have 60 days from the date they received the original overpayment notice to file an appeal. Social Security assumes that they received the letter five days after the date on it, unless the beneficiary shows them that he or she didn’t receive the letter within the five-day period. The beneficiary must have a good reason for waiting more than 60 days to ask for an appeal.

A beneficiary may request a waiver of collection if he or she believes that he or she shouldn’t have to pay the money back. He or she must submit Form SSA-632 to request a waiver, and he or she can obtain it online or
by calling or visiting the local Social Security office. There is no time limit for filing a waiver. The beneficiary will have to prove that:

- The overpayment wasn’t his or her fault; and
- Paying it back would cause financial hardship or be unfair for some other reason.

Social Security may ask for proof of income and expenses. It may ask the beneficiary or representative payee to meet with its personnel. Social Security will stop recovering the overpayment until it makes a decision on either the request for an appeal or it makes a waiver.

**Administrative Finality**

The concept of administrative finality is an important protection for both beneficiaries and Social Security. These rules protect beneficiaries by allowing Social Security to re-examine certain decisions during a set period of time if it appears that the original decision wasn’t correct. Administrative finality also protects Social Security because the agency shouldn’t be required to establish findings of fact after the lapse of a considerable time from the date of the events involved. The administrative finality rules describe the types of decisions that Social Security may re-examine, and establishes the time limits for this process.

Here are a few things to keep in mind about reopening:

- A beneficiary has the right to appeal any initial determination. Reopening, however, does not meet the definition of an initial determination. Beneficiaries don’t have a “right” to have a decision reopened or re-examined by Social Security.

- Social Security may choose to reopen a decision for up to 12 months for any reason, in both the SSI and Title II disability programs.

- If Social Security finds “good cause” to reopen a decision, the agency may reopen an SSI decision within two years of the notice of the determination in question.

- If Social Security finds good cause, the agency may reopen a Title II disability decision up to four years after the notice date of the prior determination.
• CWICs should refer beneficiaries to the local Social Security office when questions about possible reopening arise.

For more information about the reopening process, refer to:

**DI 27505.000 Rules for Reopening** found online
(https://secure.ssa.gov/apps10/poms.nsf/lnx/0427505000)

**SI 04070.010 Title XVI Administrative Finality - Reopening Policies** found online
(https://secure.ssa.gov/apps10/poms.nsf/lnx/0504070010)

**Conducting Independent Research**

**Social Security Web Page on the appeal process**
(https://www.ssa.gov/benefits/disability/appeal.html)

**Social Security Handbook sections on the appeals process**
Competency Unit 10 – The Ticket to Work Program

How the Ticket Program Began

The Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106-170) provided Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) beneficiaries a range of new or improved work incentives and employment-related services to support their movement to financial independence through work. The Ticket legislation also directed the Commissioner of Social Security to establish a Ticket to Work program to create a system to provide employment services in addition to the State Vocational Rehabilitation (VR) agencies around the country.

To understand the TTW program, it’s important to understand why Congress created it through the Ticket to Work Act. Remember, Social Security disability beneficiaries experience very high levels of unemployment and few ever leave the disability rolls due to work. Over the years, Social Security has researched the reasons for this and involved hundreds of stakeholders in discussions about changes that could be made to improve employment outcomes. While chronic unemployment is a complex problem among adults with disabilities, two primary reasons for it are:

1. A lack of services and supports needed for individuals with disabilities to obtain and maintain employment, and

2. Fear among disability beneficiaries that employment will cause the loss of critical cash payments and health insurance.

The Ticket legislation created two programs to help solve these problems. First, the legislation authorized Social Security to create agreements with other organizations to provide employment support services to beneficiaries. These organizations, called Employment Networks( EN)s receive payment from the agency when a beneficiary reaches specified earnings goals. This greatly expanded the number of service providers available to support beneficiaries to achieve employment.
Second, the Ticket legislation authorized Social Security to fund the Work Incentives Planning and Assistance (WIPA) program, which created a national cadre of trained professionals (called Community Work Incentives Coordinators (CWIC)) who provide comprehensive work incentives counseling services. This specialized counseling helps beneficiaries understand how paid employment affects public benefits, and supports beneficiaries using work incentives to ease the transition from dependence on benefits to greater financial independence through work.

These two programs (TTW and WIPA) work together to overcome the most common barriers to employment faced by disability beneficiaries.

**The Benefits of Participating in the Ticket Program**

Remember that one of the original purposes of the TTW program was to expand the availability of services that people with disabilities need to successfully obtain and maintain employment. Social Security accomplished this goal by creating “Employment Networks” (ENs). An EN is an entity that enters into an agreement with Social Security to either provide or coordinate services to Social Security disability beneficiaries needed to enter or re-enter the workforce. The EN can be an individual, a public or private partnership or a group of organizations collaborating to combine resources to serve eligible individuals. Through the TTW program, Social Security provides funding to ENs when beneficiaries achieve specific employment outcomes. There are more than five hundred ENs providing a wide range of support to disability beneficiaries to help them achieve their employment goals.

The second important benefit someone gets from participating in the TTW program is protection from Continuing Medical Reviews (CDR). Social Security conducts periodic medical reviews, called CDRs to determine whether a beneficiary continues to meet Social Security’s disability standard. If Social Security decides that a beneficiary’s impairment has medically improved to the point that the person no longer meets Social Security’s requirements, Social Security terminates the benefit based on medical improvement. Medical CDRs can be a source of real anxiety for some beneficiaries.
Participating in the Ticket program not only provides access to employment services, but also gives protection from medical CDRs. Social Security may not initiate a medical CDR when the beneficiary has assigned his or her Ticket and the beneficiary is making “timely progress”, a term we will discuss later in this unit. To participate in the TTW program, a beneficiary “assigns” his or her Ticket to an EN or the State VR agency. Assignment means that the beneficiary and an EN or a state VR agency have agreed to work together to support the beneficiary’s return to work.

The “Ticket”

The actual Ticket to Work (Ticket) is a symbolic representation of a beneficiary’s eligibility to participate in the program. Social Security mails Tickets to beneficiaries along with a package of information about the program. A beneficiary doesn’t need the paper Ticket in order to participate. In fact, Social Security periodically has suspended mailing Tickets for budgetary or systems reasons. When Social Security mails Tickets, the mailing includes a letter about the program, a paper “Ticket” inviting eligible beneficiaries to participate in the program, and a brochure titled “Your Ticket to Work.” The letter briefly describes the Ticket program, how it works, and how to find ENs and State VR agencies. It notes that the program is free and voluntary, and explains that Social Security may not start a medical CDR if the beneficiary continues to meet certain requirements. The letter also includes information on how beneficiaries can use toll-free phone numbers for specific Ticket program questions, general questions about Social Security benefits, and reporting suspected Social Security fraud.

Ticket Eligibility

Most Social Security disability beneficiaries may participate in the Ticket to Work Program. An individual whom Social Security entitles to either Title II disability benefits (SSDI, CDB or DWB) or SSI benefits based on disability or blindness must meet the following additional criteria to be eligible to assign a Ticket to an EN:

- Be 18-64 years of age, and
• If an SSI recipient, be eligible for benefits under the adult disability standard and receiving a federal cash SSI benefit.

A beneficiary isn’t eligible to participate in the Ticket program if he or she is receiving:

• “Section 301” payments (i.e., continued Title II disability or SSI benefits after a determination of medical improvement because he or she is participating in an approved VR program),
• Continued benefits while appealing a cessation of benefits based on a finding of medical improvement,
• Provisional cash benefits while Social Security is considering a request for expedited reinstatement of disability benefits, or presumptive disability payments while awaiting a final decision on an application for SSI benefits.

SSI beneficiaries who received SSI as children will qualify for the Ticket program at age 18 if Social Security finds them disabled based on the adult standard after conducting an age 18 redetermination.

### Employment Networks

As discussed in Module 1, Employment Networks are agencies that offer various types of services. They could be an employer, a vocational training provider, or a wide range of other organizations that support employment of beneficiaries. An organization becomes an EN by entering into an agreement with the Social Security Administration to function as an EN under the Ticket to Work program.

Some of the general requirements for an EN are:

• Having systems in place to protect the confidentiality of personal information about beneficiaries seeking or receiving services.
• Being both physically and programmatically accessible.
• Not discriminating based on a beneficiary’s age, gender, race, color, creed, or national origin.
• Having adequate resources to perform or otherwise provide the services required under the EN agreement.
Implementing operations necessary to carry out the Ticket program.

Additionally, EN personnel must also have licensure, education, accreditation, and other qualifications to provide the services the EN offers.

The way an EN provides employment services or supports varies by organization, but there are several basic models. In the most common model, a single EN works directly with beneficiaries to provide services. For example, a beneficiary could assign the ticket to Goodwill Industries – an approved EN. The beneficiary would then work with a staff member at Goodwill to complete a career exploration program, determine an employment goal, develop a resume and use online job boards to apply for jobs. There are many different types of services ENs provide, depending on the unique needs of individual beneficiaries.

Some ENs hire beneficiaries as employees. This type of EN uses a business model that includes the EN serving as the beneficiary's employer. Social Security requires that Employer ENs:

- Identify the jobs they have available;
- Pay wages at or above the amount that Social Security defines as Substantial Gainful Activity (SGA);
- Identify where the EN plans to place beneficiaries; and
- Describe how the EN plans to provide beneficiaries with the supports and opportunities to permit them to keep a job that pays SGA-level earnings.

The business plan submitted by prospective Employer ENs must include:

- A promise to maintain an active program for hiring and providing ongoing services and supports to their workers with disabilities;
- A plan for placing SSI and SSDI beneficiaries in jobs that pay at or above the annual SGA amount;
- A provision for paying SSI/SSDI beneficiaries in a timely manner for work they perform.

Another service model is called the Consumer Directed Services (CDS) model. The TTW program defines CDS as an EN business model that shifts responsibility for key service decisions from the EN to the
beneficiary. In this model, beneficiaries purchase a variety of their own employment support services, and based on subsequent achievement of certain work expectations, are reimbursed by the EN for all or a portion of their work-related expenses.

The following three requirements apply to ENs operating a CDS business model.

- The "cash-back" payments to the beneficiary must be used for services related to that beneficiary obtaining or retaining work and not as a wage supplement or work incentive.

- Direct payments to the beneficiary are permitted only on a reimbursement basis for allowable expenses. It is important to remember that payments to Supplemental Security Income (SSI) recipients for other than allowable expenses may result in an overpayment of previously paid SSI benefits.

- The EN must provide a detailed accounting for how the funds were spent, and the accounting for the expenditures will be considered documentation that the funds are being used for return to work expenses.

The last model is called an Administrative EN. This is an association of providers that combine their resources to function as a single EN. The EN of record is the organization that assumes responsibility for ensuring that the EN meets all requirements.

For a listing of current ENs, go to choosework.ssa.gov – Find Help (https://choosework.ssa.gov/findhelp/).

### Working with an EN in the Ticket Program

The process begins when a beneficiary contacts an EN, and both parties agree to work together. The beneficiary may contact several ENs before he or she finds one that offers the services the beneficiary wants. Note that working together is a voluntary process for both the beneficiary and the EN. That means that beneficiaries may need to shop not only for services, but also for ENs that are able and willing to work with them to provide those services.

The beneficiary and the EN jointly develop an employment plan, called the Individual Work Plan (IWP) that both parties sign. An IWP is a
required written document signed by an EN and a beneficiary or the beneficiary’s representative. A beneficiary and EN develop and implement it in partnership when they have agreed to work together to pursue the beneficiary’s employment goal. The IWP outlines the specific employment services, vocational services, and other support services that the EN and beneficiary agree are necessary to achieve the employment goal.

The EN notifies the “Ticket Program Manager” or TPM that they have accepted a Ticket. This changes the ticket status to “In Use”. The beneficiary has protection from initiation of medical reviews after Ticket assignment.

MAXIMUS, Inc. of McLean, Virginia, serves as Social Security’s Ticket Program Manager (TPM) to support Ticket program operations. As TPM, MAXIMUS is responsible for:

- Liaison with ENs and state VR agencies, from the point of initial outreach and recruitment through active EN participation;
- Training new ENs and supporting quality assurance activities to insure program integrity and effectiveness;
- Facilitating and monitoring active Ticket program participation by ENs;
- Administering and supporting the Ticket assignment process;
- Supporting the EN payment process;
- Marketing Social Security’s work incentives programs (including the Ticket to Work Program) to beneficiaries with disabilities;
- Facilitating beneficiary access to employment networks serving under the Ticket to Work program;
- Supporting Ticket program data collection and reporting activities; and
- Operating the Ticket to Work Helpline to ensure accurate and timely information to Social Security beneficiaries with disabilities.

As the beneficiary meets work and earnings milestones, Social Security pays the EN set amounts, depending on the beneficiary’s progress. The payments are based on the beneficiary’s actions and accomplishments,
rather than the amount that the EN spends to support the employment effort. ENs are paid under one of two EN payment systems described later in this unit.

**State VR Agencies and the TTW Program**

State Vocational Rehabilitation (VR) agencies across the country were serving Social Security disability beneficiaries long before Social Security implemented the Ticket to Work program. Social Security began reimbursing State VR agencies for the cost of successful rehabilitation services provided to disability beneficiaries in 1981. This program continues today. Social Security's VR Cost Reimbursement (CR) program is available only to State VR agencies; Social Security does not provide cost-reimbursement payments to ENs. However, on a case-by-case basis, State VR agencies may choose to act as ENs and be paid under one of the two EN payment systems.

The two purposes of the CR program are:

1. To make State VR services more readily available to Social Security beneficiaries with disabilities; and
2. To generate savings to the Social Security Trust Fund, for SSDI beneficiaries, and to the General Revenue Fund for SSI recipients.

Under the CR program, Social Security pays State VR agencies when beneficiaries served by State VR agencies achieve nine continuous months of earnings at or above the SGA level. When the beneficiary achieves this benchmark, the State VR agency submits a request to Social Security with supporting documentation. This documentation includes a breakdown of the direct costs for the beneficiary’s services. Social Security then reimburses the State VR agency for approved direct rehabilitation costs.

State VR agencies can choose to serve Social Security beneficiaries under the traditional VR Cost Reimbursement (CR) program or as an EN under the Ticket program. When a State VR agency chooses to act as an EN, it may elect payment under the traditional rules that allow the agency to receive reimbursement from Social Security for the cost of rehabilitation.
For individuals served in the Ticket program by a state VR agency, the agency must outline services through the Individualized Plan of Employment (IPE). We describe the IPE in a later section of this manual. In contrast to the EN, state VR agencies must serve all eligible individuals. In times of budget shortages, State VR agencies may serve only the most severely disabled applicants. When that happens, the State VR agency uses categories called “order of selection” when deciding if they are able to serve an applicant.

We include additional information about the TPM and how WIPA projects collaborate with this contractor in Module 2.

**Protection from Continuing Medical Reviews (CDR) and Use of a Ticket**

To begin to participate in the TTW program, a beneficiary “assigns” his or her Ticket to an EN or a State VR agency acting as an EN. Assignment means that the beneficiary and a state VR agency or an EN have agreed to work together to support the beneficiary’s return to work. “Use” of a Ticket means that the person continues to meet specified requirements described later in this section, and means Social Security will not initiate a medical review.

**NOTE:** Protection from medical reviews does not change the work reviews Social Security may conduct to determine whether a Title II disability beneficiary is engaging in SGA, or determinations Social Security makes about an SSI recipient’s income and resources. Even when participating in the TTW program, beneficiaries must report wages.

If Social Security initiates a medical CDR before a beneficiary assigns his or her Ticket (or begins service through a state VR agency), Social Security will complete the medical CDR. The date on the notice Social Security sent to the beneficiary that informs him or her that Social Security is beginning to review his or her disability is the date Social Security “initiates” the review.

Social Security usually conducts medical CDRs based on a reminder or “diary” that the state agency sets when they make a decision about the person’s disability. Social Security uses three levels of review diaries:
• Medical Improvement Expected (MIE),
• Medical Improvement Possible (MIP), and
• Medical Improvement Not Expected (MINE).

Each of these diaries establishes a date for the next review. MIE reviews usually occur between one and three years, MIP reviews occur between three and five years, and MINE reviews occur between five and seven years.

It’s possible for a beneficiary to assign the Ticket after Social Security initiates a medical CDR, pending the decision on the medical review. If the beneficiary has medically improved and is no longer entitled to disability-based benefits, Ticket eligibility will end.

**Important Note:** The protection from a medical CDR will be less important to some beneficiaries with permanent severe disabilities. For example, an individual with significant paralysis who uses a wheelchair may not fear a medical CDR if there is no expectation of medical improvement. For him or her, it may be less important to follow a strict pace of movement toward educational or work goals and more important to move at a pace that is realistic in light of the challenges created by his or her disability.

**Using a Ticket and Timely Progress**

Social Security defines using a Ticket as meeting specified education or employment goals. Once a beneficiary assigns a Ticket, he or she must make “Timely Progress” in order to retain the protection from medical reviews that the TTW offers. Social Security conducts periodic Timely Progress Reviews (TPR) to ensure beneficiaries are making sufficient progress to continue medical CDR protection.

During TPRs the TPM reviews the educational and work activities of a beneficiary during a specific time period. Social Security bases the relevant TPR period for a current review on how long ago the beneficiary assigned the Ticket. For example, a person who has been in the program for three years would need to make progress at the level expected for the third 12-month TPR period.
The current regulations acknowledge the importance of higher education, technical training, and vocational training, by allowing beneficiaries to meet timely progress requirements through participation in those programs.

If a beneficiary reports to the TPM that he or she is unable to make timely progress toward self-supporting employment, the TPM will give the beneficiary the choice of placing the Ticket in inactive status or, if applicable, taking the Ticket out of assignment.

## Timely Progress Requirements

Social Security conducts timely progress reviews on each assigned and in-use, Ticket every 12 months. The requirements for each 12-month progress review periods are:

### First 12-month review:

- Any three months out of the 12 at “trial work” earnings level ($850 per month in 2018), or
- Completed G.E.D. or high school diploma, or
- Sixty percent of full-time college credit for one year earned or at least 60 percent of one year’s course work for a vocational or technical school completed (based on what is considered full-time by that particular college or school).

### 24-month review:

- Six months out of the last 12 at trial work earnings level, or
- Seventy-five percent of full-time college credit earned or 75 percent of one year’s course work at vocational or technical school completed.

### 36-month review:

- Nine months work out of the last 12 with earnings greater than the SGA-level applicable to the period in which the beneficiary performed the work. (SGA is work valued above $1,260 per month for non-blind individuals and $2,110 for blind individuals in 2020), or
• Completed a two-year degree or certification program, a vocational or technical program, or an additional one-year of full-time college credit earned toward a four-year degree or certification.

48-month review:
• Nine months work out of the last 12 with earnings over SGA, or
• An additional one year of full-time college credit earned toward a four-year degree or certification.

60-month review:
• Six months work out of the last 12 with earnings in each of those six months that preclude payment of Title II disability benefits and federal Social Security cash benefits, or
• An additional one year of full-time college credit earned toward a four-year degree or certification.

72-month review:
• Six months work out of the last 12 with earnings in each of those six months that preclude payment of Title II disability benefits and federal SSI cash benefits, or
• Completed four-year degree or certification program.

Successive 12-month periods:
• Six months work out of the last 12 with earnings in each of those six months that preclude payment of Title II disability benefits and federal SSI cash benefits.

NOTE: Beneficiaries can combine work and education to meet timely progress requirements. For example, Social Security is reviewing a beneficiary after the first 12-month period and he or she worked one month at trial work level (33.3 percent of work requirement) and attended school at 40 percent of full-time credit (66.7 percent of education requirement), he or she will have met the timely progress requirement. The combined percentages must add up to at least 100 percent.
NOTE: We provide a Quick Reference Chart at the end of this unit that lists the various 12-month progress review periods and provides a description of the timely progress requirements. We recommend that you use this chart as a desk reference when counseling beneficiaries on Ticket issues.

Beneficiaries who fail to meet the timely progress requirements retain their right to participate in the Ticket program. They only lose protection from a medical CDR. Also, Social Security will not perform a CDR unless it is time for a regularly scheduled review.

Assigning a Ticket or Otherwise Using It, Reassigning a Ticket, Extension Periods and Inactive Status

In general, a beneficiary can assign a Ticket to an EN or state VR agency if the Ticket is valid and the beneficiary is receiving a cash payment. To assign a Ticket, a beneficiary must first find an EN or state VR agency that is willing to accept it. If the beneficiary decides to accept services from the state VR agency that is not acting as an EN, the agency will decide whether it wants Social Security to pay under the Ticket program or Social Security’s VR cost reimbursement program. State VR agencies may choose how they want to interact. When the VR agency chooses cost reimbursement, rather than acting as an EN, the ticket is placed in a status called “In-Use SVR.” The beneficiary will have the same rights and responsibilities when Social Security assigns the Ticket and when it’s in In-Use SVR status. Most importantly, the VR agency’s decision regarding its payment option does not affect the beneficiary’s protection from medical CDRs.

The 90-Day Extension Period

If a beneficiary takes his or her Ticket out of assignment or In-Use SVR status, the beneficiary is eligible for a 90-day extension period if the Ticket is in use at the time of retrieval (i.e., the Ticket wasn’t in inactive status and the beneficiary was making timely progress toward self-supporting employment at the time of the most recent progress review). During the 90-day extension period, Social Security will consider the Ticket still in use, and the beneficiary still to have protection from
initiation of a medical CDR. The beneficiary may reassign the Ticket during the 90-day extension period even if he or she is not due cash payments. This differs from Ticket assignment at other times, when the beneficiary may only assign his or her Ticket if currently entitled to payments.

The extension period begins on the first day on which the Ticket is no longer assigned and ends 90 days later, or when the beneficiary assigns the Ticket to a new EN or state VR agency, whichever occurs first. If the beneficiary does not reassign the Ticket during the extension period, Social Security considers it no longer in use at the end of the extension period, and Social Security could initiate medical CDRs. In addition, the beneficiary must be receiving cash benefits to assign the Ticket after the extension period. Finally, Social Security omits the extension period in determining whether the beneficiary is making timely progress toward his or her work goals.

Example of the 90-day extension period:

Lydia assigned her Ticket to EN #1 on January 15th, understanding the EN would assist her with resume writing, job interview skills, and job leads to enable her to move from her part-time job to a better paying full-time position. Lydia is unhappy with EN #1 and four months later, on May 15th, retrieves her Ticket from EN #1. Sixty days later, on July 14th, Lydia fulfills the 90-day extension period criteria. Social Security could not initiate a medical CDR during the extension period. She will continue to have protection from medical CDRs after assigning her Ticket to EN #2 as long as she continues to meet the timely progress requirements described earlier in this section.

Inactive Status

A beneficiary may place his or her Ticket in inactive status at any time by submitting a written request to the TPM. Inactive status will be effective with the first day of the month following the month of the request. Social Security will not consider the beneficiary to be making timely progress during the months of inactive status, and could initiate a medical CDR during those months. None of the months of inactive status will count toward the time limitations for making timely progress.
A beneficiary may reactivate a Ticket by submitting a written request to the TPM. Typically, the beneficiary would then return to in-use status if the Ticket is still assigned to an EN or a state VR agency acting as an EN. It’s important to note that placing the Ticket in inactive status will not affect the beneficiary’s relationship with the service provider, i.e., the beneficiary is still entitled to receive all appropriate services.

**Example of a beneficiary in inactive status:**

Lionel is receiving support from his state VR agency to attend college to become an engineer. He entered college in August 2017, completed the fall and spring semesters and, having completed more than the minimum 60 percent of his first-year credit requirements, met the first year’s timely progress requirement for the year ending August 2018. During his second year of college, he obtains 30 percent of his second-year credits during the fall semester. Then he has a six-week hospitalization, is forced to drop out of college on February 20, 2019, and will not earn credits for the spring semester. He arranges to have his Ticket placed into inactive status, effective March 1, 2019. On August 1, 2019, he asked Social Security to reactivate his ticket. He returned to college in August, taking a full course load and obtaining another 50 percent of required credits for another year of college, ending the semester in December 2019.

When the TPM does the Second 12-Month Progress Review, the relevant review period will be August 2018 through December 2019, adding an extra five months to the usual 12-month period to reflect the five months his Ticket was in inactive status. Since the review period is extended through December 2019, Lionel is able to add his 50 percent of needed credits from the fall 2019 semester to the 30 percent he achieved in the fall 2018 semester. The resulting 80 percent of credits are more than the 75 percent he needed for Year 2 timely progress. As a result, he is once again protected from a medical CDR. Lionel will now enter the third review period, which will run from January 2020 through December 2020.
NOTE: During the period Lionel’s Ticket was in inactive status, March 1 to July 31, 2019, Social Security could have initiated a medical CDR. If, for example, Social Security started the CDR during May 2019, the CDR process would continue, even if Social Security did not complete the CDR until after Lionel reactivated his Ticket.

Retrieving and Reassigning a Ticket

A beneficiary may “retrieve” a Ticket or take it out of assignment at any time and for any reason. The beneficiary must notify the TPM in writing. The Ticket will no longer be assigned to that EN or state VR agency effective with the first day of the month following the month in which the beneficiary notifies the TPM. For example, if the beneficiary notifies the TPM on February 8 that he or she is taking the Ticket out of assignment, the Ticket is no longer assigned effective March 1. If an EN goes out of business or Social Security no longer approves the EN’s participation in the Ticket program, the TPM will take the beneficiary’s Ticket out of assignment. In addition, if the beneficiary’s EN is no longer able to provide services, or if the state VR agency stops providing services because Social Security determines the beneficiary is ineligible for services, the EN or state VR agency may ask the TPM to take the beneficiary’s Ticket out of assignment. In the two latter situations, the TPM will send a notice to the beneficiary informing him or her of this decision.

A beneficiary may reassign his or her Ticket as long as he or she maintains eligibility for the program. For example, a beneficiary may choose to reassign the Ticket to a different EN or to the state VR agency. To reassign a Ticket, the beneficiary must first meet the criteria for assigning a Ticket described above. If the beneficiary meets those criteria, he or she may re-assign the Ticket only if he or she continues to meet the Ticket eligibility requirements, has an unassigned Ticket, and has an EN or state VR agency that is willing to work with him or her and sign a new IWP or IPE.

Employment Network Payment Systems

Since its inception, Social Security has based the underlying premise of the Ticket to Work program on paying ENs when the EN’s services lead to
satisfactory employment (or self-employment) outcomes of the Title II disability or SSI beneficiary. ENs may elect Social Security to pay under one of two payments systems: the Outcome Payment System or the Milestone/Outcome Payment System.

Keep in mind that Social Security pays ENs based on the beneficiary’s progress and success returning to work. Milestone payments are paid earlier in the process, for earnings milestones the beneficiary reaches. Social Security makes outcome payments when a beneficiary’s cash benefits stop due to work activity. The advantage to the Milestone-Outcome payment system is that ENs receive payments earlier in the rehabilitation process. The advantage to the Outcome system is the potential for higher overall remuneration, if the beneficiary succeeds in keeping earnings high enough to suspend or terminate benefits until the EN receives all possible outcome payments.

An EN elects one of the two payment systems when it enters into an agreement with Social Security to serve as an EN. After first electing a payment system, the EN can then make one change in its chosen system for prospective Ticket assignees during each calendar year thereafter.

The Outcome Payment System

The Outcome Payment System is the easier of the two EN payment systems to understand, because all payments are based on the same formula. Total payments under this option are potentially about 10 percent higher than under the Outcome-Milestone Payment System. However, the trade-off for the EN is that payments are only available for months when the beneficiary is not eligible for Title II or SSI disability payments due to earnings. Social Security can pay an EN for an outcome month only if the earnings suspension occurs after a beneficiary has assigned his or her Ticket to the EN and before the individual’s Ticket terminates.

Outcome Payments to Beneficiaries Who Receive SSDI Only or Who Receive Concurrent Benefits

When ENs serve Title II disability beneficiaries or concurrent beneficiaries, they can receive up to 36 outcome payments. An outcome payment would be available for each month when no monthly cash payment would be due for either Title II disability (based on performance of SGA) or, in
the case of concurrent beneficiaries, SSI (because of earnings). The outcome payments need not be for consecutive months.

The outcome payment period for beneficiaries receiving only SSI extends to sixty months in order to compensate for the lower amount of each outcome payment. This applies even if the beneficiary subsequently becomes a concurrent beneficiary, or becomes entitled to a Title II disability benefit that precludes payment of SSI. Also, keep in mind, SSI benefits may be suspended with significantly lower earnings if the beneficiary has unearned income.

**The Milestone/Outcome System**

The Milestone/Outcome system permits Social Security to pay ENs for “milestones”, or specific accomplishments as they move towards work.

The Milestone/Outcome Payment System involves three phases for payment including:

- Phase 1 payments for gross earnings at the level for a trial work period (TWP) month, with the first of four milestone payments available with earnings at 50 percent of that needed for a TWP month and the second milestone payment available with TWP-level earnings in only three months in a six-month period;
- Phase 2 payments for gross earnings at the substantial gainful activity level (ignoring deductions for work incentives); and
- Outcome payments for gross earnings that result in ineligibility for cash benefit payments (i.e., after accounting for any Title II or SSI work incentives).

The Phase 1 milestones in particular allow an EN to receive milestone payments for lower earnings levels that are often part of the incremental path toward self-supporting employment.

If you want more information about the rules for these payments refer to Social Security’s website (https://yourtickettowork.ssa.gov/employment-networks/payments.html).

Keep in mind that your role as a CWIC is to help the beneficiary use his or her Ticket if he or she chooses. CWICs do not need to be expert about EN payments.
Limitations on Payments to ENs

Social Security will pay an EN only for milestones or outcomes achieved after the beneficiary assigned the Ticket to the EN and before the Ticket terminates. If the EN offers some services beyond those it makes available under the Ticket program, the EN must be clear in its advertising of this and must list in the IWP the services it will provide under the Ticket program. An EN may not charge beneficiaries for services it provides under an IWP.

In some cases, an EN may receive a number of milestone or outcome payments based on the level of work the beneficiary reports. If during a later review, Social Security finds that the beneficiary attained the required level of work for some, but not all of the milestone or outcome payments it provided to the EN, the EN can keep the milestone and outcome payments.

There will be some cases in which two or more ENs qualify for payment on the same Ticket. This may occur because the beneficiary assigned the Ticket to more than one EN at different times, and now more than one EN is claiming that their services contributed to the achievement of a milestone or outcome. When that happens, Social Security will have to split up the milestone or outcome payments. The TPM must make an “allocation” recommendation with regard to what percentage of a particular payment will go to each EN.

Receiving Services from both the State VR Agency and an EN – The Partnership Plus Program

Under current regulations, a beneficiary may receive services from both a State VR agency and then an EN, and, if the state VR agency is serving the beneficiary under the cost reimbursement program, both agencies may seek compensation from Social Security on behalf of the same beneficiary using the same Ticket. To ensure some savings to the Social Security Trust Fund and the General Revenue Fund, Social Security can only compensate for the provision of sequential, not concurrent, services. While a beneficiary’s Ticket is in the “in-use SVR” status, it isn’t otherwise available for assignment to another EN; however, a beneficiary may
assign his or her Ticket to an EN after receiving services from the State VR agency under the “Partnership Plus” program. Social Security created the Partnership Plus option to allow a beneficiary to receive VR services to meet his or her intensive up-front service needs and, after the State VR Agency closes the case, assign his or her Ticket to an EN to receive ongoing support services.

Partnership Plus is specific to EN-VR partnerships. If two ENs serve the same beneficiary due to a change in Ticket assignment, they may agree to determine how they will share EN payments or the TPM can assist the ENs in determining how to split the EN payments based on the services each EN provides.

**How Does Partnership Plus Work?**

After a State VR agency closes their services, the beneficiary has the option of assigning his or her Ticket to an EN providing job retention and other ongoing support services. If VR served the beneficiary under the cost reimbursement program, the EN would then be eligible to receive some of the Milestone payments and any Outcome payments as the beneficiary reaches the designated levels of earnings.

If the State VR agency closed the cost reimbursement case with the beneficiary in employment (regardless of the hours of work or the beneficiary’s earnings), the Phase 1 Milestone payments aren’t available to the EN that accepts the beneficiary’s Ticket assignment. This is because the Phase 1 Milestone payments are designed to provide compensation to ENs for the initial services, including job placement, which resulted in the beneficiary’s entry into employment. Since the VR agency will be able to submit a Cost Reimbursement (CR) claim when the beneficiary reaches nine months of continuous SGA-level earnings, Social Security cannot compensate both the VR agency and the EN for providing the services that led to the job placement. However, the EN can request Phase 2 Milestone payments as soon as the beneficiary’s gross earnings exceed the applicable SGA level.

If a beneficiary assigns his or her Ticket to an EN after the VR agency closes a cost reimbursement case, and the EN is operating under the Outcome-only payment system, all outcome payments are available to the EN as the beneficiary attains the required levels of work and earnings.
Eligibility for a Second Ticket

An individual has one period of Ticket eligibility during a period of entitlement to Title II disability or SSI based on disability or blindness. However, if entitlement to Title II disability or SSI ends or Social Security terminates and later reinstates benefits, the beneficiary will begin a new period of eligibility in the Ticket program. There is no limit to the number of times an eligible beneficiary can participate in the Ticket program.

Dispute Resolution

The Ticket program offers a dispute resolution system for four types of disputes: those between beneficiaries and state VR agencies acting as ENs; those between beneficiaries and ENs that aren’t state VR agencies; those between ENs that aren’t state VR agencies and the Ticket Program Manager; and those arising under agreements between ENs and state VR agencies.

We will discuss the first two dispute resolution systems, since they are the most likely to arise in your work with beneficiaries.

Disputes between Beneficiaries and State VR Agencies

When a state VR agency serves a beneficiary, Social Security requires the agency to comply with all of the provisions under Title I of the Rehabilitation Act of 1973 and its implementing regulations. One of those requirements is the opportunity to resolve disputes through formal mediation services or an impartial hearing process.

Any individual who is seeking or receiving VR agency services, who is dissatisfied with a determination made by personnel of the agency, has the right to a timely review of that determination. Each state VR agency must develop and implement procedures to ensure that an individual may request a timely review, which must include the right to mediation and an administrative hearing before an impartial hearing officer. The VR agency must notify individuals, in writing, of their right to mediation, an impartial hearing, and the availability of the Client Assistance Program (CAP) to assist them with disputes. The agency must provide this at the following times:

- At the time the individual applies for VR services;
• At the time VR assigns the individual to a category in the state’s order of selection, if the state VR agency has established an order of selection;

• At the time the individual and VR develop the Individualized Plan for Employment (IPE); and

• Upon the denial, reduction, suspension, or cessation of VR services.

At an impartial hearing, the individual has the right to be represented by an attorney or other advocate. Both the individual and the agency can present evidence and cross-examine witnesses. The hearing decision is final and must be implemented by all parties, unless overturned upon appeal.

**Disputes between Beneficiaries and ENs**

For disputes between beneficiaries and ENs that aren’t state VR agencies, the Ticket program offers a three-step dispute resolution process:

1. The beneficiary can file a complaint through the EN’s internal grievance process.

2. If the EN’s internal grievance procedures don’t result in an agreeable resolution, either the beneficiary or the EN may seek a resolution from the TPM.

3. If either the beneficiary or the EN is dissatisfied with the resolution proposed by the TPM, either party may request a decision by Social Security.

All ENs that are not state VR agencies must establish written grievance procedures that a beneficiary can use as a first recourse to seek a resolution to a dispute under the Ticket program. The EN must give each beneficiary seeking services a copy of its internal grievance procedures and inform him or her of the right to refer a dispute to the TPM for review, and then to Social Security for a decision. The EN also must inform each beneficiary of the availability of assistance from the State Protection and Advocacy system.

At a minimum, the EN must inform each beneficiary seeking services under the Ticket program of the procedures for resolving disputes when:

• The EN and the beneficiary complete and sign the IWP;
• The EN reduces, suspends, or terminates services in the beneficiary’s IWP; and

• A dispute arises related to the services spelled out in the beneficiary’s IWP or to the beneficiary’s participation in the program.

When the EN’s grievance procedures don’t result in a satisfactory resolution, either the beneficiary or the EN may ask the TPM to review a disputed issue. The regulations do not have a time limit for requesting this review, but do require the TPM to contact the EN to submit all relevant information within 10 working days. The information the beneficiary should submit should include:

• A description of the disputed issue(s);

• A summary of the beneficiary’s position, prepared by the beneficiary or a representative of the beneficiary, related to each disputed issue;

• A summary of the EN’s position related to each disputed issue; and

• A description of any solutions the EN proposed when the beneficiary sought resolution through the EN’s grievance procedures, including the reasons the beneficiary rejected each proposed solution.

The TPM has 20 working days to develop a “written recommendation” that should explain the reasoning for the “proposed resolution.” Upon receiving the TPM’s recommendation, either the beneficiary or the EN may request, in writing, a review by Social Security. The TPM must receive that request for review within 15 working days of the beneficiary’s or EN’s receipt of the TPM’s recommendation. The TPM has 10 more working days to refer this request to Social Security. The request for Social Security review must include a copy of the beneficiary’s IWP; information and evidence related to the disputed issue(s); and the TPM’s conclusion(s) and recommendation(s).

Social Security’s decision in response to this request is final, and no appeal is possible.
Representation of Beneficiaries in Ticket Disputes

If a beneficiary is using either the appeals system for resolving disputes with state VR agencies, pursuant to Title I of the Rehabilitation Act, or using the more informal procedures for resolving disputes with ENs, pursuant to the Ticket regulations, an attorney, advocate, or any other person can represent the beneficiary. The two advocacy programs, available in every state and territory to assist beneficiaries with these disputes, are the Client Assistance Program (CAP) and the Protection and Advocacy program. The CAP was created in the mid-1980s, largely to assist individuals with disabilities in connection with state VR agency disputes, and may also be available to assist with EN disputes.

Role of the WIPA Projects in Working with Beneficiaries on Ticket Issues

CWICs have a critically important role in helping beneficiaries understand and use the Ticket to Work as part of a holistic strategy for achieving employment and enhancing self-sufficiency. The Ticket to Work is a powerful work incentive for certain individuals, and may make the difference between remaining unemployed or successfully attaining a satisfying career.

CWICs can support participation in the Ticket program in the following ways:

- Screening all beneficiaries who request services to identify those who would most benefit from Ticket assignment and who would make strong candidates for Ticket assignment.

- Explaining in clear and understandable terms how the Ticket to Work program functions and what benefits individuals receive from using their Ticket.

- Encouraging beneficiaries who are strong Ticket candidates and who would benefit from the Ticket to Work program to consider Ticket assignment.

- Counseling beneficiaries on Ticket assignment by providing information about available ENs and helping the beneficiaries select an EN that best matches the individual’s service or support needs and preferences.
• Counseling beneficiaries on what constitutes “timely progress” for applicable 12-month review period in the Ticket program. This will vary depending on the amount and type of employment preparation the beneficiary needs to achieve the desired occupational goal. Some beneficiaries will start with a goal of attaining a GED, while others may move directly into paid employment. Still others will pursue various types of post-secondary education or training. CWICs need a solid understanding of the planned route for achieving employment and will need to counsel individual beneficiaries on the timely progress requirements applicable to them.

• Coordinating with ENs to ensure that Social Security properly applies work incentives, conducts work CDRs in a timely fashion, and adjusts or ceases cash benefits. CWICs should work collaboratively with the EN, the beneficiary, and Social Security to make sure that they apply countable earnings correctly and cease cash payments when they should.

• Assisting with making Ticket assignment changes such as placing the Ticket in inactive status, un-assigning a Ticket, or re-assigning a Ticket.

• Helping resolve any problems with assigning or using a Ticket. Potential Ticket problems would include eligible individuals who failed to receive a Ticket, individuals whose Ticket isn’t showing as being assigned, and individuals who do not receive correct determinations of timely progress during annual reviews.

Role of WIPA Projects in Working with ENs on Ticket Issues

The WIPA projects have an important role to play in supporting the efforts of ENs. CWICs need to work in close partnership with ENs to overcome potential barriers to employment related to the Social Security disability benefits or other federal, state, or local benefits.

CWICs have an obligation under the Ticket Program to support ENs in the following ways:
1. CWICs should be knowledgeable about the ENs serving the WIPA project catchment area and help ENs understand and use WIPA services.

CWICs also must move beyond simply providing beneficiaries with basic information about ENs. Under the WIPA program, CWICs are encouraged to help beneficiaries choose an appropriate service provider for Ticket assignment and make referrals to ENs. To fulfill this role, CWICs must be able to suggest available ENs based on individual employment goals and service preferences. When possible, CWICs should develop in-depth knowledge of how these providers operate, the services they provide, and eligibility procedures and criteria.

Finally, CWICs can provide specific information to ENs about WIPA services. This includes:

- The overall mission and goals of the WIPA program;
- Eligibility requirements for WIPA services;
- Characteristics of a high-priority WIPA referral;
- Services provided by WIPA projects;
- How the WIPA program delivers services to eligible high priority beneficiaries; and
- How to make a referral for WIPA services.

CWICs are responsible for helping ENs understand how WIPA services fit into the larger picture of the Ticket Program and how these services can help ENs be more effective in helping beneficiaries obtain and maintain paid employment. CWICs can provide a great deal of education to new ENs to help staff members understand how they can use WIPA services to promote employment and decrease dependency on Social Security disability benefits.

2. CWICs should assist ENs to understand and use Benefits Summary & Analysis (BS&A) reports and Work Incentive Plans (WIPs) when working with beneficiaries to plan and deliver employment services and supports.

CWICs have an obligation to provide high-quality individualized work incentives planning, counseling and assistance to beneficiaries with Tickets assigned to local ENs. As a matter of fact, beneficiaries with
Tickets in assignment and in use constitute a very high priority for WIPA services. As a part of this, CWICs need to help ENs understand how paid employment or self-employment affects a beneficiary’s Social Security disability benefits, Medicaid/Medicare, and all other applicable federal, state, and local benefit programs. This includes helping ENs to understand when and how Social Security applies specific work incentives to the Social Security disability benefit programs to help beneficiaries achieve employment goals.

With the beneficiary’s permission, CWICs can use the Benefits Summary and Analysis to help an EN gain an understanding of how work incentives apply to a specific beneficiary’s situation. Of course, before CWICs can share any documents or reports with EN staff members, CWICs must obtain a signed release of information from the beneficiary. CWICs may not share information with anyone without the express written approval of the individual or his or her legal guardian.

CWICs are not required to provide training, technical assistance, or other information on EN payment mechanisms under the Ticket Program. You should refer ENs with questions about how Social Security pays for services under the Ticket Program to Maximus, the TPM. CWICs are also not required to provide intensive training or technical assistance to ENs on Social Security benefits and work incentives, except as part of working collaboratively to serve specific beneficiaries who have tickets assigned and in use.

3. CWICs should be knowledgeable about the Ticket Program provisions and how the Ticket Program functions as an important work incentive for beneficiaries.

CWICs can also support the efforts of ENs by providing complete and accurate information to beneficiaries on topics such as placing Tickets in assignment, re-assigning Tickets, moving a Ticket in or out of inactive status, or understanding the medical CDR protections. In addition, CWICs can help beneficiaries understand the employment or educational requirements for the various timely progress certification periods.

WIPA projects have a critically important role to play in helping beneficiaries realize their employment goals. However, the WIPA program cannot provide all of the services necessary to achieve these ends. Only by working in tandem with ENs that provide the actual vocational rehabilitation, career preparation, and employment services
will CWICs achieve the most positive employment outcomes for the beneficiaries they serve.

**Conclusion**

Module 6 will provide a great deal more information on how to provide high-quality WIPA services to beneficiaries. Counseling on use of the Ticket to Work is an important part of service provision. CWICs should remember that the Ticket program is one of many work incentives available to beneficiaries of the Social Security disability programs. Like all work incentives, it’s designed to meet the needs of certain beneficiaries, but isn’t applicable to every individual or to resolve every barrier to employment a beneficiary may encounter.

**Conducting Independent Research**

**Federal Regulations on Ticket to Work Program**  
(https://www.ssa.gov/OP_Home/cfr20/411/411-0000.htm)

**Ticket to Work FAQs**  
(https://choosework.ssa.gov/about/faqs/index.html)

**Ticket to Work Website**  
(https://choosework.ssa.gov/)

**Ticket to Work POMS citations**  
(https://secure.ssa.gov/apps10/poms.nsf/lnx/0455000000)

**Additional Resources**

A quick reference chart on timely progress reviews is provided on the following page. CWICs can provide this handout to beneficiaries when explaining the Ticket to Work program.
Timely Progress for Ticket Users Quick Reference Chart

<table>
<thead>
<tr>
<th>12-Month Review Period</th>
<th>High School Diploma / GED</th>
<th>Technical Trade or Vocational Program</th>
<th>Degree / Certification Program</th>
<th>Work Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>Obtained high school diploma or GED certificate.</td>
<td>Completed 60% of full time course load for 1 academic year.</td>
<td>Completed 60% of full time course load for 1 academic year.</td>
<td>3 out of 12 months with gross earnings at TWP level or above.</td>
</tr>
<tr>
<td>2nd</td>
<td>n/a</td>
<td>Completed 75% of full time course load for 1 academic year.</td>
<td>Completed 75% of full time course load for 1 academic year.</td>
<td>6 out of 12 months with gross earnings at TWP level or above.</td>
</tr>
<tr>
<td>3rd</td>
<td>n/a</td>
<td>Completed the technical, trade or vocational program.</td>
<td>Completed a 2-year program, or for a 4-year program, completed an additional academic year of full time study.</td>
<td>9 out of 12 months with gross earnings at non-blind SGA level or above.</td>
</tr>
<tr>
<td>12-Month Review Period</td>
<td>High School Diploma / GED</td>
<td>Technical Trade or Vocational Program</td>
<td>Degree / Certification Program</td>
<td>Work Requirement</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------</td>
<td>--------------------------------------</td>
<td>--------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>4th</td>
<td>n/a</td>
<td>n/a</td>
<td>For a 4-year program, completed an additional academic year of full time study.</td>
<td>9 out of 12 months with gross earnings at non-blind SGA level or above.</td>
</tr>
<tr>
<td>5th</td>
<td>n/a</td>
<td>n/a</td>
<td>For a 4-year program, completed an additional academic year of full time study or completed the 4-year degree program.</td>
<td>6 out of 12 months with earnings that preclude cash payments from either SSI or the Title II disability benefit programs.</td>
</tr>
<tr>
<td>6th</td>
<td>n/a</td>
<td>n/a</td>
<td>Completed the 4-year degree program.</td>
<td>Work requirements are the same for the 5th and all subsequent 12-month review periods.</td>
</tr>
</tbody>
</table>
Note: In lieu of fully meeting the guidelines for one category of progress, Social Security considers a beneficiary to have met the requirements of a 12-month period when the percentage of the educational or vocational training requirement completed and the percentage of the work requirement completed adds up to 100 percent or more.

In addition, Social Security affords Ticket users a “variance tolerance” to provide a margin of flexibility in determining when they are making timely progress. Social Security considers the beneficiary to be making timely progress when the completed course hours or course requirements are within 10 percent of the specified goal.
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Module 4 – Healthcare Planning and Counseling

Introduction

Transitioning from dependence on public benefits to greater financial independence through paid employment involves more than just monthly income. Many Social Security beneficiaries also rely heavily on publicly supported health insurance such as Medicaid or Medicare to pay for essential healthcare services and products. CWICs must be able to offer competent counseling in the area of healthcare planning to ensure that they explore all available options to meet the healthcare needs of beneficiaries over time.

Content in this module will focus on:

- Medicaid;
- Medicaid waiver programs;
- Medicare (Medicare Parts A, B, and D);
- Medicare Savings Programs;
- Medicare Part D Low Income Subsidy Programs;
- Healthcare options for veterans;
- Private health insurance coverage options (employer-sponsored health plans and health plans on the Marketplace); and
- Interaction of Medicaid, Medicare, and other health insurance options

CWIC Core Competencies

- Demonstrates knowledge of the availability and eligibility for all state Medicaid programs including categorically eligible Medicaid group, optional Medicaid groups, Medicaid buy-in programs, Medicaid waiver programs, and SCHIP, as well as Health Insurance Premium Payment programs that Medicaid funds.
• Demonstrates an understanding of eligibility for and the operations of the federal Medicare program including Medicare Parts A (Hospital) and B (Medical), Medigap insurance plans, the Medicare Prescription Drug Program (Part D), as well as the interaction of Medicare with other public and private health insurance.

• Demonstrates knowledge of the key components of the Affordable Care Act (ACA) applicable to Social Security disability beneficiaries and their families and the relationship of ACA provisions to multiple public health insurance programs for individuals with disabilities.

• Demonstrates an understanding of eligibility for and key provisions of TRICARE and the VA healthcare programs for veterans and how these programs interact with Medicare and Medicaid.

• Demonstrates knowledge of regulations protecting the healthcare rights of persons with disabilities starting new jobs or changing jobs.

• Demonstrates an understanding of the complex interactions between private healthcare coverage and public healthcare programs as well as key considerations in counseling beneficiaries as they make choices regarding health coverage options and opportunities resulting from employment.

• Demonstrates the ability to provide effective counseling to support beneficiaries in understanding available healthcare options and making informed healthcare coverage choices throughout the employment process.
Competency Unit 1 – Understanding Medicaid

Introduction

Medicaid is a critical health insurance program for many people with disabilities. Supplemental Security Income (SSI) or Title II disability beneficiaries frequently cite the fear of losing healthcare coverage as a major barrier to successful employment. Medicaid is typically the most important of all the healthcare programs because it provides coverage for basic healthcare needs as well as long-term care services, which aren’t covered by other health insurance programs. Because of this, CWICs need a general understanding of what Medicaid has to offer and the various methods of establishing or retaining eligibility.

Medicaid Basics

Medicaid, also known as Medical Assistance, is a cooperative federal-state program authorized by Title 19 of the Social Security Act. It was created in 1965 as an optional program for states to provide healthcare coverage to certain categories of people with low income. Since the early 1980s, all states have chosen to have a Medicaid program.

To understand how Medicaid works, it’s essential to recognize it’s a jointly funded federal and state program. At the federal level, the Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services (DHHS) administer Medicaid. CMS provides regulations and guidance about how states must operate their program. For a state to receive the federal funding, it must abide by the federal regulations. The purpose of these federal guidelines is to ensure each Medicaid program provides a basic level of coverage to certain groups of people.

Examples of federal guidelines include:

- Covered services must be available statewide;
- Service providers must be reasonably prompt;
• Beneficiaries have free choice of providers;
• Services must be available in a manner similar to the general population;
• Amount, duration, and scope of services must be sufficient to reasonably achieve the services’ purpose;
• Service providers mustn’t reduce or deny the amount, duration, and scope of services for an individual based upon his or her diagnosis, disability, or condition.

States may request a waiver from one or more of these regulations. However, to get a waiver, CMS must approve it, and the deviations must improve the quality or efficiency of the Medicaid program. It’s also important to recognize that federal regulations provide states with considerable flexibility in designing their Medicaid program. As a result, Medicaid programs vary significantly from state to state in terms of who receives covered services, what services the program pays for, and when recipients receive the services. No two states are the same when it comes to the design of their Medicaid program. Within broad federal guidelines and state options available from the federal government, states use a great deal of discretion in establishing the eligibility standards for their Medicaid program, determining the types, amounts, and duration of services available to Medicaid recipients, and in setting the rates of payments for services. In designing their Medicaid program, some states have even given their Medicaid program a unique name, such as California’s Medi-Cal program or Tennessee’s TennCare program.

At the state level, overall responsibility for Medicaid must rest with one state agency. That agency is responsible for developing the Medicaid State Plan, which is the written contract between CMS and the state outlining the details of the Medicaid program. The State Plan provides details for how the state will meet the federal requirements and defines the way that the state will implement specific options where states have flexibility. While the state agency is also responsible for administering Medicaid, it often delegates program operations to any number of other entities, including one or more other state agencies, county-run agencies, or health maintenance organizations (if the state uses a managed care model for any part of its Medicaid delivery system).

Because Medicaid differs substantially from one state to another, this unit won’t provide the details of each individual state’s Medicaid program.
Instead, this unit will provide details about the federal regulations and some common state variations. CWICs need to learn the state-specific nuances of their state’s Medicaid program, in particular:

- The specific name of the state Medicaid program;
- The name of the state agency responsible for administering Medicaid;
- How to access the state Medicaid agency’s policy manual (online or paper version);
- The services Medicaid covers;
- The Medicaid eligibility groups (in particular for people with disabilities);
- The long-term service waivers currently approved by CMS in the state;
- The process to apply for Medicaid;
- The process to appeal an adverse Medicaid decision.

In gathering this information, CWICs should reach out to other CWICs who have been doing this work for several years, as they are likely familiar with these details. Additionally, CWICs should build relationships at the local Medicaid office and at the state Medicaid policy unit.

**Services Medicaid Covers**

In creating the State Plan, the state must outline the medical services and items that the state will cover in the Medicaid program. CMS requires states to provide certain medical items or services to individuals who are “categorically eligible” for Medicaid. There are many Medicaid eligibility criteria (e.g., income, resources), but before these criteria are evaluated, an applicant first must be considered “categorically” eligible. In other words, an individual has an attribute (e.g., a disability, is pregnant, is a child, is a parent) for which there is a mandatory or optional Medicaid program. In many states, most if not all Medicaid eligibility groups (optional as well as the mandatory) have access to the same set of services listed in the State Plan. States do have some leeway to change the services provided under section 1115 of the Medicaid law that will be explained further on in this unit.
NOTE: The service entitlements below don’t apply to the Children’s Health Insurance Program (CHIP) which is covered at the end of this unit.

The mandatory services states must, at least, include in the State Plan for those categorically eligible for Medicaid include:

- Inpatient hospital (excluding inpatient services in institutions for mental disease);
- Outpatient hospital including Federally Qualified Health Centers (FQHCs) and, if permitted under state law, rural health clinic and other ambulatory services provided by a rural health clinic that are otherwise included under states’ plans;
- Other laboratory and x-ray;
- Certified pediatric and family nurse practitioners (when licensed to practice under state law);
- Nursing facility services for beneficiaries age 21 and older;
- Early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21;
- Family planning services and supplies;
- Physicians’ services;
- Medical and surgical services of a dentist;
- Home health services for beneficiaries entitled to nursing facility services under the state’s Medicaid plan;
- Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when there is no home health agency in the area;
- Home health aides;
- Medical supplies and appliances for use in the home;
- Nurse midwife services;
- Pregnancy-related services and service for other conditions that might complicate pregnancy; and
- 60 days postpartum pregnancy-related services.
States may also include optional services in their Medicaid State Plan, including:

- Podiatrist services;
- Optometrist services and eyeglasses;
- Chiropractor services;
- Private duty nursing;
- Clinic services;
- Dental services;
- Physical therapy;
- Occupational therapy;
- Speech, hearing, and language therapy;
- Prescribed drugs (some exceptions);
- Dentures;
- Prosthetic devices;
- Diagnostic services;
- Screening services;
- Preventive services;
- Rehabilitative services;
- Transportation services;
- Services for persons age 65 or older in mental institutions;
- Intermediate care facility services;
- Intermediate care facility services for persons with intellectual or developmental disabilities and related conditions;
- Inpatient psychiatric services for persons under age 22;
- Services furnished in a religious nonmedical health care institution;
- Nursing facility services for persons under age 21;
- Emergency hospital services;
• Personal care services;
• Personal assistance services (non-medical);
• Hospice care;
• Case management services;
• Respiratory care services; and
• Home and community-based services for individuals with disabilities and chronic medical conditions.

Other factors to consider with Medicaid include how much of a particular service a person can receive and for how long he or she can receive that service. Individual states define both the amount and duration of services offered under their Medicaid programs within broad federal guidelines. For instance, states may limit the number of days of hospital care, the number of physician visits, or the number of hours per week of personal assistance services. However, in setting these parameters, states must meet several requirements. First, they have to ensure that the level of services they are providing is sufficient to reasonably achieve the purpose of the service. Second, states mustn’t discriminate amongst beneficiaries based on medical diagnosis or condition in setting these limits. Generally, states must meet a comparability standard, meaning that the services they provide to all groups must be equal or comparable in terms of scope, intensity, and duration.

There are important exceptions to this requirement. First, included in the list of mandatory Medicaid services is the Early Prevention Screening Diagnosis Treatment (EPSDT) Program. The EPSDT program applies to children with disabilities under the age of 21. Under the EPSDT program, states must provide all medically necessary services to children enrolled in Medicaid. This includes a requirement to provide “optional” services, even if the state elects not to cover these services for adults. A second exception to the comparable services standard is under the Medicaid waiver provisions, which will be explained later in this unit.

As a CWIC, your job doesn’t include being an expert on Medicaid covered services. However, to be able to help beneficiaries make decisions about whether to obtain, maintain, or stop Medicaid when working, CWICs must have a basic understanding of the covered services. As a result, CWICs should, at the very least, locate a list of the Medicaid-covered services in
their state and identify the appropriate place to refer beneficiaries to get more details on coverage, if needed.

**Eligibility for Medicaid: In General**

In order to provide effective work incentives counseling, CWICs must become experts in Medicaid eligibility for people with disabilities. To be eligible for Medicaid, someone must first be a member of a category. There are six categories:

1. People with disabilities,
2. People age 65 or older,
3. Children,
4. Pregnant women,
5. Parents or caretaker relatives, and
6. Adults.

Within each category are Medicaid eligibility groups. Each Medicaid eligibility group has specific eligibility criteria, including income, and, in many cases, resource limits. To be eligible for Medicaid, a person must first fit into a category and then meet the requirements of a specific Medicaid eligibility group within that category.

There are more than 60 different Medicaid eligibility groups. Some are mandatory, which means states must provide Medicaid to those who meet the eligibility criteria. Other groups are optional, which means the state can choose to include them in the State Plan. If a person meets the eligibility criteria of a mandatory and an optional eligibility group, his or her eligibility should default to the mandatory group. The details of every Medicaid eligibility group won’t be covered in this unit. Instead, this unit will provide the details for the mandatory eligibility groups for people with disabilities plus some general information about the more common optional eligibility groups for people with disabilities.
Mandatory Medicaid Eligibility Groups

There are a number of mandatory eligibility groups for individuals who are blind or disabled. This unit will focus on the eligibility groups that people with disabilities living in the community (not in an institution, such as a nursing facility) can use. The most commonly used mandatory eligibility groups are directly tied to receipt of SSI benefits: SSI eligible and 1619(b). The other mandatory eligibility groups that will be covered are for people who had SSI at one time but lost it due to very specific reasons. Those groups include Pickle Amendment individuals, Medicaid Protected Childhood Disability Beneficiaries, and Disabled Widow(er)s. These groups are referred to collectively as “special Medicaid beneficiaries.” In total, five mandatory Medicaid eligibility groups will be covered in this unit.

IMPORTANT Clarification of Terms:

- The terms “SSI program” and “SSI benefits” are used throughout this manual. By that, we mean the individual may either be receiving cash benefits under Title XVI (SSI) or be a 1619(b) participant who is receiving Medicaid benefits but not SSI cash payments.

- By State Supplementary Payment (SSP), we mean individuals who receive a cash benefit in addition to a federal SSI benefit, which the state or the federal government may administer.

- In some cases, individuals may receive only the State Supplementary Payments (SSP) with no federal SSI cash payments. In both cases, these individuals are eligible for the special Medicaid continuation groups described here, and the state should have eligibility processes in place to assess whether these individuals would be eligible for one of these special groups.

Mandatory Group #1: SSI Eligible

In most states, Medicaid eligibility is automatic once Social Security establishes SSI eligibility. When Congress created SSI in 1972, it wanted states to give Medicaid to those who were SSI eligible. Some states supported this idea; other states didn’t. As a result, Congress decided to give states three options:
• **1634 States:** A state would use Social Security’s approval of SSI as an automatic approval of Medicaid. In other words, if Social Security finds a person entitled to SSI, he or she automatically receives Medicaid. Thirty-four states and the District of Columbia use this option and are called “1634 states.” This title refers to the part of the Social Security Act that authorizes the states to enter into agreements with Social Security to make Medicaid eligibility decisions.

• **SSI Criteria or SSI Eligibility States:** A state would use the same income and resource rules as SSI to determine Medicaid eligibility, but a beneficiary must file an application specifically for Medicaid with the state Medicaid agency (or its designee). Eight states (Alaska, Idaho, Kansas, Nebraska, Nevada, Oklahoma, Oregon, and Utah) and the Northern Mariana Islands use this option and are called “SSI Criteria States” or “SSI Eligibility States.” In these states, Social Security doesn’t make any Medicaid decisions; instead, the state makes all Medicaid eligibility decisions.

• **209(b) States:** A state would use most, but not all, of the SSI income and resource rules to determine Medicaid eligibility. These states use at least one more restrictive eligibility criterion than the SSI program. The beneficiary must apply for Medicaid at the state Medicaid agency (or its designee). The Medicaid eligibility employed by 209(b) states vary greatly from state to state. These requirements may be more restrictive or more liberal than SSI’s criteria for different parts of the decision.

Eight states have chosen this option: Connecticut, Illinois, Minnesota, New Hampshire, Virginia, Hawaii, Missouri, and North Dakota. Every 209(b) state is different in terms of how it defines Medicaid eligibility. CWICs residing in 209(b) states need to contact the state Medicaid agency to access the income and resource rules specific to that state. In these states, Social Security doesn’t make any Medicaid decisions; instead, the state makes all Medicaid eligibility decisions.

**Mandatory Group #2: 1619(b) Eligible**

Since 1987, Section 1619(b) of the Social Security Act has provided one of the most powerful work incentives currently available for SSI recipients. Section 1619(b) provides continued Medicaid eligibility for SSI
recipients whose earned income is too high to qualify for SSI cash payments, but not high enough to offset the loss of Medicaid. Individuals who are eligible for Section 1619(b) don’t receive SSI payments because their countable income is over the break-even point (BEP) after Social Security has applied all income exclusions and deductions. There’s no time limit regarding 1619(b); a person can continue to use it as long as he or she continues to meet the eligibility criteria.

To benefit from the 1619(b) provisions, an individual must meet all five of the eligibility criteria described below. If at any point a beneficiary fails to meet one or more of these criteria, the individual won’t be eligible for Medicaid coverage under the 1619(b) provision.

1. **Eligible individuals must continue to meet the Social Security disability requirement.** Individuals in 1619(b) status continue to be subject to medical continuing disability reviews and must pass those reviews (not be found medically improved) to remain eligible. Because those in 1619(b) status aren’t receiving an SSI payment, beneficiaries may assume that medical CDRs won’t occur anymore. It’s important to remind beneficiaries that they are still subject to those reviews and must respond to related paperwork in a timely manner. If a person turns 65 and elects to have his or her SSI based on age, rather than being based on disability or blindness, he or she won’t be able to use 1619(b).

2. **Individuals must have been eligible for a regular SSI cash payment based on disability for a previous month within the current period of eligibility.** This “prerequisite month” requirement simply means that 1619(b) isn’t available to someone who wasn’t previously eligible for SSI due to disability. Additionally, for those in 209(b) states, the SSI beneficiary must have been eligible for Medicaid in the month immediately prior to becoming 1619(b) eligible.

3. **Eligible individuals must continue to meet all other non-disability SSI requirements:** Countable resources must remain under the allowable limits of $2,000 for an individual and $3,000 for an eligible couple. In addition, countable unearned income must remain under the current
Federal Benefit Rate (FBR). Finally, individuals must also meet all SSI citizenship and living arrangement requirements. All of these non-disability SSI requirements apply when Social Security initially establishes 1619(b) eligibility and remain in effect forever onward.

4. **Eligible individuals must need Medicaid benefits in order to continue working.** Social Security determines this “need” by applying something called the “Medicaid Use Test.” This “test” has three parts; a person only needs to meet one of the parts to pass. An individual depends on Medicaid coverage if he or she:

- Used Medicaid coverage within the past 12 months; or
- Expect to use Medicaid coverage in the next 12 months;
- or Would be unable to pay unexpected medical bills in the next 12 months without Medicaid coverage.

To make this determination a Social Security employee must call or meet with the recipient to ask questions related to the three parts listed above. A “yes” answer to any of the questions indicates that the person does need Medicaid in order to continue working. A “no” response indicates there are sufficient alternate sources available to the individual to pay for his or her medical care (e.g., comprehensive medical coverage through health insurance or membership in a health plan, access to other health programs). The Social Security employee makes the initial Medicaid use determination at the time the individual reports earnings that will cause ineligibility for an SSI cash payment. Social Security personnel make subsequent Medicaid use determinations at each scheduled 1619(b) re-determination.

For more information about the Medicaid use test, refer to [POMS SI 02302.040 The Medicaid Use Test for Section 1619(b) Eligibility](https://secure.ssa.gov/apps10/poms.nsf/lnx/0502302040).
5. **Eligible individuals can’t have earnings sufficient to replace SSI cash benefits, Medicaid benefits, and publicly funded personal or attendant care that they would lose due to their earnings.** Social Security uses the “threshold” concept to measure whether an individual has sufficient earnings to replace these benefits. Social Security only looks at gross earnings in making this threshold determination; it doesn’t consider unearned income. Social Security makes the initial threshold determination at the time the individual reports earnings that would cause ineligibility for SSI cash payments (i.e., the break-even point). The agency makes threshold determinations for the 12-month period beginning with the month 1619(b) status begins and conducts them annually during the 1619(b) re-determination. In addition to the annual re-determination Social Security requires for 1619(b) cases, Social Security must verify earned income and exclusions from earned income at least quarterly. Local Social Security offices may choose to do this more frequently.

For more information about the threshold test, refer to [POMS SI 02302.045 The Threshold Test for Section 1619(b) Eligibility](https://secure.ssa.gov/apps10/poms.nsf/lnx/0502302045)

**1619(b) Threshold Amounts and How Social Security Determines Them**

Social Security uses a threshold amount to measure whether an individual’s earnings are high enough to replace his or her SSI and Medicaid benefits. This threshold is based on the amount of earnings that would cause SSI payments to stop in a person’s home state and average Medicaid expenses in that state. Each state calculates its threshold in this manner:

1. Multiply the annual state supplementation rate (if any) by 2
2. Add to this the current annual SSI break-even point (FBR × 2 + $85 × 12)
3. Add the average per capita Medicaid expenses by state
4. The total amount equals the state threshold amount
The **current threshold amounts for each state** are shown in the POMS (https://secure.ssa.gov/poms.nsf/lnx/0502302200).

Social Security revises these charted threshold amounts on an annual basis. If Social Security determines the individual’s countable earned income for the 12-month period is equal to or less than the threshold amount shown on the chart, he or she meets this threshold requirement.

**1619(b) Individualized Threshold Amounts**

If an individual has gross earnings above the charted threshold amount for the state, Social Security can look to see if the agency should calculate a higher individualized threshold. A person may get a higher individualized threshold amount if he or she has above-average Medicaid costs. The objective of the individualized threshold calculation is to determine if the individual has earnings sufficient to replace all the benefits that he or she would actually receive in the absence of those earnings. Obviously, for individuals with unusually high Medicaid costs, they would need a higher amount of earned income to replace the Medicaid coverage.

In addition, when Social Security is evaluating income for threshold determinations, it’s required to consider any Impairment Related Work Expenses (IRWE) or Blind Work Expenses (BWE) the person has, as well as income excluded under an approved PASS. In some instances, applying these income exclusions may lower countable income below the standard threshold amount, thus allowing an individual to retain Medicaid eligibility under 1619(b) even though gross earnings exceed the state’s charted threshold amount.

Finally, Social Security considers the value of publicly funded (other than Medicaid) personal or attendant care the individual receives when making a threshold determination. Social Security recognizes that some SSI recipients may require attendant care services to assist with essential work-related or personal care functions. For purposes of determining Section 1619(b) eligibility, attendant care (including personal care and other domestic assistance and supportive services) means assistance with:

- Work-related functions; and
- Personal needs such as bathing, communicating, cooking, dressing, homemaking, eating, and transportation, regardless of whether such needs are work-related.
Social Security considers the cost to the governmental entity for providing such services when performing the individualized threshold calculation if:

- A person paid under a publicly funded program other than Medicaid provides or provided assistance; and
- The SSI individual would no longer qualify for attendant care service due to earnings of an amount that causes ineligibility for SSI benefits.

Social Security assesses Medicaid expenses and attendant care or personal care costs used in making individualized threshold determinations for the 12-month period preceding the determination.

For more information about individualized threshold determinations, refer to POMS SI 02302.050 Individualized Threshold Calculation (https://secure.ssa.gov/apps10/poms.nsf/lnx/0502302050).

You will find an individualized threshold calculation worksheet Social Security personnel use to make these determinations at POMS SI 02302.300 Individualized Threshold Calculation Worksheet – Exhibit (https://secure.ssa.gov/apps10/poms.nsf/lnx/0502302300).

**How Social Security Counts Earnings during 1619(b) Threshold Determinations**

Social Security makes threshold determinations prospectively for the period beginning the month 1619(b) status begins — meaning when the person first hits the break-even point and SSI cash payments cease. Social Security personnel estimate future earnings using the standard procedures described in POMS SI 00820.150 - Estimating Future Wages. If the beneficiary has estimated annual earnings under the current threshold amount and meets all other eligibility requirements, Social Security will find the person eligible for 1619(b). If estimated earnings are over the standard state threshold amount, the Social Security employee checks to see if he or she can establish an individualized threshold amount. When estimating future earnings, Social Security generally uses the amounts the beneficiary earned in the past few months, which are often the best guide. However, Social Security may consider any indication given by the recipient that he or she anticipates a change in earnings.

Social Security reviews earnings annually during the 1619(b) re-determination, as it does all other forms of unearned income, resources
and other relevant eligibility information. In addition to the annual re-determination required for Section 1619(b) cases, Social Security must verify earned income and exclusions from earned income at least quarterly, although local Social Security offices may choose to do this more frequently. It’s important to reassure recipients that Social Security doesn’t re-determine 1619(b) eligibility under the threshold test each quarter; the agency merely verifies earnings against the original estimate. However, if during these quarterly evaluations the annual estimate for the upcoming 12-month period exceeds the current threshold amount, and if there is no indication that an individualized threshold is in order, eligibility for 1619(b) may stop. If Social Security finds an individual ineligible for 1619(b) because of excess income (earned or unearned) or resources, Social Security doesn’t terminate the individual, but the individual goes into a 12-month suspension period. If the individual can re-establish eligibility again within this 12-consecutive-month period, Social Security may reinstate benefits again without the individual filing a new application.

**Other Benefits of 1619(b)**

As a work incentive, Section 1619(b) preserves Medicaid coverage for SSI recipients whose earnings cause total countable income to go over the break-even point. This is an exceptional benefit, but 1619(b) offers more than this.

**For example, 1619(b):**

- Allows eligible recipients to receive an SSI cash payment in any month in which countable income falls below the break-even point;

- Enables people who are ineligible for 1619(b) because earnings exceed the 1619(b) earning threshold to get SSI cash payments again if earnings fall below the break-even point within 12 months;

- Allows people who are ineligible for 1619(b) because earnings exceed the 1619(b) threshold amount to regain Medicaid eligibility if earnings drop below the threshold amount within 12 months; and

- Enables people whose eligibility (including 1619(b) eligibility) Social Security suspends for less than 12 months to be
reinstated to cash benefits or 1619(b) status without a new application or new disability determination.

1619(b) in 209(b) States
As mentioned before, certain states (referred to as 209(b) states) have their own eligibility criteria for Medicaid. Many 209(b) states have a more restrictive definition of disability than that of the SSI program. Individuals who are eligible under 1619(a) or 1619(b) status and reside in a 209(b) state can retain their Medicaid eligibility (as long as they meet all 1619 requirements) provided they were eligible for Medicaid in the month prior to becoming eligible for 1619 provisions. The state must continue Medicaid coverage so long as the individual continues to be eligible under section 1619(a) or (b).

1619(b) for Eligible Couples
There are some important details about 1619(b) and eligible couples. For the purposes of SSI, an eligible couple exists when two SSI recipients are married to each other or are holding themselves out as married to the local community. For more information about how Social Security determines when an eligible couple exists, refer to Unit 5 of Module 3.

If both members of the eligible couple are working, both can get 1619(b) protection. For 1619(b) to apply to both members of the couple, it doesn’t matter how much either person is earning. One person may even be earning less than the $65 earned income exclusion. If both members have earned income at some level, both may be eligible for 1619(b). In addition, the threshold amount applies to each member of the couple individually. In other words, each member can earn up to the state charted or individualized threshold amount and remain in 1619(b) status. Unfortunately, if only one member has earned income, 1619(b) can only apply to that one person, not the unemployed spouse. Because 1619(b) is a work incentive, it’s only available to persons who are working. This means that the working spouse will receive 1619(b), and the non-working spouse will lose the SSI-related Medicaid eligibility group (unless he or she is found eligible under a different Medicaid eligibility group).

Keep in mind that an SSI recipient who marries an ineligible spouse will be subject to all applicable income and resource deeming rules. If the ineligible spouse’s income cause’s the eligible spouse’s SSI to drop to $0, 1619(b) won’t be an option for that SSI eligible spouse. The SSI eligible
spouse must be ineligible for SSI solely due to his or her own earned income.

**1619(b) Eligibility and Redeterminations**

Social Security is responsible for determining whether a person meets the 1619(b) eligibility criteria. The process can and should occur when the beneficiary starts reporting earned income to Social Security. Once the Social Security employee makes a determination, he or she must enter a special code on the SSI record to note the beginning of 1619(b). The steps that follow vary depending on whether the person is in a 1634 state, a SSI Criteria and Eligibility state, or a 209(b) state.

- **1634 State:** Because Social Security’s SSI eligibility determination serves as the Medicaid eligibility determination, Medicaid simply continues when Social Security finds the person eligible for 1619(b). If the agency finds the person ineligible for 1619(b), it will send a letter with appeal rights.

- **SSI Criteria Eligibility and 209(b) States:** Because the state Medicaid agency or its designee determines Medicaid eligibility for SSI recipients in these states, the process differs from that of 1634 states. The state Medicaid agency and Social Security share data through a shared data system known as the State Data Exchange (SDX). When Social Security enters the special code on the beneficiary’s record noting 1619(b) status, the Medicaid eligibility worker will be able to see that code. When the beneficiary reports his or her earnings to the Medicaid agency, the Medicaid eligibility worker will need to look in the data system to see that Social Security has made a 1619(b) determination for that person. With that coding in place, the Medicaid eligibility worker can continue the person’s eligibility. If there is no coding indicating that Social Security made a 1619(b) determination, or if the worker isn’t familiar with the code, the Medicaid worker will generally issue a Medicaid termination notice, which will come with appeal rights.

Once Social Security determines a person is eligible for 1619(b), the agency will conduct annual re-determinations. Social Security conducts these re-determinations to ensure that individual continues to meet the 1619(b) eligibility criteria.
Mandatory Group #3: Pickle Amendment

Effective July 1, 1977, under section 503 of Public Law 94-566, the “Pickle Amendment,” Title II beneficiaries who would continue to receive SSI or State Supplement Payments (SSP), or would continue to be eligible for benefits under section 1619(b) but for their Title II COLAs, the state continues to consider SSI recipients for Medicaid purposes. If an individual’s other income wouldn’t have precluded continuing SSI payments, or deemed payments under 1619(b), without the Title II COLAs, the state must continue to consider the individual to be Medicaid eligible.

NOTE: As used in this provision, the term “Pickle” refers to the surname of the Congressman who introduced the legislation. This legislation is also referred to as Section 503, referring to the section of P.L. 94-566 that requires states to continue Medicaid in these circumstances.

Beneficiaries must meet three eligibility requirements for states to find them eligible for continued Medicaid coverage under the Pickle Amendment. States provide Medicaid only to an individual who:

1. Is receiving Title II benefits;
2. Lost SSI/SSP but would still be eligible for SSI/SSP benefits if all the Title II cost-of-living increases he or she received since losing SSI and SSP benefits were deducted from his or her income; and
3. Was eligible for and receiving SSI or a state supplement concurrently with Title II benefits for at least one month after April 1, 1977.

Social Security doesn’t make Pickle eligibility decisions; the state Medicaid agencies are responsible for these determinations. When a state Medicaid agency computes Pickle eligibility, it subtracts all the COLAs from the Title II benefit since the SSI and SSP stopped. It combines the reduced Title II amount with any other unearned income, then applies a $20 General Income Exclusion. The agency then calculates countable earned income using the SSI income deductions. Finally, the agency then compares total countable income to the current Federal Benefit Rate (FBR). If the countable income, using the reduced Title II amount, is less than the current year’s FBR, then the person could get Medicaid through
the Pickle Amendment. The person must continue to meet all other SSI eligibility requirements (e.g., resources below the limit, etc.).

There are two common misperceptions about who is eligible to receive continued Medicaid under the Pickle Amendment. First, many people mistakenly think that individuals must have been receiving both SSI and Title II cash payments simultaneously before the loss of the SSI payment, or deemed payment under section 1619(b). This is generally referred to as being a “concurrent beneficiary.” In actuality, the individual simply needs to have been “entitled” by Social Security to both Title II and SSI for the same month. There is a one-month lag in Title II payments because Social Security doesn’t disburse them until the month after entitlement. In comparison, Social Security makes SSI payments in the month of entitlement.

**Examples of this one-month overlap of entitlement:**

a. A person receives SSI while awaiting receipt of Title II payments. Once the monthly Title II begins, if it exceeds the current FBR, the beneficiary will no longer receive the SSI payment, just the Title II. Even though the person never actually received simultaneous payments from both programs in a single month, he or she would still meet the first Pickle requirement because entitlement for the two programs overlapped.

b. Social Security finds an SSI recipient entitled to retroactive Title II payments that exceed the SSI/SSP limit for unearned income. Under the “windfall offset” provisions, Social Security deducts SSI benefits paid up to this point from the retroactive Title II award, and the individual ceases to be eligible for SSI. For the purposes of Pickle Amendment, Social Security actually considers these individuals to have been eligible for and receiving both Title II and SSI benefits concurrently during this retroactive period.

Secondly, there is a common belief that the annual Title II program COLAs must have caused the loss of SSI or 1619(b) in order to qualify for the Pickle provision. This isn’t the case. The critical issue for Pickle eligibility is whether the person would otherwise be eligible for SSI and
SSP if Social Security deducted the Title II COLA(s), not what actually caused the loss of the SSI.

On several occasions, judicial decisions have clarified this misinterpretation of the Pickle Amendment. Due to these important court cases, it’s no longer necessary for an individual to show that a Title II COLA was the original cause of the loss of SSI and SSP in order to establish eligibility for continued Medicaid under the Pickle provisions. This clarification of the Pickle Amendment has actually made Pickle eligibility determinations much simpler for state Medicaid agencies. Because causation is no longer relevant, there is no need to research why the individual actually lost eligibility for SSI/SSP and a person’s past Title II disability payment status no longer matters. Under the judicial interpretation, it’s only necessary to apply a simple mathematical formula to “back out” any COLAs that Social Security added to the Title II payment since the last month in which the individual was eligible for both Title II and SSI/SSP.

**Example of how the Pickle Amendment applies:**

Casey was receiving $579 of SSI in January 2005, which was the Federal Benefit Rate that year. He had no other income. In June 2005, Social Security found that he had reached insured status on his own work record and awarded him a $700 SSDI benefit, with an entitlement date of June 1, 2005. Following the normal SSDI payment process, he received his June 2005 SSDI payment on July 3rd. As a result, in June he was still due $579 of SSI. That means in June 2005 he was entitled to both SSI and SSDI.

Now, in July 2005, when his SSI and Medicaid stop, Casey only meets the first and third Pickle criteria; he’s receiving a Title II benefit and was eligible for both SSI and Title II in at least one month. He doesn’t yet meet the final criteria; he wouldn’t be eligible for SSI after deducting for the COLAs, because COLAs haven’t occurred yet.

Once Casey reaches a future year where the SSI FBR is more than $680 (his SSDI without any COLAs, less the $20 General Income Exclusion), he could potentially get Pickle eligibility. In January 2012, the FBR increased to $698. At
that point, it may be possible for Casey to get Medicaid eligibility through the Pickle Amendment.

Social Security informs all states annually about potential members of this group at COLA time. Each state receives two separate files to help it locate potential eligible beneficiaries. SSI recipients who go into payment status E01 because of Title II COLAs are also potential members of this group. 209(b) states have the option to disregard part, all, or none of the Title II benefit or increases. CWICs in 209(b) states will need to research their state specific rules.

**WARNING!** Pickle People are a growing class. If the SSI FBR keeps going up as it has, the FBR can eventually overtake an individual’s frozen Title II plus other countable income. In practice this means that over time, there are more and more people who could establish eligibility for Medicaid under the Pickle provisions. CWICs must be aware that some Title II beneficiaries who were once entitled to SSI may become “Pickle-eligible” some years after they initially lost SSI eligibility. You can use a Pickle eligibility screening tool available at the VCU NTDC website at any time to determine whether an individual currently meets the criterion to establish eligibility for Medicaid under the Pickle provisions. States may establish Pickle eligibility at any point in time. There is no “sunset” date or statute of limitation.

**The pickle screening tool** is available at the VCU NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=138).

**Mandatory Group #4: Medicaid Protected Childhood Disability Beneficiaries**

The Social Security Act requires states to consider certain Title II Childhood Disability Beneficiaries (CDBs) who lose SSI/1619(b) eligibility as if they were still SSI recipients for Medicaid purposes. For this provision to apply, the individual must continue to be otherwise eligible for SSI or 1619(b), but for their entitlement to (or increases in) CDB benefits on or after July 1, 1987. Social Security affords this protection only to individuals who lost SSI or 1619(b) eligibility because of becoming eligible for or getting an increase in the CDB payment. After excluding the CDB (or increase in CDB), the person’s countable income must be
below the current FBR, or he or she must meet the 1619(b) criteria. 209(b) states have the option to disregard part, all, or none of the CDB benefit or increases. CWICs in 209(b) states will need to research their state-specific rules.

**Example when Social Security may exclude the entire CDB payment:**

Cindy is 20 and receives SSI. Her mother retired and applied for Social Security Retirement Insurance Benefits. Her mother had high earnings. As a result, Cindy’s CDB payment will be $1,000 per month. Cindy is required to apply for this Title II benefit because SSI is payer of last resort. Because $1,000 is more than the current FBR plus the $20 GIE, it’s too much unearned income to allow SSI payments. However, because Cindy had no CDB before her mother retired, the state must exclude all of Cindy’s CDB benefits when determining her eligibility for Medicaid. If Cindy has other income, it might affect her entitlement to Medicaid.

**Example when Social Security may exclude only a CDB payment increase:**

Lucy was receiving CDB based on the work record of her stepmother. While the stepmother was alive, Lucy received $600 per month in CDB payments and a small SSI check. The stepmother died recently, however, and Social Security raised Lucy’s CDB benefit to the survivor’s benefit level of $900 per month. Regardless of whether or not Lucy is working, it’s excess unearned income that has now made her ineligible for SSI payments. In Lucy’s situation, the state Medicaid agency must exclude the $300 difference between what Lucy was receiving in CDB cash payments before her stepmother’s death, and what she currently receives. If Lucy has no other income, she would still be eligible for Medicaid. If she has other income, she may or may not be eligible for Medicaid, depending on the type and amount of the income.

**IMPORTANT NOTE:** In some states, the Medicaid agency disregards the entire CDB payment when determining eligibility for special Medicaid even
in cases when it was an increase in the CDB payment that caused ineligibility for SSI. This is clearly advantageous to beneficiaries. CWICs must conduct research in their home states to determine whether or not their state applies this more generous deduction.

When Social Security sends former SSI recipients their notice indicating that the agency has ceased their SSI benefits due to establishing their eligibility for or receiving an increase in CDB payments, the agency includes special language in the letter indicating that it may be possible to retain Medicaid.

This language reads as follows:

“(You) may be receiving Medicaid from (your state). If (you are), (you) may be able to keep (your) Medicaid coverage under special rules even though (your) SSI payments are stopping. (You) may receive Medicaid under these special rules if all of the following are true:

• (You) are disabled or blind and age 18 or older;
• (You) became disabled or blind before age 22;
• (You no longer receive) SSI because (your) Social Security payments started or increased; AND
• (You meet) the other state rules for Medicaid coverage.

Even if these statements aren’t true about you, you may still be able to receive Medicaid under other state rules.”

In all states, it’s the Medicaid agency, not Social Security, who is responsible for making Medicaid Protected CDB determinations. Beneficiaries need to take the notice from Social Security to the local agency that makes Medicaid eligibility determinations and apply for this eligibility group.

There is no time limit for establishing eligibility for special Medicaid coverage as a former SSI recipient who lost SSI due to CDB payments or increases in CDB benefits. If beneficiaries don’t retain this coverage when Social Security first stops the SSI benefits, they can apply for it at a later date, and Social Security can find them eligible. However, special Medicaid coverage isn’t retroactive prior to the date of initial application.

There are certain points in time when CWICs need to be aware that an SSI recipient may establish entitlement for CDB, or when existing CDB
payments may increase. These three critical transition points will require specialized counseling on the CWIC’s part to ensure that beneficiaries don’t lose Medicaid coverage needlessly and that their Medicaid continues under this provision in a seamless manner.

1. Social Security may establish CDB eligibility when a parent dies, retires and starts to collect Social Security benefits, or becomes disabled and collects Social Security benefits. Any time one of these events occurs, there is potential for change in Medicaid status. In some cases, one of the parents is estranged from the beneficiary and the beneficiary won’t anticipate CDB entitlement.

2. When an individual begins receiving CDB off of one parent, and subsequently the other parent dies, retires, and collects Social Security benefits, or becomes disabled and collects Social Security benefits, there is potential for an increase in CDB payments. If two parental work records are available to the beneficiary, Social Security is required to pay the highest benefit available. It’s possible that the beneficiary will be transitioned to a higher benefit amount when the second parental work record becomes available.

3. Social Security affords higher CDB payments to beneficiaries when the parent dies than the agency provides when the parent is merely disabled or retired. The death of a parent is always a potential critical transition point with respect to CDB.

**Mandatory Group #5: Disabled Widow(er) Beneficiaries**

Effective January 1, 1991, Congress amended the Social Security Act to provide Medicaid to any former SSI eligible widow(er) who:

- Would continue to be eligible for SSI benefits or SSP but for his or her Title II benefits;
- Received an SSI/SSP benefit the month before his or her Title II payments began; and
- Isn’t entitled to Medicare Part A.

The state will consider a beneficiary to be an SSI/SSP recipient for Medicaid purposes until he or she becomes entitled to Medicare Part A.
As with the other special Medicaid beneficiaries, the state Medicaid agency determines eligibility and will apply the SSI deductions to determine countable income. If the countable income, less the DWB, is below the FBR, then the beneficiary could keep his or her Medicaid. The special rule for this group is that the entire or increased DWB isn’t listed as unearned income. The 209(b) states have the option to disregard part, all, or none of the DWB benefit or increases. CWICs in 209(b) states will need to research their state specific rules.

**NOTE:** When Social Security finds a former SSI recipient entitled to DWB benefits, it credits all months on the SSI rolls at any time against the five-month disability waiting period and the 24-month Medicare Qualifying Period (MQP). The SSI months count from the first month of any (including prorated) payment to the month of DWB entitlement. All months count, including months of nonpayment, suspension, and termination for any reason. As a result, a DWB who received as little as one payment from SSI more than two years ago and meets the non-disability entitlement factors can become entitled to Title II and Medicare Part A with no waiting period.

**Example of how Disabled Widow’s Benefit Applies:**

Katherine is 53 years old and has never worked. She was receiving an SSI payment in the amount of $783 (the full FBR for 2020) when her ex-husband, Hal, died in 2020. Katherine applied for benefits on Hal’s record as a Disabled Widow, and Social Security awarded them. Katherine’s benefit was $959 per month, and she was no longer eligible for SSI because her countable unearned income was over the 2020 FBR ($783). The state Medicaid agency must exclude all of Katherine’s Disabled Widow’s benefit when making a determination about Katherine’s eligibility for benefits.

**NOTE:** The Disabled Widow’s Medicaid eligibility group differs from the Pickle and CDB Medicaid eligibility groups in that the Disabled Widow’s Medicaid eligibility ends once entitlement to Medicare begins. It’s also important to note that this provision doesn’t “sunset;” it’s permanent. Social Security notifies members of this group as they become
ineligible for federally administered payments due to excess income and notifies the 1634 states as these cases occur through the State Date Exchange (SDX).

**What Happens to Special Medicaid Beneficiaries When Other Income is Involved?**

Both 1634 and SSI eligibility states treat income for Special Medicaid Beneficiaries the same way that the SSI program treats income. States apply the $20 General Income Exclusion to unearned income; if not used there, states apply it to earned income. The regular SSI earned income exclusions also apply: SEIE, EIE, IRWE, divide by 2, BWE, and PASS. Only what is left after these deductions counts in determining eligibility for Special Medicaid.

Medicaid agencies in 209(b) states must provide Special Medicaid using the same eligibility criteria basis as Medicaid is provided to individuals who receive SSI benefits. These states have the option of disregarding part, all, or none of the title II benefit or increases in that benefit that make the individual ineligible provided that the same amount is disregarded for all members of the group. For CWICs in 209(b) states, it is critical that they locate and study the income and resource rules that apply to the various state Medicaid programs.

**Example of How Earned Income Affects Special Medicaid Eligibility in 1634 States that Follow the SSI Rules:**

**Medicaid Protected CDB and Earned Income:** Let’s go back to the example of Cindy who lost SSI eligibility when her mother retired and Cindy became eligible for $800 per month in CDB. Because Cindy had no CDB before her mother retired, the state excluded all of Cindy’s CDB benefits when determining her eligibility for Special Medicaid. After establishing eligibility for Special Medicaid Cindy got a job earning $1,000 per month. How would this affect her Special Medicaid?

The state Medicaid agency would apply the SSI income disregards to determine countable income for the purposes of Special Medicaid eligibility. Remember that Cindy has NO unearned income to count since the entire CDB check is disregarded. The Medicaid worker would take the gross earned income of $1,000 and subtract both the $20 GIE, the $65 EID, and any approved IRWEs or BWEs. The Medicaid worker would divide the remaining amount of income in half ($1,000 - $85 = $915) due to the one-for-two offset. Since the remaining $457 is less than the FBR,
Cindy would continue to be eligible for Medicaid as a Special Medicaid Beneficiary.

**Special Medicaid Eligibility when Earned Income Exceeds the FBR**

State Medicaid agencies are required to disregard certain Title II disability payments (or portions of payments) when determining eligibility for Medicaid under the Special Medicaid rules. This exclusion occurs strictly for the purpose of establishing eligibility for this category of Medicaid and applies only if the individual is “otherwise eligible” for SSI. “Otherwise eligible” means that after the Medicaid agency subtracted the excludable part of the Title II benefit, the remaining countable income and resources would meet SSI eligibility criteria.

CWICs must keep in mind that the term otherwise “SSI eligible” refers not just to “otherwise eligible” to receive SSI/SSP cash benefits, but also “otherwise eligible” for 1619(b). When a person meets the requirements for 1619(b) Medicaid While Working, he or she is considered to be an SSI eligible individual, simply not in cash payment status. A person in 1619(b) status is neither suspended nor terminated from the SSI program. Continued Medicaid under 1619(b) represents a very unique form of SSI eligibility that simply doesn’t come with a cash payment. The individual remains in Social Security’s computer system and is listed as SSI eligible, but in payment status N01 (non-payment).

So, what does this mean as it relates to Special Medicaid eligibility? Technically, this interpretation of being “otherwise eligible for SSI” means that state Medicaid agencies should allow Special Medicaid eligibility to continue as long as earned income remains below the state’s charted threshold amount and all other SSI eligibility requirements are met. To read a CMS technical assistance document clarifying the definition of “otherwise SSI/SSP eligible” refer to the resource entitled “Groups Deemed to be Receiving SSI for Medicaid Purposes” posted on the VCU NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=137).

Unfortunately, state agencies that make Medicaid eligibility determinations often deny benefits to individuals whose total countable income is over the FBR due to earnings. When Medicaid workers are determining eligibility for Special Medicaid, they often assess eligibility based on whether or not the person would otherwise be eligible for a cash SSI payment (countable income under the FBR). Many state Medicaid agencies are unaware that CMS has interpreted “otherwise eligible for
SSI” in the past as including meeting the eligibility requirements for 1619(b). The critical difference is the limit on earned income. Under the 1619(b) provisions, the countable earned income limit is NOT the FBR; but rather the state threshold amount (or individual threshold amount, if applicable). For examples of how this policy should be applied when making Special Medicaid eligibility determinations, refer to the resource document entitled “Special Medicaid Beneficiaries,” located on the VCU NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=136).

The Challenge for CWICs when Counseling Special Medicaid Beneficiaries

At the present time, the majority of state Medicaid agencies are not recognizing the charted threshold amount as the earned income limit for Special Medicaid eligibility. Most states terminate Special Medicaid when beneficiaries’ countable income exceeds the FBR. This presents a significant challenge for CWICs. How should CWICs counsel beneficiaries when the policy we believe is correct is not applied in practice? The best course of action is to explain the issue as clearly as possible and suggest that beneficiaries appeal adverse eligibility determinations. Check with your state PABSS program or other advocacy groups to see if they will represent beneficiaries in these cases. Reach out to your VCU TA Liaison for further guidance.

Identifying Potential Special Medicaid Beneficiaries

It’s very likely that you will encounter individuals who may be eligible for continued Medicaid, but never were informed by the Medicaid agency or Social Security of this option when they lost the SSI or 1619(b). CWICs are in a prime position to help identify beneficiaries who may fall into one of these groups because of the detailed benefit history that they gather in the normal course of service delivery.

When CWICs identify a potential Special Medicaid Beneficiary, they should encourage these individuals to go to the Medicaid agency, or its designee, and ask for an eligibility determination. The beneficiary may need assistance with this process or may even need a referral to the Protection and Advocacy program if the state wrongfully denies his or her Medicaid eligibility. The CWIC may need to assist the beneficiary with proving that he or she is a member of one of these special protected classes of former SSI recipients — a task that isn’t always easy!
First, the beneficiary will need to gather documentation from Social Security indicating when the person’s SSI stopped and when his or her SSDI, CDB, or DWB started or was increased. Most beneficiaries won’t have kept the original letters Social Security sent them indicating these facts. In most cases, the CWIC will need to help the beneficiary with this task. Second, the individual will need to prove that he or she meets all other SSI eligibility criteria (earned income, unearned income, and resource limits) after the allowable amount of the Title II payment is exempted. Finally, the worker at the state agency that conducts Medicaid eligibility determinations may be unfamiliar with the special Medicaid provisions or how to apply them, which may cause an improper denial of coverage. In these cases, the beneficiary may have to appeal an initial adverse determination. In these cases, assistance from the state Protection and Advocacy program or other advocacy groups may be necessary. CWICs are advised to have copies of the state Medicaid regulations covering special Medicaid beneficiaries available to show the Medicaid eligibility worker if there seems to be confusion about how to apply these provisions.

**An Important Reminder:** Because states base these special Medicaid groups on deemed SSI entitlement, the individual must still meet all of the non-income rules for SSI or 1619(b). For example, the individual’s countable resources must be at or below the SSI resource limit and the person must continue to have a disability or be 65 or older.

Another important point to remember is that the special Medicaid protections continue to apply to eligible individuals with no “sunset” date. This means that individuals who meet the basic eligibility criteria for one of these groups may establish entitlement for Medicaid at any point in time. It’s NOT the case that these protections only apply at the initial point when beneficiaries lose SSI/SSP eligibility due to establishing eligibility for or receiving an increase in a Title II disability benefit. In fact, certain SSDI beneficiaries may not initially be eligible for continued Medicaid under the Pickle provisions, but may become eligible later as the SSI FBR increases.

Special Medicaid provisions serve as a valuable resource when conducting counseling on health care issues. It’s imperative that CWICs be
knowledgeable about how these provisions apply and who is potentially eligible for them.

Optional Medicaid Eligibility Groups

Over the years, Congress has created a number of optional Medicaid eligibility groups that states can choose to cover. When state budgets are strong, states may add new optional groups. Conversely, when state budgets are tight, states may cut one or more of these groups. Because the availability of these groups varies substantially from one state to another, only the most commonly used groups are described in this unit. It’s also important to note that many of the optional eligibility groups come with some flexibility, allowing states to set some of the eligibility criteria, such as income and resource limits. As a result, the explanation of each optional Medicaid eligibility group will be generic in nature. Additionally, with most optional eligibility groups, each state has created a unique name; for example, the Medicaid Buy-In Program is called Apple Health for Workers with Disabilities (HWD) in Washington, while in Minnesota it’s called Medical Assistance for Employed Persons with Disabilities (MA-EPD). CWICs must conduct research in their state to clarify which optional Medicaid eligibility groups are available, the state specific name used for each group, and the details on the eligibility criteria.

Optional Group #1: Medicaid Buy-In (MBI)

This optional Medicaid eligibility group, the Medicaid Buy-In (MBI), Congress specifically created to provide Medicaid eligibility for workers with a disability. The Balanced Budget Act (BBA) of 1997 and the Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket Act) authorized the MBI. MBI can provide health coverage to working people with disabilities who, because of increased earnings, resources, or both, can’t qualify for Medicaid under another category. When using MBI, people with disabilities who are working pay affordable monthly premiums for their Medicaid coverage.

IMPORTANT: CMS gives states a wide berth to set their own rules for the MBI in their state. Some states have no cap on the amount of earned income or resources someone can have in an MBI. Other states, by comparison, are very
restrictive as to who gets in but have more liberal rules on earnings and resources after they find the person eligible for and have enrolled him or her in the MBI. Each state’s MBI is unique in its mix of features within the federal rules with which it must operate.

A number of beneficiaries may find the MBI a helpful work incentive. In some states, MBIs may be an affordable way for Title II beneficiaries who return to work to access Medicaid in their state. For people who stopped receiving SSI due to earnings, but can’t meet the 1619(b) eligibility criteria, MBI may be a way to maintain Medicaid. Additionally, in some states people with disabilities who have never received SSI or Title II disability because of excess income or resources may be able to apply for the Medicaid Buy-In once they begin working. States generally require the person to meet Social Security’s definition of disability, but some states exclude SGA or allow an increased SGA amount when conducting step one of the five-step sequential evaluation process. The state will perform a determination at the time of application for the MBI.

As noted, a state can structure the buy-in in many different ways based on the authorizing federal law the state chose to work with, either the BBA of 1997 or the Ticket Act of 1999.

The original 1997 buy-in included these key eligibility components:

- Most states don’t require individuals to have been on SSI or SSDI or any Title II, Title XVI, or Title XIX (Medicaid) benefit for the state to find them eligible for the state’s MBI.

- Individuals must have earned income to qualify for this Medicaid option in almost all states.

- States set allowable MBI earned income limits the net countable income of less than 250 percent of the current Federal Poverty Level (FPL), with all SSI income exclusions allowable, for example Impairment Related Work Expenses (IRWEs).

- States may also establish additional disregards that are more generous than SSI exclusions and effectively increase the income limit.

- Except for their earned income, the person with a disability would be otherwise eligible for SSI at time of award of benefits. While this means that SSI resource limits are in effect at the

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time of application to an MBI, in some states resource rules can change and radically improve after states find the applicant eligible and he or she enrolls in an MBI.

- Substantial gainful activity isn’t an eligibility consideration. A person could be eligible at time of application for the buy-in despite earnings in excess of the substantial gainful activity amount. Most states require proof of earned income.

- States could effectively increase the Medicaid resource limits by disregarding resources above the $2,000 SSI resource standard both at time of application as well as post-enrollment.

- States could charge premiums or other cost-sharing charges with no federal limit on the amount they charge.

- There is no age limit per se (e.g., the person must be under age 65) with a BBA-authorized MBI.

Section 201 of the Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket Act) created a second MBI program with several key provisions to make the buy-in program more attractive:

- It allows states to offer a buy-in to individuals at any income or resource level the state elects to establish.

- Individuals must have earned income to qualify for this Medicaid option in all states.

- CMS now allows states to require cost sharing and affordable premiums, based on income on a sliding scale. A state could require some individuals to pay the full premium as long as the premiums don’t exceed 7.5 percent of the individual’s total monthly income.

- The state must require payment of 100 percent of the premium for individuals with incomes over approximately 450 percent of the FPL.

- MBI enrollees authorized by the Ticket Act must be at least 18 but below 65 years of age.

CMS provides an **overview of the Medicaid Buy-In option** at the following website (https://www.medicaid.gov/medicaid/ltss/employment/index.html).
Optional Group #2: Medically Needy

The Medically Needy eligibility group (also known as spend-down) is an optional category of Medicaid coverage in 1634 and SSI criteria states. These states have the option of expanding Medicaid eligibility to blind or disabled persons who have high medical costs and too much income to qualify for Medicaid under any other group. Because 209(b) states have at least one more restrictive criterion than the SSI rules, they must offer a spend-down to meet eligibility standards.

With Medicaid Medically Needy, each state sets its medically needy income limit based on family size. Resource limits are typically the same as those in the SSI program. States must also establish income and resource rules for determining eligibility for the Medically Needy eligibility group. The federal government requires that the state’s methodology employed in determining income and resource eligibility “shall be no more restrictive than the methodology which would be employed under the [SSI] program in the case of ... blind, or disabled individuals.” (NOTE: This requirement doesn’t apply to 209(b) states.) States may develop income and resource methodologies that are less restrictive (or more generous) than the SSI program rules by applying Section 1902(r)(2) of the Social Security Act. States may also set their own budget periods, and these may vary based upon an individual’s living arrangement.

Finally, states may offer a more restrictive package of medical services for this group than applies to the mandatory eligibility groups. It’s important to note that states’ rules governing what income or resources count in determining eligibility for the spend-down program vary widely. CWICs must access a copy of their state’s Medicaid policy manual to find out exactly how their state determines countable income and resources and what medical services are available for this group.

Individuals above the Medically Needy income limit must meet the spend-down before they can get Medicaid coverage. The spend-down is the amount of income that exceeds the Medically Needy income limit, after subtracting all allowable income deductions. The spend-down acts like a deductible that the beneficiary must pay or incur before coverage begins. Most medical expenses that beneficiaries pay or incur can meet a spend-down requirement, even if it’s for goods or services the Medicaid state plan doesn’t cover. The following is a list of typical out-of-pocket costs or expenses that the beneficiary can use to meet the spend-down requirement:
• Health insurance premiums and co-payments;
• Doctor bills;
• Mental health treatment bills (including a psychiatrist’s services and mental health counseling services);
• Dental bills;
• Home health care;
• Prescriptions drugs;
• Eyeglasses and optometry bills; and
• Over-the-counter drugs or purchases related to health care.

**Example of the Medically Needy eligibility group:**

Shauna receives $1,075 per month of SSDI. She has Medicare, but she still spends about $500 per month on co-insurance and uncovered services. The Medically Needy income limit in her state, given her household size, is $783 per month. In her state, all her unearned income counts (no unearned income deductions). As a result, Shauna’s spend-down will be $292 per month ($1,075 – $783 = $292). Once Shauna meets her spend-down ($292 per month), Medicaid will begin providing coverage.

Remember, the rules for calculating a spend-down and the budget period vary substantially from state to state; CWICs must research these details in their state.

When a person using Medically Needy Medicaid begins working, it generally means he or she will have an increase in the amount of his or her spend-down. It’s important for CWICs to understand the income and resource limits associated with this eligibility group, as well as the basics for how to calculate the spend-down.

**Example of what happens to Shauna when she begins working:**

Shauna got a job making $800 per month. She will continue receiving her SSDI of $1,075 per month since this level of earnings would not be SGA. The state allows the following earned income deductions: SEIE, $65 earned income exclusion, IRWE, BWE, one-half disregard, and
PASS. Shauna will have $367.50 of countable earned income, given her situation ($800 − $65 ÷ 2 = $367.50). Plus, Shauna has $1,075 of SSDI, which makes her total countable income $1,442.50 per month. As a result, Shauna’s spend-down will increase to $659.50 per month ($1,442.50 − $783 = $659.50). Shauna will no longer be able to get Medicaid through the Medically Needy eligibility group because she doesn’t have enough out-of-pocket medical expenses to meet the spend-down.

CWICs must be prepared to identify and communicate with beneficiaries when their spend-down will increase due to working. They must also be able to identify alternatives, such as the Medicaid Buy-In.

**Optional Group #3: State Supplemental Payment (SSP) Eligible**

Some states provide a cash payment called a State Supplement Payment (SSP) to supplement the federal SSI benefit and low Title II disability benefit amounts. The maximum SSP amount varies by state as well as by factors such as marital status, living situation, and blind status. Income and resource limits also vary by state. Social Security administers the SSPs for some states (https://www.ssa.gov/ssi/text-benefits-ussi.htm).

If a person is eligible for a SSP, he or she may also be able to get Medicaid through this related Medicaid eligibility group. If this optional group is available, a CWIC must confirm the SSP income limits, the resource limit, the methodology the state uses to calculate countable income, and the methodology the state uses to determine countable resources.

**Example of the SSP eligibility group:**

Phillip receives $820 of SSDI. His state offers up to $150 per month of a SSP. The income limit for the SSP is $933 per month, and the state allows all the SSI income deductions when determining eligibility. Phillip’s countable income is $800 ($820 − $20 GIE = $800). As a result, he is eligible for $133 per month of SSP. Because he is eligible for a SSP, he is also Medicaid eligible through the SSP Medicaid eligibility group.
When a person eligible for Medicaid through this group begins working, it’s likely his or her earned income could push him or her over the income limit.

**Example of what happens to Phillip when he begins working:**

Phillip gets a job making $500 per month, plus he will continue to receive $820 of SSDI. Using the SSI income deductions, Phillip’s countable unearned income is $800 ($820 − $20 = $800) and his countable earned income is $217.50 ($500 − $65 ÷ 2 = $217.50). That means his total countable income is $1,017.50. The income limit for the SSP is only $933 per month, which means Phillip is now over income. His SSP cash payment will stop, and he won’t be eligible for Medicaid under this eligibility group.

When Social Security administers the SSP, it’s treated as if it were an SSI benefit. As a result, a person who loses a Social Security administered SSP can use 1619(b) to maintain Medicaid. With state administered SSPs, CWICs must research the state’s Medicaid policy manual to clarify whether loss of SSP due to earned income will result in loss of the related Medicaid. If that could occur, CWICs must be prepared to identify alternatives, such as the Medicaid Buy-In.

**Optional Group #4: Low Income Eligibility**

Another optional Medicaid eligibility group that some states use provides Medicaid for people with disabilities with income up to 100 percent of the Federal Poverty Level (FPL). The state can choose the specific income limit, but it can’t exceed 100 percent of the FPL. The state must also establish a resource limit. If this optional group is available, CWICs must confirm the income limit, the resource limit, the methodology used to calculate countable income, and the methodology the state uses to determine countable resources.

**A Word about Federal Poverty Levels (FPLs)**

The U.S. Department for Health and Human Services (DHHS) establishes annual poverty guidelines that are widely used as a poverty measure for administrative purposes — for instance, when determining financial eligibility for certain federal or state programs. The
poverty guidelines are often loosely referred to as the “federal poverty level” (FPL).

DHHS bases the FPL amounts on family size. For example, in 2019 the FPL for a family size of one was $12,490 ($1,041 per month) and for a family size of two it was $16,910 ($1,409 per month). Each year, there is one set of FPL figures for the 48 contiguous states and a set with higher figures for Alaska and Hawaii. The FPLs (or percentages of them) are used frequently as a standard for income eligibility for various Medicaid programs. The examples in this module use the 2019 FPLs. This is because DHHS publishes updated FPLs January or February of each year, after we publish the updated manual. CWICs will need to research the 2020 FPLs when they become available. More information about the FPLs is available at the DHHS website (https://aspe.hhs.gov/poverty-guidelines).

Example of the Low Income eligibility group:

Kallie receives $990 of SSDI. The income limit in her state for this eligibility group is $1,041, given her household size, and the state allows all the SSI income deductions when determining eligibility. Kallie’s countable income is $970 ($990 − $20 GIE = $970). Because her countable income is below the state’s income limit for this Medicaid eligibility group, she can access Medicaid this way.

When a person eligible for Medicaid through this group begins working, it’s likely his or her earned income could push him or her over the income limit.

Example of what happens to Kallie when she begins working:

Kallie gets a job making $700 per month, plus she will continue to receive $990 of SSDI. Using the SSI income deductions, Kallie’s countable unearned income is $970 ($990 − $20 = $970) and her countable earned income is $317.50 ($700 − $65 ÷ 2 = $317.50). That means her total countable income is $1,287.50. The income limit for the Low Income eligibility group is only $1,041 per month,
which means she is now over the income limit and won’t be eligible for Medicaid under this eligibility group.

CWICs must be prepared to identify and communicate with beneficiaries when their income will exceed the Low Income eligibility group’s limit due to working. They must also be able to identify alternatives, such as the Medicaid Buy-In.

Optional Group #5: Home and Community Based Services (HCBS) Waiver Eligible

This next optional eligibility group is available to people who are eligible for a Medicaid Home and Community Based Services (HCBS) waiver. HCBS waivers are a set of special Medicaid services provided to targeted populations, thereby making it possible for the individuals to live with maximum independence in the community rather than live in an institution (e.g., nursing facility).

To use this group, a person must have income below a standard set by the state (not to exceed 300 percent of the SSI FBR), have resources below $2,000 ($3,000 for a couple), and be eligible for a HCBS waiver. If a state chooses to use this optional Medicaid eligibility group, they may require “post eligibility treatment of income,” which is often called a cost share, patient liability, offset, or cost of care. This cost share is a specific amount of the beneficiary’s monthly income that he or she must pay to help cover some of the HCBS waiver services.

It’s important to note that a beneficiary doesn’t need to use this Medicaid eligibility group to be eligible for a HCBS waiver. On the HCBS waiver application, which the state creates and CMS must approve, there will be a list of Medicaid eligibility groups that can use the waiver (e.g., SSI eligible, Medicaid Buy-In, Low Income Eligible), one of which could be this optional eligibility group. If a beneficiary is eligible for Medicaid through his or her SSI eligibility and that group is listed on the HCBS waiver application, then the beneficiary wouldn’t need to use this optional Medicaid eligibility group. But, if the beneficiary was over the income limit for SSI, then this could be a way for the person to become eligible for Medicaid and access the HCBS waiver.
Example of the Home and Community Based Services waiver eligibility group:

Denbe receives $1,500 of SSDI. The income limit in his state for this eligibility group is $2,349 (300% of the SSI FBR for 2020). All of his income counts when the state determines if he is above or below this limit. Because $1,500 is below the current income limit, he can access Medicaid this way. When a person is eligible for Medicaid through the HCBS waiver group, his or her total income could exceed the income limit when working and cause eligibility to end.

Example of what happens to Denbe when he begins working:

Denbe gets a job making $900 per month, plus he will continue to receive $1,500 of SSDI. Because the state counts all income when determining if a person is above or below this income limit, his total income is $2,400. He is now over the income limit and will no longer be eligible for Medicaid under this eligibility group.

Some states allow individuals to put excess income into a Miller’s Trust, thereby allowing them to meet the income limit for this eligibility group. The availability of Miller’s Trusts varies from state to state, so CWICs will need to conduct state-specific research. It’s also important to note that if a person has a cost share, the amount he or she pays may also increase when he or she begins working.

It’s critical that CWICs understand the income and resource limits associated with this eligibility group, whether Miller’s Trusts are an option, and the basics for how the cost share is calculated. CWICs must be prepared to let beneficiaries know if their cost share will increase due to working or if they will likely exceed the income limit. If either of those results is expected, CWICs must help identify alternatives, such as the Medicaid Buy-In, for maintaining Medicaid and waiver services.

Optional Group #6: Affordable Care Act Medicaid Expansion – Adults Group

This final eligibility group isn’t specifically for people with disabilities, but it could be useful for Title II disability beneficiaries in the Medicare 24-month qualifying period. This Medicaid eligibility group is referred to as
the “adult group,” the “133 percent group,” or the “VIII group.” Individual states may establish a different name if they adopt this eligibility group. When Congress passed the Affordable Care Act (ACA), it designed the adult group to be a mandatory Medicaid eligibility group. To continue receiving federal funds for the Medicaid program, states would be required to provide Medicaid to everyone who met the eligibility criteria. However, in 2012 the Supreme Court ruled that the mandatory expansion was unfairly coercive on states and determined that a state could refuse to adopt the expansion. As a result, this eligibility group isn’t available in all states.

For states that add the adult group to their Medicaid State Plan, there are five specific federal rules that dictate the eligibility criteria. To be eligible, a person must:

1. Have income at or below 133 percent of the Federal Poverty Level (FPL);
2. Be between 19 and 64 years of age;
3. Not be pregnant;
4. Not be eligible for Medicare; and
5. Not be eligible for Medicaid under a mandatory eligibility group.

The state won’t cover a parent or other caretaker relative who is living with a dependent child under the adult group unless the child is enrolled in Medicaid, the Children’s Health Insurance Program (CHIP), or another health care plan with at least minimal essential coverage. The state uses Modified Adjusted Gross Income Based (MAGI-based) methodology to determine whether a person meets the income limit for this group. It finds this by taking the tax-filing group’s adjusted gross income (an IRS concept) and adding in all Social Security income. Then it makes a few additional adjustments for things such as lump sum payments, education scholarships, awards, or grants, and American Indian or Alaskan Native income.

Once the state determines MAGI-based income, it applies a 5 percent Federal Poverty Level (FPL) disregard. As a result, the effective eligibility limit for this group is 138 percent of FPL. The state bases the household size on the tax household size, which generally means married adults and children living together; however, there are some instances where IRS
and Medicaid household rules may differ. There is no resource limit for the adult group.

CMS doesn’t require states to provide the full scope of Medicaid State Plan services to those in the adult group. They must instead provide “essential health benefits.” Those benefits include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorders, prescription drugs, rehabilitation and habilitation services and devices, laboratory services, preventative and wellness services and chronic disease management, and pediatric services. States have the option to propose alternate benefits packages for the adult group, which could include Medicaid State Plan benefits.

**Example of the Adult eligibility group:**

Luther receives $1,270 of SSDI. He doesn’t have Medicare yet. Given his household size, the income limit for this Medicaid eligibility group is $1,436 per month (138% of 2019 FPL). His MAGI-based income is below that limit and, as a result, he can access Medicaid this way.

When counseling beneficiaries who use this group, it’s important to recognize returning to work could make them ineligible.

**Example of what happens to Luther when he begins working:**

Luther gets a job making $500 per month, plus he will continue to receive $1,270 of SSDI. His MAGI-based income is $1,770 per month, which is over the income limit for this group. As a result, the state would need to find Luther eligible under a different Medicaid eligibility group in order for him to maintain Medicaid.

CWICs should identify those who could be eligible for this group, and should also be familiar with other Medicaid eligibility groups in their state that could benefit workers with disabilities, such as the Medicaid Buy-in group (if available).
Home and Community-Based Services (HCBS) Waivers

Historically, Medicaid only funded long-term care services in an institutional setting. Long-term care (LTC) services include support with activities of daily living (ADLs), such as bathing, dressing, and eating. LTC services have also included support with instrumental activities of daily living (IADLs), such as taking medications as prescribed, managing money, shopping for groceries, and transportation within the community. If an individual needed this type of support, in the past Medicaid would only provide those services in nursing facilities, intermediate care facilitates (ICF), intermediate care facilities for those with intellectual disabilities (formerly called ICF/ID), or hospitals.

Example of LTC services:

Denise was in a car accident that caused total paralysis below her waist. She was in the hospital for several weeks, which her parents’ insurance covered. Afterwards, she entered a nursing facility, where she had access to nursing care, physical therapy, and occupational therapy. Her parents’ insurance had covered much of her care, but there were limitations on the amount of rehabilitation care. She signed up for Medicaid, which covered the services her parents’ insurance didn’t cover.

After three months of services in the nursing facility, Denise began asking when she could move back to her apartment. She met with the facility’s social worker, and they created a plan. Denise applied for a program through the state Medicaid agency that provided LTC services to people in their own homes (they also provided support to people in foster homes and group homes, but she wasn’t interested in that). A caseworker from the state Medicaid agency came to the nursing facility and conducted an assessment of her LTC support needs. The caseworker let Denise know there were a special set of services to assist people with LTC needs to live in the community, called Home and Community Based Services. She explained that, based on the assessment results, Denise could have a
certain number of hours per day of personal care attendant services and nursing services to support her in living in her own apartment. Denise talked this option over with her parents and the social worker at the nursing facility. Together, with the Medicaid caseworker, they came up with a plan for Denise to move back into the community, using the Home and Community Based Services to support her in living in her apartment.

Over the years, Congress has created several options for states to provide LTC services to support people in living in the community, rather than in a Medicaid funded institution. This concept took off in the 1980’s when Congress enacted section 1915(c) of the Social Security Act. That has been the main authority states have used to provide home and community-based services over the years. More recently, under the Deficit Reduction Act of 2005, Congress created another option, 1915(i), and then, through the Affordable Care Act of 2010, created the 1915(k) option. The fourth authority that states could use to provide LTC services in the community is through an 1115 demonstration waiver. That authority is broader in context as it allows states to operate their Medicaid program in a unique way so that it can provide better quality services more efficiently.

Beneficiaries who receive these services are often concerned about how working may affect their eligibility. These services provide critical support, without which the individual would most likely need to live in an institution. Given the importance of these services, it’s essential that CWICs understand these special Medicaid programs and are clear about how earnings will or won’t affect eligibility.

1915 (c) Home and Community Based Services (HCBS) Waivers

This provision allows states, with approval from CMS, to “waive” (or not follow) certain federal Medicaid requirements. These are often referred to as “section 1915(c) waivers.” Currently, 47 states participate in these optional waivers to varying degrees, and some states operate several 1915(c) waivers simultaneously. Arizona, Rhode Island, and Vermont use the 1115 demonstration waiver authority to provide home and community-based services, rather than the 1915(c) authority. HCBS waivers are important for persons with disabilities because they provide a
means for receiving critical services that make it possible to live in the community rather than in an institution.

To qualify for HCBS waiver services, applicants must meet the following criteria:

1. Require an institutional-level care (nursing facility, hospital, intermediate care facility, or intermediate care facility for intellectual disabilities);

2. Meet the definition of the target group being served by the waiver (e.g., physical disability, developmental or intellectual disability, traumatic brain injury); and

3. Qualify for Medicaid under one of the Medicaid eligibility groups listed on the specific waiver the person is using.

Under the HCBS waiver authority a state may provide a wider range of long-term care services than is generally allowed under a state’s Medicaid program, including non-medical services such as minor home modifications like ramps or special safety devices. Some states have several different HCBS waivers targeted to different populations. States can use the HCBS waiver to waive three key federal Medicaid requirements:

1. **Waiver of statewideness:** Ordinarily, the state’s Medicaid plan must offer comparable coverage in all regions of a state. The state could establish a waiver that allows them to offer a level of Medicaid coverage in one or more sections of the state that isn’t available to recipients statewide.

2. **Waiver of comparability:** Ordinarily, the state’s Medicaid plan must treat all similarly situated recipients equally. With a waiver, the state can select a targeted group of Medicaid recipients (such as persons with traumatic brain injury) and offer them a set of services not available to persons who have different disabilities but similar needs.

3. **Waiver of certain income and resource rules:** The state can implement a waiver that exempts certain populations from the general income and resource requirements. For example, many states operate waiver
programs that insure children with very severe disabilities are eligible for Medicaid without regard to parental income and resources.

The expanded scope of services potentially available through an HCBS waiver can be very important to individuals with disabilities who are pursuing employment. Under federal HCBS waiver regulations, the state can provide a very wide range of services, including:

- Case management
- Homemaker services
- Home health aide services
- Personal care services
- Adult day health
- Habilitation, including Supported Employment services
- Respite
- Partial hospitalization and psychosocial rehabilitation for persons with psychiatric diagnoses
- Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization

States have used the “other services” category to approve things such as home modifications and even modifications to vehicles.

HCBS waivers also differ from standard Medicaid in that they allow states to limit enrollment and to establish waiting lists for services. Under standard Medicaid policies, states must provide services to all eligible individuals with reasonable promptness. However, the states may place on a waiting list any individuals they determine eligible for HCBS waivers and not provide them services until a slot in the waiver becomes available.

In 1997, CMS amended the HCBS regulations to allow for “expanded habilitation services,” which include “prevocational services” and “educational services.” Under the prevocational and educational services categories, CMS will allow an approved waiver to provide a wide range of services that would prepare an individual with a severe disability to eventually move to either competitive employment, long-term supported employment, or a more traditional vocational rehabilitation program. As
a result, CWICs may work with beneficiaries who are receiving crucial employment services that are funded by a HCBS waiver.

A beneficiary may have concerns about how work will affect his or her eligibility for the HCBS waiver he or she is using. To maintain the HCBS waiver services, the beneficiary must continue to meet the three eligibility criteria. The first two are generally not affected when a person begins working; generally, the person continues to have an institutional-level of care need and he or she continues to meet the criteria for the target group. The third criterion is the waiver’s financial criteria; the person must continue to be eligible for one of the Medicaid eligibility groups listed on the waiver. If the state projects the individual will stay in the same Medicaid eligibility group when he or she begins working, then he or she could maintain eligibility for the waiver. If the state projects that the individual will lose eligibility for his or her current Medicaid eligibility group given his or her earning goal, the CWIC should support the beneficiary in identifying other Medicaid eligibility groups listed on the waiver he or she could use.

To provide that support, CWICs must identify which HCBS waivers are available in their state, locate the HCBS waiver application (the approved agreement between CMS and the state) for the waiver the beneficiary is using, and locate Appendix B-4 on that waiver. Appendix B-4 provides a list of the Medicaid eligibility groups that the beneficiary can use to access that specific waiver.

CMS has a website that provides a list of all the approved 1915(c) waivers in each state (https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html).

Most states have uploaded the approved HCBS waiver application to each waiver description on this site or onto the state’s Medicaid website. If the state hasn’t uploaded the waiver application, CWICs will need to do some networking to locate a copy.

1915(i) State Plan HCBS Benefit

Through the 1915(i) option, states can include a variety of Home and Community Based services under the Medicaid State Plan. In comparison, under the 1915(c) option the state doesn’t consider the services part of the State Plan. Instead, 1915(c) waiver services are special Medicaid programs separate from the State Plan that can only be accessed by those who meet the eligibility criteria. CMS doesn’t allow
states to limit enrollment for 1915(i) benefits or to establish waiting lists for services under this option.

Additionally, with the 1915(i) option, states can provide the services to a broader group of people than the 1915(c) waivers can serve. The clinical eligibility standards under the 1915(i) must be less stringent than the institutional level of care that is required under 1915(c). What that means is that states can use the 1915(i) option to provide home and community- based services to people with less significant disabilities than those the state serves under the 1915(c) waivers.

**Example of 1915(i) option:**

Iowa was one of the first states to use the 1915(i) option. The Iowa Department of Human Services worked with CMS to design a program to meet the service needs of Iowans with the functional limitations typically associated with chronic mental illness. This is an example of a population of people who generally don’t meet the 1915(c) institutional-level of care eligibility criteria. The services included in this option assist participants in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based setting. Services available through this State Plan option include case management, home-based habilitation, day habilitation, prevocational services, and supported employment.

To qualify for 1915(i) specific services, an individual must:

1. Meet the clinical eligibility criteria for 1915(i) services set by the state; and
2. Be eligible for Medicaid; and
3. Have income below 150 percent of the FPL (states may choose to increase the income limit to 300 percent of the SSI rate for individuals who meet institutional-level of care criteria).

The last two criteria are of particular importance for CWICs, because earned income can affect whether a person continues to meet those eligibility standards. Regarding the second criteria, the earlier sections in this unit explain how earnings affect various Medicaid eligibility groups.
CWICs must to be prepared to help beneficiaries explore other Medicaid eligibility groups that they could use, if needed. The third criterion is actually a new concept in the world of Medicaid. Up to this point, a specific set of services hasn’t had an income limit tied to it. But, for a beneficiary to become eligible for and maintain 1915(i) services, his or her income must be below the limit noted in criteria three above, regardless of the income limit for the individual’s Medicaid eligibility group. When determining if a person’s income is above or below that limit, the state will use the income deductions allowed under the Medicaid eligibility group the person is using.

1915 (k) Community First Choice

Most states currently provide a limited amount of personal care services through the Medicaid State Plan benefit. The Affordable Care Act established Community First Choice (CFC) under 1915(k) of the Social Security Act as a new Medicaid State Plan option that allows states to provide statewide home and community-based attendant services and supports to individuals who would otherwise require an institutional level of care. States taking up the option will receive a 6 percent increase in their federal medical assistance percentage (FMAP) for CFC services. There is no time limit or expiration on the enhanced FMAP and CMS has indicated that the enhanced FMAP also will be available for required CFC activities such as assessments and person-centered planning.

States must provide CFC services statewide with no enrollment caps. States can provide services under an agency-provider model (within which individuals must maintain the ability to have a significant role in the selection and dismissal of providers of their choice), a self-directed model, or other models approved by CMS. States determine specific services following a face-to-face assessment of an individual’s needs and a person-centered planning process directed by the individual to the maximum extent possible. Required CFC services include: services that assist beneficiaries with activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing; services for the acquisition, maintenance, and enhancement of skills necessary for individuals to accomplish activities of daily living, instrumental activities of daily living, and health-related tasks; “self-direction” opportunities including voluntary training on how to select, manage, and dismiss direct care workers; and backup systems
(such as beepers or other electronic devices) to ensure continuity of services and supports.

To be eligible for CFC services, beneficiaries must:

- Otherwise require an institutional-level of care;
- Be eligible for Medicaid; and
- If using a Medicaid eligibility group that doesn’t offer nursing facility services, the beneficiary must have income below 150 percent of the FPL. **NOTE:** There is no secondary income limit for 1915(k) coverage if an individual is enrolled in a Medicaid category in which coverage for nursing facility services is part of the benefit package.

The last two criteria are of particular importance for CWICs, because earned income can affect whether a person continues to meet the criteria. Regarding the second criteria, the earlier sections in this unit explain how earnings affect various Medicaid eligibility groups. CWICs must be prepared to help beneficiaries explore other Medicaid eligibility groups that they could use, if needed. As noted under the 1915(i) explanation, the third criterion is a new concept in the world of Medicaid. Up to this point, a specific set of services hasn’t had an income limit tied to it. But, for a beneficiary to become eligible for and maintain 1915(k) services, he or she must also meet the third criteria. When determining if a person’s income is above or below that limit, the state will use the income deductions allowed under the Medicaid eligibility group they are using.

**Medicaid and Other Health Insurance**

Many beneficiaries have concerns that when they become eligible for Medicare or an employer-sponsored health insurance plan, they will lose eligibility for Medicaid; however, there are many options for individuals to maintain Medicaid and other insurance. Since it is a financial needs-based program, Medicaid is a payer of last resort. As a result, it encourages beneficiaries to pursue other health insurance options. By accessing other health insurance, Medicaid can save money, because the other insurance becomes the primary payer. Some states will require a Medicaid beneficiary to take Medicare if he or she is eligible. If his or her employer or a family member’s employer offers the beneficiary “cost-effective” employer-sponsored health insurance, the state may require
the beneficiary to take the coverage, and in return, the state will pay the premium. When a beneficiary becomes eligible for new health care coverage, it’s important to remind the beneficiary to report this option to his or her Medicaid eligibility worker to clarify his or her options and responsibilities.

**Medicaid and Medicare**

A number of the beneficiaries a CWIC works with will be concurrent beneficiaries who receive both SSI and Title II disability benefits. In most states, these beneficiaries will eventually be eligible for both Medicare and Medicaid. When a person is eligible for both Medicare and Medicaid, he or she is “dually eligible” concerning their health insurance. It’s also possible that a Title II disability beneficiary can have too much income for SSI but could be eligible for Medicaid through a Medicaid eligibility group that has a higher unearned income limit (e.g., Medicaid Buy-In, HCBS waiver, Medically Needy). When this happens, the person will be eligible for both Medicare and Medicaid. When a Medicaid beneficiary has or can get Medicare, most state Medicaid agencies will require the beneficiary to enroll in the Medicare program. CWICs should research details about this requirement in their state’s Medicaid policy manual. When a beneficiary has both Medicare and Medicaid coverage, Medicare always pays first, and Medicaid pays second. Dually eligible individuals often receive assistance with Medicare expenses including premiums, cost sharing, and deductibles.

**Medicaid and Employer-Sponsored Health Insurance**

In some states, if a beneficiary can get health insurance through his or her own employer, his or her spouse’s employer, or his or her parents’ employer, the state requires the beneficiary to take it. When a Medicaid beneficiary becomes eligible to apply for another form of health insurance, the state Medicaid agency usually will require that the beneficiary report this new option to the Medicaid eligibility worker. The Medicaid staff will ask the beneficiaries for details about the health insurance policy (e.g., monthly premium amount, deductible, coverage amount, services covered, etc.). With that information the Medicaid staff will determine if the plan is “cost effective.” If it’s cost effective, in order to maintain Medicaid, the state may require the beneficiary to take the new health insurance option. Generally, if state Medicaid rules require beneficiaries to take the new option, the state will pay the monthly...
premium. This is called a Health Insurance Premium Payment (HIPP). In many cases, Medicaid will also pay for cost sharing associated with the health insurance, including co-payments and deductibles. If Medicaid doesn’t consider the plan cost effective, generally the state won’t require the beneficiary to take the new health insurance option. The beneficiary could still choose to take it if he or she wants, but the state generally won’t pay the premium.

**Introduction to Children’s Health Insurance Program (CHIP)**

While Social Security beneficiaries returning to work are generally able to continue receiving Medicaid coverage for themselves in most states, what about their children? What if they find a job that pays too much for their children to continue on Medicaid, but the employer doesn’t provide health insurance? For these individuals, the Children’s Health Insurance Program (CHIP) may provide health care coverage. CHIP provides coverage to eligible children, through both Medicaid and separate CHIP programs. CHIP is administered by states, according to federal requirements. States and the federal government jointly fund the program.

The Children’s Health Insurance Program (CHIP) serves uninsured children up to age 19 in families with incomes too high to qualify them for Medicaid. States have broad discretion in setting their income eligibility standards, and eligibility varies across states. Forty-eight states and the District of Columbia cover children up to or above 200 percent of the FPL, and 19 of these states offer coverage to children in families with income at 300 percent of the FPL or higher. States have the option to provide continuous eligibility to children who remain eligible for CHIP.

It’s important that CWICs understand CHIP, its eligibility criteria, and the covered services so that they can offer accurate information to beneficiaries who may have children using this health insurance coverage. For more information on CHIP, visit their website (https://www.medicaid.gov/chip/eligibility/index.html).
Appealing Medicaid Decisions

Under federal Medicaid law, a Medicaid applicant or recipient is entitled to an administrative hearing after any decision that affects his or her right to Medicaid or to any service for which he or she is seeking Medicaid funding. This is known as a “fair hearing” and is available in all states.

A person is entitled to a written when his or her Medicaid benefits or right to services funded by Medicaid are either denied or terminated by the state. In most cases, the letter will read: NOTICE OF ACTION. The notice must explain the action the state is taking, the reason for the action, the right to a hearing to appeal the decision, and the availability of free services from a legal services, legal aid, or similar program (such as a Protection & Advocacy program). States may establish their own time limits for requesting hearings. Typically, states will permit the Medicaid recipient a time limit (to 60 days) for requesting the hearing. However, if the notice indicates that the state will terminate an ongoing benefit, such as funding for home health care services, on a certain date, the recipient will need to request the hearing before the termination date if he or she will request continued services pending the appeal. Federal Medicaid law provides that state continue benefits pending the appeal (a concept often referred to as “aid continuing”) if the beneficiary requests a hearing before the effective termination date and the recipient (or advocate working on his or her behalf) specifically requests the continuation of benefits.

Conducting Independent Research

1619(b) Charted Thresholds
(https://secure.ssa.gov/apps10/poms.nsf/lnx/0502302200!opendocument)

Social Security’s Program Operations Manual section on Special Medicaid Beneficiaries
(https://secure.ssa.gov/apps10/poms.nsf/lnx/0501715015)
Additional Resources

A handout CWICs may use to help explain 1619(b) titled “What will Happen to My Medicaid When I go to Work” is attached on the following page. CWICs may personalize this handout by adding their State Threshold figure.
What Will Happen to my Medicaid When I go to Work?

Continued Medicaid Eligibility - Section 1619(b)

This incentive continues Medicaid coverage for most working SSI beneficiaries even after earnings become too high to allow a cash benefit. To qualify for this incentive the person must:

- Have been eligible for SSI cash payment for a least one month.
- Still meet the disability requirement.
- Meet the Medicaid “needs” test.
- Have GROSS annual earned income less than the current state “threshold amount” (enter amount here).
- Have countable unearned income of less than the current FBR and resources under the current limit for SSI recipients.

What does the 1619(b) provision do?

- Enables people who are ineligible for continued Medicaid coverage because earnings exceed the threshold amount to get SSI cash payments again if earnings fall below the break-even point within 12 months.
- Allows people who are ineligible for continued Medicaid coverage because earnings exceed the threshold amount to regain Medicaid eligibility if earnings drop below the threshold amount within 12 months.
- Allow eligible 1619(b) recipients to get SSI cash payments at any time earnings fall below the break-even point.
- Enables people to maintain eligibility for SSI cash payments or continued Medicaid coverage after a period of ineligibility without filing a new application.
Competency Unit 2 – Understanding Medicare

What is Medicare?

Medicare is our country’s health insurance program for people age 65 or older, certain people with disabilities who are under age 65, and people of any age who have permanent kidney failure. It provides basic protection against the cost of health care, but it doesn’t cover all medical expenses or the cost of most long-term care. A portion of the Federal Insurance Contributions Act (FICA) taxes that workers and their employers pay finances the Medicare program. It’s also financed in part by monthly premiums that beneficiaries pay. The Centers for Medicare and Medicaid Services (CMS) is the federal agency in charge of the Medicare program. However, the Social Security Administration determines who is eligible for Medicare, enrolls people in the program, and disseminates general Medicare information.

Medicare Versus Medicaid

Many people think that Medicaid and Medicare are two different names for the same program. Actually, they are two very different programs. Medicaid is a state-run program designed primarily to help those with low income and few resources. Medicare, by comparison, is an entitlement earned by someone who has paid into the Medicare trust fund through taxes on earned income; it’s not needs based. The federal government helps pay for Medicaid, but each state has its own rules about who is eligible and what services are covered. In contrast, original Medicare is a federally run program that has the same eligibility standards and coverage rules across all 50 states. Medicaid coverage is typically free (with some exceptions in some states), while Medicare coverage involves premiums, co-payments, and deductibles. Some people receive both Medicaid and Medicare. CMS refers to these people as “dual eligible.” Unit 1 of this module offers in-depth explanations of the various Medicaid programs available to individuals with disabilities.
**Medicare Basics**

There are three core parts to Medicare: Parts A, B, and D. Medicare Part A (hospital insurance) and Part B (supplemental medical insurance) were the original parts to Medicare; as a result, CMS refers to them as “Original Medicare.” Congress established Medicare Part D (prescription coverage) in 2006. You may be wondering, “What about Part C?” Part C is a way for beneficiaries to get their Part A and B benefits, and even Part D, through a private health insurance company.

The following chart outlines the parts of Medicare:

<table>
<thead>
<tr>
<th>Medicare Part</th>
<th>Overview</th>
<th>Out of Pocket Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part A: Hospital Insurance (HI)</strong></td>
<td>Inpatient hospital care</td>
<td>Deductibles, plus co-insurance based on length of stay</td>
</tr>
<tr>
<td></td>
<td>Post-acute rehabilitation</td>
<td></td>
</tr>
<tr>
<td><strong>Part B Supplemental Medical Insurance (SMI)</strong></td>
<td>Doctor’s services and outpatient care</td>
<td>Monthly premiums, plus typically 20% of approved customary outpatient charges after an annual deductible</td>
</tr>
<tr>
<td><strong>Part D Prescription Drug Coverage</strong></td>
<td>Prescription drug costs</td>
<td>Varies by Part D Plan, usually has monthly premiums, deductible, co-pays, and coinsurance</td>
</tr>
</tbody>
</table>

This unit will provide details about each part of Medicare, but keep in mind that CWICs aren’t expected to be experts on what Medicare does or doesn’t cover. When beneficiaries have questions about Medicare coverage, CWICs should refer them to the State Health Insurance Assistance Program (SHIP). SHIP is a national program that offers one-on-one counseling and assistance to people with Medicare and their families. Through federal grants directed to states, SHIPs provide free counseling and assistance via telephone and face-to-face meetings. SHIP counselors may be paid employees or volunteers and complete a
thorough training process to help address a number of Medicare coverage questions. We provide details about SHIPs further on in this unit.

**NOTE:** The annual CMS publication “Medicare and You” provides an easy-to-understand overview of the parts of Medicare. This publication is an invaluable reference guide for CWICs on Medicare program rules. You can ask Medicare to mail you a copy by calling 1-800-MEDICARE or download “Medicare and You” (https://www.medicare.gov/medicare-and-you/medicare-and-you.html).

**Medicare Part A**

Medicare “Part A” (also known as Hospital Insurance or HI) helps pay for care in a hospital and skilled nursing facility, home health care, and hospice care. When a Title II disability beneficiary becomes eligible for Medicare, he or she is automatically enrolled in Medicare Part A. Part A hospital insurance is premium-free for these individuals and isn’t optional. Social Security beneficiaries who are eligible for Medicare Part A don’t have the option of declining participation. Social Security manages the enrollment process for Part A. While there is no Part A monthly premium for Title II disability beneficiaries, there are **deductibles and co-insurance.** Details of the Part A deductibles and co-insurance are available at the following Medicare website (https://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html).

Under the original Medicare model, to use Part A the beneficiary locates a medical provider that accepts Medicare and receives medical services from that provider; then, the provider bills Medicare (generally a contractor of Medicare who processes claims and payments) to cover what is allowable within Medicare rules.

**Medicare Part B**

Medicare “Part B” (also known as Supplemental Medical Insurance or SMI) helps pay for doctors, outpatient hospital care, and other medical services. Anyone who is eligible for premium-free Medicare hospital insurance (Part A) can also enroll in Medicare supplemental medical insurance (Part B). When a Title II disability beneficiary becomes eligible for Medicare, he or she is automatically enrolled in Part B. Social Security
manages the enrollment process for Part B. The standard monthly premium for Part B is $144.60/month in 2020. If a beneficiary’s yearly income were more than $87,000 ($174,000 for a couple), he or she would have a higher premium. Social Security generally deducts the Part B premium from the beneficiary’s Title II benefit. Part B also has an annual deductible of $198 (in 2020) and co-insurance of approximately 20 percent. Details of the Part B premium, deductible, and co-insurance can be found at the Medicare website (https://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html).

Beneficiaries do have the choice to opt out of Part B, but it’s important they understand the consequences of that decision. Beneficiaries who decline Part B may have to pay a premium penalty (a higher monthly premium) if they decide to enroll in Part B later on. The monthly Part B premium will increase 10 percent for each full 12-month period the beneficiary could have had Part B but didn’t sign up for it. There is no premium penalty for any month the beneficiary had employer-sponsored health insurance (through their own employer or their spouse’s employer). Months of coverage under COBRA don’t qualify as coverage under an employer-sponsored health plan.

Information is available later in this unit about financial assistance called Medicare Savings Programs (MSPs) that can help pay the Part B premium and other Medicare out-of-pocket costs. Some beneficiaries say they don’t want to enroll in Part B because they feel they can’t afford it. When this happens, CWICs should provide information about the Medicare Savings Programs and refer the person to a SHIP counselor to talk through their options. If a beneficiary is subject to a higher Part B premium because of the premium penalty, it’s possible to eliminate the penalty if the beneficiary is found eligible for a new period of Medicare entitlement (such as when turning 65) or if the state finds him or her eligible for the Medicare Savings Program. Just as with Part A, to use Medicare Part B under the original model, the beneficiary locates a medical provider that accepts Medicare and receives medical services from that provider; then the provider bills Medicare (generally a contractor of Medicare who processes claims and payments) to cover what is allowable within Medicare rules.
**Medicare Part D**

Medicare Part D is the newest part of Medicare; it helps pay the costs of prescription drugs for Medicare beneficiaries in the United States. It was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and went into effect on January 1, 2006. Anyone who is enrolled in Medicare Part A or Part B can also enroll in Part D. Unlike with Parts A and B, Social Security doesn’t process Part D enrollments. Beneficiaries must enroll directly with a Medicare Part D Prescription Drug Plan (PDP) or a Medicare Advantage Plan (Part C – described later). Private insurance companies that contract with CMS to participate in the Medicare Part D program develop and operate the prescription drug plans. Depending on the Prescription Drug Plan, beneficiaries may have a monthly premium, an annual deductible, and co-insurance payments.

With regard to the premium, beneficiaries who opt out of Part D may have to pay a premium penalty (a higher monthly penalty) if they decide to enroll in Part D later. A premium penalty would be due if the beneficiary goes for a continuous period of 63 days or longer without “creditable coverage”. The monthly Part D premium would increase 1 percent of the “national base beneficiary premium” times the number of full, uncovered months the beneficiary could have had Part D but chose not to enroll. Months the beneficiary had creditable coverage won’t count in calculating the penalty. There is a financial assistance program, Low Income Subsidy (also known as Extra Help), which can help pay the Part D premium. We will discuss that program later in this unit.

For more information about what CMS considers to be **“creditable coverage”**, refer to the Medicare website ([https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/index?redirect=/crediblecoverage/](https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/index?redirect=/crediblecoverage/)).

For more information about the **Medicare premium penalty and ways to avoid incurring this cost**, refer to the Medicare website ([https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/part-d-late-enrollment-penalty/3-ways-to-avoid-the-late-enrollment-penalty](https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/part-d-late-enrollment-penalty/3-ways-to-avoid-the-late-enrollment-penalty)).

A prescription drug plan (PDP) could have a deductible and three phases of coinsurance:

- **Deductible**: No more than $435 a year in 2020
• **Phase 1 - Initial Coverage:** A beneficiary could be charged up to a 25 percent co-insurance. This phase ends when the beneficiary and his or her drug plan pay $4,020 in drug costs in 2020.

• **Phase 2 - Coverage Gap:** If a plan has a coverage gap, the beneficiary will pay 25 percent for brand-name drugs and generic drugs in 2020. The coverage gap used to be called the “donut hole” because beneficiaries, historically, had to pay 100 percent of their drug costs. Under the Affordable Care Act (ACA) the coverage gap is phasing out. By 2020 the beneficiary’s co-insurance will reduce to 25 percent for generic and brand names, until he or she reaches catastrophic coverage level.

• **Phase 3 - Catastrophic Coverage:** After a beneficiary has paid $6,350(2020) in drug costs, he or she moves into catastrophic coverage. In this phase, beneficiaries only pay a small coinsurance amount or copayment for covered drugs for the rest of the year.

Beneficiaries who are eligible for the Low income Subsidy (LIS) program will receive financial help to pay these Part D out-of-pocket expenses. Details about **when the coverage gap begins and ends** is available at the following Medicare website (https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap).

CWICs should refer beneficiaries to SHIP if they are thinking about declining Part D or need help choosing a plan. States will automatically enroll beneficiaries who are eligible for Medicaid into a Part D plan when Medicare begins, unless they choose a plan themselves.

**Medicare Advantage Plans (Part C)**

CMS often refers to Part C of Medicare as Medicare Advantage (MA). MA Plans provide an option for Medicare beneficiaries to get their Medicare Part A and Part B services, and in some cases, Part D, through a private health plan. These health plan options are part of the federal Medicare program, but private insurance companies operate them. A wide range of MA plans are available in many areas of the country. Different MA plans cover different services, and costs for these plans also vary widely. Individuals who join one of these plans generally get all of their Medicare-
covered health care through that plan, and coverage can include prescription drug coverage.

Medicare Advantage Plans include:

- Medicare Health Maintenance Organization (HMOs)
- Preferred Provider Organizations (PPO)
- Private Fee-for-Service Plans
- Medicare Special Needs Plans
- Medicare Medical Savings Account Plans

Individuals who join a Medicare Advantage Plan use the health insurance card that they receive from the plan for all health care items or services. In many of these plans, there are extra benefits and lower co-payments than in the Original Medicare Plan. However, some individuals may have to see doctors that belong to the plan or go to certain hospitals to get services.

To join a Medicare Advantage Plan, individuals must have both Medicare Part A and Part B. In addition to the regular Part B premium, participants in some Medicare Advantage Plans might have to pay an additional monthly premium to their Medicare Advantage Plan for the extra benefits that their plan offers. Individuals who join a Medicare Advantage Plan don’t need a Medigap policy (described below), because Medigap plans won’t pay any deductibles, co-payments, or other cost-sharing under a Medicare Advantage Health Plan. Therefore, individuals who decide to join a Medicare Advantage Plan may want to drop Medigap policies.

Medicare Advantage plans often offer extra benefits that people enrolled in the Original Medicare Plan don’t receive. CMS assesses the quality of services provided through Part C plans using a “star rating system” that can assist individuals in evaluating different plans. More information on plans, services, and ratings is available (http://www.medicare.gov).

**Medicare Supplements or Medigap Plans**

Although Medicare is a valuable resource, it doesn’t cover all medical items or services an individual might need. In addition, because Medicare involves deductibles and coinsurance payments, some people end up with large out-of-pocket expenses. Medicare supplemental insurance policies,
also called “Medigap Plans,” may help fill gaps in services and cover certain out-of-pocket expenses. These are private insurance policies that are optional for Medicare beneficiaries to purchase but are mandated to exist in each state. A wide array of plans is available, and plans vary significantly in the amount of coverage they provide and how much they cost. Insurance companies can only sell “standardized” Medigap policies, which are required to provide specific benefits so that individuals can compare them easily. It’s important to compare Medigap policies, because costs and coverage can vary significantly.

If a beneficiary has Medicaid, generally the insurance companies are prohibited from selling the individual a Medigap plan. This is because Medicaid will act as a secondary insurance to Medicare and cover the types of costs Medigap would normally cover. Another consideration is that Medicare beneficiaries may also reduce their out-of-pocket costs by enrolling in a Medicare Advantage Plan. For some beneficiaries, this may be a better option than purchasing a Medigap policy, depending on their specific health care needs.

Beneficiaries can go to www.medicare.gov to find interactive electronic tools that compare various Medicare and Medigap plans. CWICs can also refer beneficiaries to a SHIP counselor for help deciding whether a Medigap plan would be useful. For additional information on Medigap policies, including how to decide if a Medigap policy makes sense, and what Medigap policies cover, CWICs are advised to read the publication titled “Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare,” which can be found online (https://www.medicare.gov/pubs/pdf/02110-medicare-medigap.guide.pdf).

### Medicare Eligibility

These specific groups of people are eligible for Medicare:

- Individuals age 65 and older who are insured for retirement benefits under Social Security, either through their own work or through a spouse’s work.

- Individuals receiving Social Security Disability Insurance (SSDI) who have met the 24-month qualifying period for Medicare.
• Individuals receiving benefits as a Childhood Disability Beneficiary (CDB) who have met the 24-month qualifying period.

• Individuals who meet the Social Security disability standards and who are either entitled to Disabled Widow(er)s benefits (DWB) or Medicare on a deceased worker’s record and who have met the 24-month qualifying period.

• Individuals who lost Title II disability benefits due to work and are in the Extended Period of Medicare Coverage (EPMC).

• Individuals with disabilities who have exhausted their Extended Period of Medicare Coverage (EPMC) and are eligible to purchase Medicare Parts A, B, and D coverage through Premium-HI for the Working Disabled.

• Individuals who have End-Stage Renal Disease (ESRD) who have been receiving dialysis for three months, or who have been performing self-dialysis for one month, or who have received a kidney transplant. Note that people receiving Medicare under the End Stage Renal Disease (ESRD) provisions don’t have to meet a 24-month qualifying period.

• Government employees who paid Medicare taxes and meet any of these above categories.

• People who are age 65 or older, aren’t insured for Social Security retirement benefits, and pay a premium for Part A as well as the other parts of Medicare.

The majority of the beneficiaries WIPA projects serve are eligible for Medicare based on their entitlement to a Title II disability benefit (SSDI, CDB, or DWB). There are two other ways to get Medicare that CWICs may run across: Medicare for People with End Stage Renal Disease and Medicare Qualified Government Employees.

**Medicare for People with End Stage Renal Disease (ESRD)**

ESRD is a condition of the kidneys caused by many factors that require dialysis or a kidney transplant. It’s possible for a person to become eligible for Medicare based on having this diagnosis if he or she meets other criteria, including:
• Has been receiving dialysis for three months, or has been performing self-dialysis for one month, or has received a kidney transplant; and

• Is entitled to a monthly benefit under Title II or the Railroad Retirement Act, or is fully or currently insured, or has a spouse or is a dependent child of person who is entitled to a monthly benefit or is fully or currently insured.

To access Medicare based on the ESRD diagnosis, the person doesn’t need to receive a cash benefit from Social Security, meet the Social Security disability definition, or be a certain age. As a result, the requirements for establishing insured status for ESRD Medicare are much easier to meet than the requirements for cash disability benefits.

ESRD Medicare also has different rules for when the coverage begins and when it ends. ESRD Medicare usually begins with the third month after dialysis begins. Coverage can begin earlier if the person self-administers dialysis or was previously entitled to Medicare under the ESRD provisions. Coverage ends 12 months after dialysis stops or 36 months after a successful transplant. An important point for CWICs to know is that work activity doesn’t affect a person’s ongoing eligibility for ESRD Medicare.


Medicare Qualified Government Employees (MQGE)

Medicare Qualified Government Employees (MQGEs) are people who worked and paid taxes into the Medicare trust fund, but didn’t pay taxes into the Social Security trust fund. Medicare benefits for these individuals follow all of the same disability benefit rules that apply to benefits for people who paid Social Security taxes. For example, these individuals must wait 29 full calendar months from their disability onset date to become eligible for Medicare. This represents the five full months of the benefit waiting period plus the 24-month Medicare Qualifying Period (MQP). In addition, certain dependents may become entitled on MQGE work records. These dependents don’t receive cash payments, but if they meet the appropriate requirements for Medicare coverage, they may receive Medicare. People who receive Medicare coverage under the
MQGE can continue this coverage if they pass medical reviews and pay the Medicare premiums.

Unlike ESRD Medicare, work can affect Medicare eligibility for a MQGE. When the beneficiary’s Medicare entitlement begins, he or she is given a 9-month Trial Work Period (TWP). During the TWP the beneficiary keeps Medicare regardless of the amount he or she earns. After the TWP, if the beneficiary’s countable earnings are below the Substantial Gainful Activity (SGA) level, Medicare eligibility simply continues. If Social Security determines that the beneficiary is performing SGA, the Extended Period of Medicare Coverage (EPMC) extends the MQGE Medicare eligibility as it would for someone receiving SSDI payments. The EPMC is a work incentive that we will explain later in this unit.

**Medicare Qualifying Period**

The Medicare Qualifying Period (MQP) is different from the five-month Social Security disability benefit waiting period. The 24-month MQP begins with the first month the person is entitled to a payment after the five-month waiting period. Medicare coverage generally begins the first day of the 25th month of Title II disability benefit entitlement, with a few exceptions.

**Example of a Qualifying Period for a SSDI beneficiary:**

Denny had a spinal cord injury on November 10, 2016. Because the disability waiting period must be full calendar months, Denny’s five-month disability waiting period for SSDI was December 2016 through April 2017. His entitlement to SSDI began May 2017. Medicare coverage and entitlement begin for Denny on May 1, 2019, provided that Denny still has a disability that meets the Social Security rules.

When Social Security approves a beneficiary’s disability benefit years after applying, it’s possible that an individual may have met all or part of the 24-month qualifying period by the time cash benefits start being paid.
Example of a Qualifying Period for a SSDI beneficiary:

Frieda received the approval letter for her Social Security disability benefits in December 2017, after appealing her initial denial. The Disability Determination Service in the state where she lived determined that Frieda became disabled on March 15, 2015. Frieda’s five-month disability waiting period was April through August 2015. As a result, her first month of entitlement was September 2015. Even though Frieda didn’t receive cash payments until January 2017, the Medicare qualifying period began in September 2015, her first month of entitlement to payments. Frieda will be due Medicare coverage effective September 1, 2017, the first day of the 25th month after her entitlement to SSDI began.

The 24-month qualifying period doesn’t have to be served consecutively. If Social Security terminates an individual’s entitlement to cash benefits and re-entitles him or her within five years of the termination, the earlier months of entitlement may fully or partially meet the qualifying period for Medicare entitlement. If the disability is the same as or related to that of the earlier entitlement, it’s possible that the time period for re-entitlement without a new qualifying period could be indefinite.

Example of earlier entitlement helping to meet qualifying period:

Dorothy developed breast cancer and was entitled to Social Security Disability Insurance. Her date of onset was April 15, 2018. Her five-month disability waiting period was May through September 2018, and she became entitled to SSDI beginning in October 2017. In September 2019, Dorothy’s cancer was in complete remission, and she reported medical improvement. Social Security terminated her benefits in October 2019. At that point she had served 12 months of her Medicare Qualifying Period. If Dorothy becomes entitled to disability payments again within five years from the date Social Security terminated her benefits, she would only need to serve the last 12 months of the qualifying period for her Medicare coverage to begin.
Example of individual with same disability becoming re-entitled to benefits:

Frances was born with a severe physical disability. When she was 25, she became entitled to SSDI. She received benefits for five years, before working off of benefits in January 2011. In May 2020, Frances became re-entitled to SSDI based on the same disability. Because Frances was entitled to SSDI under the same disability, she didn’t have to again meet the 24-month Medicare Qualifying Period.

Beneficiaries continue to serve the MQP even when the beneficiary isn’t in cash payment status due to SGA level earnings during the Extended Period of Eligibility (EPE). There is a common misperception that if cash payments cease, beneficiaries also stop serving the MQP. In fact, there is no relationship between receipt of cash payments during the EPE and serving MQP months.

Example of qualifying period and the EPE:

Gary became disabled on January 1, 2017 due to an auto accident. Gary’s disability is permanent. His waiting period for SSDI benefits was January through May 2017. He became entitled to SSDI effective with the month of June 2017. In May 2018, Gary returned to work. Although Gary wasn’t due payments effective May 2019, his MQP was still running. His Medicare coverage began effective June 2019.

Medicare Qualifying Period for Childhood Disability Beneficiaries (CDB)

A Childhood Disability Beneficiary (CDB) can’t meet the MQP before his or her 20th birthday. Remember, the earliest CDB eligibility can begin is the month of the individual’s 18th birthday. That means the 24-month MQP clock can’t begin ticking until the month of the 18th birthday, at the earliest. As a result, the soonest the 24 month MQP could end for a Childhood Disability Beneficiary is the 20th birthday. Individuals who lose entitlement to CDB and whom Social Security re-entitles to CDB later won’t have to serve another 24-month qualifying period if the re-entitlement occurs within seven years.
Example of qualifying period for CDBs:

Michael has been disabled since birth. He turned 18 in January 2018. He was entitled to regular child’s benefits until December 2017, and became entitled to CDB benefits in January 2018. Even though Michael had a disability that began earlier, the qualifying period can’t begin until the month he turned 18. Michael will receive Medicare coverage in January 2020. (Note: There is never a five-month waiting period for CDB benefits.)

Medicare Qualifying Period for Disabled Widow(er)s Benefits (DWB)

Disabled Widow(er) Beneficiaries may meet the MQP through current entitlement to DWB benefits, or they may meet the MQP with prior entitlement to SSI benefits. People who receive DWB may continue to receive Medicare based on DWB eligibility, even if they are entitled to a different type of Title II cash benefit, such as early retirement, that doesn’t provide Medicare eligibility.

When a current or former SSI recipient becomes entitled (or deemed entitled for Medicare purposes only) to DWB, the DWB will receive credit toward the 24-month MQP for all months in an SSI period of eligibility beginning with the first month for which the individual received any payment up to the month of (deemed) DWB entitlement. All months count, including months of nonpayment, suspension, and termination. The same months of SSI/SSP that Social Security credits toward the five-month DWB waiting period the agency may also credit toward the 24-month MQP.

Example of qualifying period for DWB with no prior SSI entitlement:


Example of qualifying period for DWB with prior SSI entitlement:

Linda received SSI for several years then her ex-husband died in May 2019. Social Security used her prior SSI
entitlement to meet the qualifying period for Medicare. Linda’s Medicare coverage began in May 2019.

Example of qualifying period with DWB Medicare and Child-in-Care or Mother’s benefits:

Jane was 58 when her husband died in February 2018. Their youngest child was 15. Although Jane had a disability, it was financially to her advantage to receive benefits as a mother of a child under age 16, called Mother’s benefits or “Child-in-Care” benefits. Jane applied for Child-in-Care benefits and for Medicare under DWB. Even though Jane wasn’t previously entitled to Social Security benefits, Social Security was able to establish that her disability began nine months prior to application. Thus, Jane served her five-month waiting period prior to applying for both Mother’s and DWB benefits. Even though the disability began in the past, her cash benefits couldn’t be retroactive, since the month her husband died was the first possible month of payment for this benefit. Her MQP began with the first month of entitlement to Mother’s benefits, and her Medicare became effective two years later, in February 2020.

Exceptions to the Medicare Qualifying Period (MQP)

Individuals who become entitled to Title II disability benefits must complete the MQP before Medicare coverage may begin. There are some specific exceptions to this general rule, especially for people who were on disability benefits at some point in the past and subsequently Social Security re-entitled to benefits.

The 1980 Amendments to the Social Security Act made some important changes to the MQP rules. Beginning with December 1980, Social Security may count months from previous periods of disability benefit entitlement in determining when beneficiaries meet the 24-month MQP requirement under certain circumstances. This exception applies when one of the following situations occurs:

- A prior period of DIB entitlement ended no more than five years (60 months) before the month of current disability onset. This means that if an individual terminated from DI benefits no more than five years ago, and is now re-entitled to benefits, he or she can apply whatever months he or she served of the MQP from the previous period of entitlement to the current period of
entitlement. For many people, that means they have already served the MQP, and Medicare can start right away.

- A prior period of DWB or CDB entitlement ended no more than seven years (84 months) before the month of current disability onset. Again, this exception allows these individuals to apply any MQP months they served under the prior period of entitlement to the current period of entitlement. In many cases, the individuals will have served the full MQP in the past, and Medicare may begin immediately upon re-entitlement to benefits.

- The current disabling impairment is the same as, or directly related to, the impairment that served as the basis for disability during a previous period of disability benefit entitlement. This exception only applies to individuals whose prior period of entitlement ended after February 29, 1988.

- An individual whose previous disability entitlement ended for non-disability reasons prior to March 1, 1988 and is re-entitled to disability benefits with the same disability onset date. If the individual’s previous period of entitlement ended after February 29, 1988, prior months of entitlement may count under the preceding rule.

This information is available at [POMS HI 00801.152 - Counting Months in Reentitlement Cases](https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801152). This citation also gives some good examples that make these situations a little easier to understand. This citation is available online (https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801152).

There are also some additional circumstances when the MQP is either waived entirely or shortened for people who haven’t had a previous period of entitlement:

- Individuals with End Stage Renal Disease (ESRD) can apply for and receive Medicare coverage without waiting for a full disability review and entitlement to cash payments. This Medicare eligibility group is specifically designed for people with ESRD and has its own set of rules.

- Public Law 106-554 amended section 226 of the Social Security Act to waive the 24-month waiting period for Medicare coverage
for disabled individuals medically determined to have Amyotrophic Lateral Sclerosis (ALS), better known as Lou Gehrig’s disease. The date of Medicare entitlement is the date of entitlement to DIB, DWB, or CDB based on a diagnosis of ALS, or July 1, 2001, whichever is later. This provision affects both new and current beneficiaries.

- When a current or former SSI recipient becomes entitled (or deemed entitled for Medicare purposes only) to DWB, the DWB will receive credit toward the 24-month MQP for all months in an SSI period of eligibility beginning with the first month for which the individual received any payment up to the month of (deemed) DWB entitlement. All months count, including months of nonpayment, suspension, and termination. The same months of SSI/SSP that Social Security credits toward the five-month DWB waiting period the agency may also credit toward the 24-month MQP.

**WARNING:** There are some intricate Medicare rules for DWBs that aren’t described in this unit because they are relatively obscure. Remember, CWICs should always verify exactly what type of Title II disability benefits a person is receiving. When CWICs encounter DWBs with Medicare issues, they should contact their VCU NTDC Technical Assistance Liaison for assistance.

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**Medicare Enrollment Periods**

Eligible individuals may enroll in Medicare only at specific times. The Initial Enrollment Period (IEP) occurs when people first become eligible for Medicare. The General Enrollment Period (GEP) occurs annually, and a Special Enrollment Period (SEP) is provided to eligible individuals when certain changes occur with other health coverage. Social Security automatically enrolls disability beneficiaries in Medicare Parts A and B when they first become eligible for Medicare, except for residents of Puerto Rico and foreign countries.

**Initial Enrollment Program (IEP)**

The initial enrollment period is the first opportunity a person has to enroll in Medicare based on disability benefits or attainment of age 65. It’s a
seven-month period beginning three months before the first month of potential Medicare coverage and ending three months following that month. CMS sends out a Medicare card automatically. If an individual wants both parts of Medicare, he or she need only keep the card and Medicare Parts A and B coverage will begin automatically. If a person doesn’t want Medicare Part B, the individual returns the signed card to the sender. Returning the card indicates refusal of Part B coverage. During this time, an individual can choose to enroll in a Medicare Advantage Plan (Part C) and a Prescription Drug Plan (Part D).

**General Enrollment Period (GEP) or Open Enrollment Period**

Each calendar year eligible individuals who don’t have Medicare Part A or B may enroll during the General Enrollment Period (GEP). The GEP lasts from January 1 through March 31 of each year. When people enroll during the GEP, Medicare coverage begins the first day of July of the year in which the beneficiary made the request. Remember, if more than 12 months have elapsed between the time the person first could have received Medicare Part B and the time the beneficiary actually enrolls, the premium may be higher. For Medicare Parts C and D, an Open Enrollment Period occurs October 15 through December 7. And as with Part B, if a beneficiary doesn’t opt to enroll in Part D when he or she is first eligible, he or she could have a higher premium if he or she enrolls in Part D during this period.

**Special Enrollment Period (SEP)**

Once a beneficiary’s Initial Enrollment Period ends, he or she may have the chance to sign up for Medicare during a Special Enrollment Period (SEP). The SEP allows certain individuals to sign up for Part A and/or Part B at any time as long as they meet certain criteria.

To be eligible for a Special Enrollment Period, the individual must be enrolled in a group health plan (GHP) or large group health plan (LGHP) based on employment (the individual’s employment or the employment of a spouse). Individuals also have an 8-month SEP to sign up for Part A and/or Part B that starts at the earliest of these times:

- The month after the employment ends, or
- The month after group health plan insurance based on current employment ends.
In most cases, individuals who enroll in Medicare during an SEP do not have to pay a premium surcharge.

The SEP for Part C and D involves a different set of circumstances. The list of circumstances is provided in the CMS Publication “Understanding Medicare Part C and D Enrollment Periods” which can be found online (https://www.medicare.gov/Pubs/pdf/11219-Understanding-Medicare-Part-C-D.pdf).

**Annual Coordinated Election Period**

Medicare uses an additional annual election period for changes to Medicare Part D and Medicare Part C (Medicare Advantage plans). This is called the Annual Coordinated Election Period (ACEP). During the ACEP, Medicare beneficiaries may change prescription drug plans, change Medicare Advantage plans, return to original Medicare, or enroll in a Medicare Advantage plan for the first time. Starting in the fall of 2011, the ACEP each year will last from October 15 through December 7.

**NOTE:** If a beneficiary has Medicare and Medicaid, or is enrolled in the Part D Low-Income Subsidy Program (also known as “Extra Help”), he or she can join, switch, or drop a Medicare Advantage plan or a Medicare Part D plan at any time. We provide more information about the Low-Income Subsidy Program later in this unit.

**Medicare Work Incentives and When Medicare Ends**

Medicare entitlement for individuals with disabilities begins when the MQP is over. This is generally the first day of the 25th month of entitlement to cash benefits. That is the first month for which medical services providers can bill Medicare. Medicare offers no retroactivity of coverage, which means that beneficiaries can’t use Medicare to cover medical bills they incur prior to the initial month of coverage.

**When Medicare Ends**

Medicare coverage will stop if an individual ceases to meet the Social Security disability standard. In most cases, the earliest Medicare coverage can stop is the month after the month the person receives the
notice that Social Security has terminated his or her disability benefits. There is no retroactivity to the Medicare termination. Medicare coverage will also end if a beneficiary fails to pay premiums.

When Title II disability beneficiaries turn 65 years of age, the Medicare entitlement based on disability ends and Medicare eligibility based on age begins. There is no break in coverage, and beneficiaries don’t have to re-enroll in Medicare. If the beneficiary had any premium penalties, those wouldn’t carry into this new period of entitlement. Employment does not affect Medicare entitlement based on age.

**Medicare and Work**

Beneficiaries of the Title II disability programs often believe that Medicare entitlement stops when cash payments stop. In fact, there are two work incentives built into the Medicare program that, when combined, permit beneficiaries to retain Medicare for an indefinite period if they continue to have a disability after cash payments stop due to work activity.

The first Medicare work incentive is called Extended Period of Medicare Coverage (EPMC). Provided that the disabling condition continues, individuals who lose cash payments due to SGA-level work can use EPMC to retain premium-free Medicare Part A, as well as the option to have Part B, Part C, and Part D coverage, for at least 93 months after the end of the Trial Work Period. In many cases, the period will be longer.

Once beneficiaries exhaust the EPMC, they may continue Medicare coverage through the second work incentive, Premium-HI for the Working Disabled. This second work incentive has no time limit, but the individual must continue to have a disability and must begin paying (or get assistance paying) the Part A premium.

**Extended Period of Medicare Coverage (EPMC)**

The Ticket to Work and Work Incentives Improvement Act of 1999 made an important change to the Medicare program for working beneficiaries with disabilities. It significantly extended the amount of time beneficiaries who lose entitlement because of substantial work may receive Medicare. The rule, referred to as the Extended Period of Medicare Coverage (EPMC), applies to anyone who currently has Medicare coverage based on disability benefits, provided that the disabling condition continues. Social Security made some additional changes to
and clarifications of the EPMC several years after the Ticket legislation passed. The following rules became effective on November 23, 2004:

“If an individual’s entitlement to disability benefits ends because he or she engaged in, or demonstrated the ability to engage in Substantial Gainful Activity after the 36 months following the end of the trial work period, Medicare entitlement continues until the earlier of the following:

• The last day of the 78th month following the first month of Substantial Gainful Activity occurring after the 15th month of the individual’s re-entitlement period or, if later,

• The end of the month following the month the individual’s disability benefit entitlement ends.”

Centers for Medicare & Medicaid Services 42 CFR, Part 406, Federal Register: September 24, 2004 (Volume 69, Number 185, Pages 57224-57225).

While this might sound complicated, in practice it’s actually fairly straightforward. To begin with, CWICs need to understand that the EPMC involves several key time periods:

• The end of the TWP;

• The first 15 months of the EPE;

• The cessation month; and

• The 78 months of the EPMC.

The opening paragraph states that the EPMC provides at least 93 months of coverage after the end of the TWP, and this 93-month figure is derived from the time periods listed above. Historically, Medicare coverage only extended to 15 months of the EPE. Congress has extended this original 15-month rule several times over the years, but because of the way the laws are written, Social Security has to use this original limit when counting months for EPMC purposes. Because of this, under the current EPMC rules, the EPMC period will never begin earlier than the 16th month of the EPE.

The current rules added 78 months of Medicare coverage after this original 15 months for a total of at least 93 months. The 93-months number represents the fewest number of months a person will have Medicare if his or her cash benefit stops due to work and he or she
continues to have a disability. The period can be longer (and often is much longer) depending on when the Cessation month occurs.

**Cessation prior to 14th month of EPE:** If cessation occurs prior to the 14th month of the EPE, there are two possibilities for when the EPMC will end:

1. If SGA also occurs in the 16th month of the EPE, EPMC will end 93 months after the TWP. The beneficiary must continue to have a disability throughout this period.

2. If SGA doesn’t also occur in the 16th month of the EPE, EPMC will end 78 months from the first SGA month that occurs after that 16th month. The beneficiary must continue to have a disability throughout this period.

**Cessation on or after the 14th month of the EPE:** If cessation occurs on or after the 14th month of the EPE, EPMC will end 78 months after the Grace Period. The beneficiary must continue to have a disability throughout this period.

We provide a decision tree at the end of this unit that provides a visual representation of the EPMC process. Additionally, you can refer to the requirements in [POMS HI 00820.025 Termination of Disability HI](https://secure.ssa.gov/poms.nsf/lnx/0600820025).

**Example of EPMC lasting for the minimum of 93 months:**

Kali goes to work in January 2018. Kali completes his TWP nine months later in September 2018. His cessation month occurs in December 2018, prior to 14th month of the EPE. Kali continues to earn above SGA for the next 10 years. Kali’s SSDI benefits terminate after the 36-month EPE, but he has EPMC coverage for 93 months from the end of his TWP.

What would make Kali’s Medicare continue past those first 93 months?

- If Kali became entitled to payments again during the EPE, and continued to be due payments indefinitely, his Medicare would also be indefinite.
- If Kali stopped working and requested Expedited Reinstatement, or reapplied for benefits within five years of termination, his Medicare would also last longer than 93 months.
Predicting the exact end of the EPMC is impossible unless three events have occurred:

1. The TWP has ended;
2. Cessation has occurred; and
3. The person is past the 16th month of the EPE.

An important point for CWICs to emphasize is that as long as a beneficiary remains entitled to Title II disability payments, Medicare coverage will continue. If an individual completed his or her TWP and more than 15 months have passed since that time, then Medicare eligibility will continue for at least 78 months after the last cash payment is due.

**Examples of EPMC lasting longer than 93 months:**

- **Example 1:** Connie started working in March 2016 earning above the Trial Work Period threshold but below SGA. In month 30 of her EPE she began doing SGA-level work. Connie’s Medicare will last at least 78 months after the last grace month. If she is re-entitled, however, she will have Medicare as long as she is due a payment, even if it’s for the rest of her life.

- **Example 2:** Kelly completed her Trial Work Period in 2001. She has worked since then, but has never performed Substantial Gainful Activity. Kelly will continue to have Medicare as long as she is entitled to a disability payment. When she performs SGA, she would be due payments for her cessation and grace months, and then she would have Medicare at least another 78 months through the EPMC.

Keep in mind that it’s impossible to know exactly when a beneficiary’s EPMC would end if the beneficiary hasn’t yet engaged in SGA. The EPMC months don’t begin to count until the TWP is over, SGA work has occurred, and Social Security has established the cessation month.

It’s important to understand that the EPMC is a work incentive for Title II disability beneficiaries. It’s afforded to individuals who have lost cash benefits due to work. It’s NOT a way to keep Medicare when beneficiaries lose benefits due to medical recovery. People in the EPMC must still meet the Social Security disability requirement, even though these individuals may not be due cash payments.
**EPMC Complications**

When advising beneficiaries about Medicare continuation, remember that Social Security is the only place to find out how long the coverage will last. The beneficiary may not know when or if the TWP ended, whether cessation has occurred, or even that work should have caused benefit termination. Some beneficiaries may have used most or all of their EPMC in the past without even realizing it.

Because performance of Substantial Gainful Activity is so important to the length of time someone has EPMC, CWICs should always remember that SGA is a decision, and work that appears to be SGA may not end up being SGA. For example, someone may begin performing work at a high enough level that, at first, may appear to be SGA. SGA, however, represents sustained work effort valued above a certain amount. Thus, if the work effort is short, and ends because of the person’s disability, the person may actually have an Unsuccessful Work Attempt. In these situations, Social Security may go back and reverse the cessation, because the person wasn’t performing SGA, which could have a direct effect on calculating the end of the EPMC.

**Extended Medicare and Expedited Reinstatement**

Because the EPMC is a work incentive, people must still meet the medical disability criteria for Social Security to entitle them. This creates a potential risk for individuals who request Expedited Reinstatement (EXR). There are two standards Social Security uses to determine disability status. One, used for new applications, is tougher because the burden of proof lies with the applicant. The other standard, called the Medical Improvement Review Standard (MIRS), Social Security uses in both medical Continuing Disability Reviews and EXR.

Requesting Expedited Reinstatement when Social Security has medically denied the beneficiary is the same as the beneficiary having a medical CDR when receiving benefits and Social Security finding that person to have medically improved. When medical improvement occurs, all work incentives, including the EPMC, stop. If losing Medicare is a concern, the person may want to reapply for benefits instead of requesting EXR. Denial of a reapplication wouldn’t affect Medicare entitlement, because the application process uses a different disability standard. The decisions aren’t equivalent. For a further discussion of this topic, refer to unit 9 of Module 3.
Medicare Premiums during the EPMC

Under the EPMC provision, Medicare Part A continues to be premium-free, while Medicare Parts B, C, and D continue to have a monthly premium. Beneficiaries usually pay their Medicare Part B premiums by having Social Security deduct them from cash benefits. When no cash benefits are payable, the person receives a bill for Medicare premiums. There are four ways to pay the Medicare bill. The beneficiary can:

1. Pay directly from his or her bank account through the bank’s online bill payment service.

2. Sign up for Medicare Easy Pay, which is a free service that automatically deducts the premium payments from the beneficiary’s savings or checking account each month (https://www.medicare.gov/your-medicare-costs/ways-to-pay-part-a-part-b-premiums/medicare-easy-pay).

3. Pay by check or money order to: Medicare Payment Collection Center, P.O. Box 790355, St. Louis, MO, 63179-0355.

Pay by credit or debit card by creating a MyMedicare.gov online account. Beneficiaries need a copy of the Medicare bill to enter the amount owed and credit/debit card information. Beneficiaries who use this option get a confirmation number when they make the payment. The credit/debit card statement will show a payment made to "CMS Medicare."

You can read more about Medicare payment options online (https://www.medicare.gov/your-medicare-costs/paying-parts-a-and-b/pay-parts-a-and-b-premiums.html).

If a beneficiary has an employer group health plan, or is covered by an employer group health plan from a spouse’s work, he or she may wish to opt out of the Medicare Part B coverage until:

- The beneficiary’s or spouse’s employment stops;
- The beneficiary’s or spouse’s insurance becomes secondary to Medicare; or,
- The insurance coverage terminates.
In these circumstances, eligible individuals can re-enroll for Medicare Part B coverage during the Special Enrollment Period (SEP). Individuals who are not eligible for the SEP may be subject to a premium surcharge penalty. The beneficiary should check with the employer-sponsored health plan before opting out of Part B, as some plans require a person to keep Part B.

Another common scenario is that the person may be eligible for financial assistance with the Part B premium, such as through a Medicare Savings Program. A person using EPMC to maintain Medicare will have lost the Title II benefit check, which means he or she potentially has countable income low enough to continue getting help through the Medicare Savings Program. In this case, the beneficiary won’t have to pay the Part B premium.

**CWIC Responsibilities in EPMC Cases**

EPMC can be very complex. A CWIC may not have enough information about the person’s work history, nor sufficient expertise to determine the exact end of the EPMC. In addition, a CWIC can’t predict the future. Will the person again become entitled to benefits? Will there be a decision of medical improvement? Will the individual keep working? The best plan is to stress the positive aspects of the EPMC in general terms. The points CWICs need to make are:

- Medicare will continue for AT LEAST 93 months after the TWP ends no matter how much a beneficiary earns. CWICs should communicate this to beneficiaries who are still within the first 15 months of their EPE.

- Beneficiaries currently entitled to Medicare will have AT LEAST 78 months of Medicare coverage after cash benefits end due to SGA level employment. CWICs should communicate this to beneficiaries who are outside the first 15 months of the EPE and didn’t cease during the first 15 months.

- Individuals who work but who never engage in SGA will maintain their Medicare coverage simply because of ongoing receipt of the cash benefit.
**Premium-HI for the Working Disabled**

Keep in mind that during the EPMC, Medicare Part A continues to be premium-free. At the end of the EPMC, if a person is not receiving the Title II cash benefit because of SGA level work, it’s possible for eligible individuals to continue Medicare coverage (all parts) by “buying into” the Medicare program. This provision is referred to as “Premium-HI for the Working Disabled.”

Essentially, this work incentive allows disabled, working individuals to enroll in Medicare Part A alone, or in both Part A and Part B, as well as Part D, by paying the monthly premiums. An individual who qualifies for this provision may continue to “buy into” Medicare for as long as he or she continues to have a disabling impairment.

To enroll in Premium-HI for the Working Disabled, an individual must be under age 65, and:

- Have lost entitlement to premium-free Medicare Part A solely because he or she was engaging in SGA;
- Continue to have a disabling physical or mental impairment; and
- Be ineligible for Medicare on any other basis.

An individual may not enroll in Medicare Part B under this provision without also enrolling in Part A. There is no provision that allows individuals to only purchase Medicare Part B. Individuals may purchase Part A by itself, or may purchase both Part A and Part B.

An individual may enroll in Premium-HI for the Working Disabled during any Medicare enrollment period: the Initial Enrollment Period, the General Enrollment Period, or during a Special Enrollment Period. The Part A premium for the Working Disabled isn’t subject to increases for late enrollment. The Part B premium under the Premium-HI for the Working Disabled provision is subject to increases for late enrollment following normal Part B premium increase rules. If an individual were paying an increased Part B premium during the last month of premium-free Part A, but enrolls for SMI under the Working Disabled provision during his or her Initial Enrollment Period, the Part B premium reverts to the standard rate, and the surcharge disappears.

Premium-HI for the Working Disabled continues until the earliest of the following points in time:
• End of the month following the month Social Security notifies the individual that he or she no longer has a disabling impairment;

• End of the month following the month the individual files a request for termination of Premium-HI;

• End of the month before the month the individual becomes re-entitled to premium-free HI. In this case, Part B coverage continues without interruption. (The amount of the Part B premium reverts to the standard amount, effective with the first month of re-entitlement to premium-free HI, if the individual was paying a rate increased for late enrollment.);

• End of the grace period for non-payment of premiums; or

• Date of death.

**IMPORTANT:** Re-entitlement to disability benefits by an individual required to serve a new 24-month MQP doesn’t result in termination of Premium-HI for the Working Disabled. Premium-HI entitlement continues until the individual becomes re-entitled to premium-free Part A based on meeting the 24-month qualifying period requirement.

The 2020 Medicare Part A premium is $458 per month. The Part A premium reduces by 45 percent (to $252 in 2020) if beneficiaries:

• Have 30 or more quarters of coverage on their own earning record; or

• Have been married for at least 1 year to a worker with 30 or more quarters of coverage; or

• Were married for at least 1 year to a deceased worker with 30 or more quarters of coverage; or

• Are divorced, after at least 10 years of marriage, from a worker who had 30 or more quarters of coverage at the time the divorce became final.

States are required to pay Part A (but not Part B) premiums under a type of Medicare Savings Program called Qualified Disabled and Working Individuals (QDWI). To be eligible for this program the individual must have limited income and resources and not meet qualifications for
Medicaid. The QDWI resources standard is twice the SSI standard ($4,000 for an individual and $6,000 for an eligible couple), and countable family income may not exceed 200 percent of the current federal poverty guidelines. Resources and income are usually counted according to the SSI rules.

**Medicare and Other Forms of Insurance**

When individuals have multiple forms of insurance, Medicare usually operates as the primary insurer, paying all possible medical expense first. In some circumstances Medicare is the secondary payer.

**Medicare and Medicaid**

Medicare usually pays first when an individual has both Medicare and Medicaid coverage, because Medicaid is considered the payer of last resort. Medicaid pays for the remaining expenses that are within the confines of the Medicaid coverage rules for that state. For example, if both Medicare and Medicaid cover a service, then Medicare would pay for its approved portion and Medicaid would pick up the remaining amount, assuming it’s within the coverage rules for that state. Given the nature of this arrangement, Medicaid often ends up paying the Medicare deductible and co-insurance for Part A and B. If Medicaid doesn’t pay the full amount of the co-insurance, healthcare providers may not seek remaining payment from beneficiaries.

**Medicare and VA Health Benefits**

Most of the veterans who are under the age of 65 and who receive Medicare have become eligible for Medicare through the SSDI program. SSDI beneficiaries become eligible for Medicare in the month after receiving 24 months of SSDI cash benefits. Veterans with both Medicare and VA health benefits can choose which health coverage to use when they receive care. The veteran can either receive care at a VA facility or choose to use Medicare by seeing a provider outside of the VA system. In general, the two health care programs are independent, and there is no coordination of benefits. When a veteran uses Medicare, he or she is responsible for all Medicare premiums, deductibles, and coinsurance. When the veteran receives care through the VA, Medicare won’t pay anything. The only instance in which both Medicare and the VA can pay for services is when the VA authorizes services in a non-VA hospital. In
this case, if the VA doesn’t pay for all of the medical services the veteran received during the stay, Medicare can pay for the Medicare-covered part of the services for which the VA doesn’t pay. Also, if a doctor or hospital that isn’t part of the VA system bills a veteran for VA-authorized care, Medicare may pay all or part of the co-pays for these services.

When veterans are considering whether to decline or unenroll from Medicare Part B, they should carefully explore all options before making a decision. If a veteran doesn’t enroll in Medicare Part B when it’s first available, the veteran will have to pay a late enrollment penalty if he or she later decides to enroll in Part B. Having VA healthcare benefits won’t make him or her exempt from this penalty. However, if a veteran declines Part B coverage because he or she is covered by a group health plan based on current employment, there will be no late enrollment penalty if he or she enrolls in Part B later.

REMEMBER: The Part B late enrollment penalty is 10 percent of the current Part B premium for every 12-month period that the veteran delays enrollment. In addition, the veteran may have to wait to enroll in Part B. As a rule, beneficiaries can only enroll in Part B during the General Enrollment Period (January 1 to March 31). Part B coverage will then become effective on July 1 of that year. For this and other reasons, the VA strongly encourages veterans with VA healthcare benefits to maintain other types of health insurance, including Medicare and Medicaid. Funding set aside by Congress for the VA changes each year. It’s possible that veterans in lower priority groups could lose their eligibility for VA healthcare benefits when this funding decreases. Veterans should be careful about choosing to end other health insurance solely because they have VA healthcare benefits. For more information about healthcare options for veterans, see unit 3 of this module.

Medicare Part D is a different story. CMS considers VA healthcare to be “creditable coverage” for Part D. As a result, the veteran could choose to opt out of Part D and avoid paying a penalty if he or she decides to take it at some point in the future. In making this decision the veteran will need to decide whether the VA prescription drug coverage is sufficient to meet his or her needs.
Medicare and Other Forms of Health Insurance

A beneficiary may have other forms of health insurance in addition to Medicare. For example, a young adult receiving SSDI and Medicare may still be eligible for his or her parents’ health insurance, or an SSDI beneficiary who is married may be eligible based on his or her spouse’s employer-based health insurance. In some cases Medicare will pay first, and in other cases it will be the secondary payer. Other forms of insurance that may pay first include the following:

- Employer or union group health plan coverage (when coverage is based on the beneficiary’s or a family member’s current employment):
  - If the beneficiary is under age 65 and disabled, Medicare is secondary if the employer has 100 or more employees.
  - If the beneficiary is over age 65 and still working, Medicare will be secondary if the employer has 20 or more employees.
- Employer or union group health plan coverage (as described above), regardless of size and regardless of current employment status, for 30 months if the individual has Medicare because of ESRD.
- No-fault insurance (including automobile insurance)
- Liability insurance (including automobile insurance)
- Black-lung benefits
- Workers’ compensation

Individuals who have other forms of insurance in addition to Medicare need to inform their healthcare providers (i.e., doctors, hospitals, and pharmacies) to make sure that they pay medical bills correctly. Rules about which insurance pays first are called primary payer rules, but Medicare also uses the term “Coordination of Benefits” when referring to this issue. For questions about who pays first, individuals can read “Medicare and Other Health Benefits: Your Guide to Who Pays First” (https://www.medicare.gov/Pubs/pdf/02179-Medicare-Coordination-Benefits-Payer.pdf). This is an easy-to-read publication by CMS that explains Coordination of Benefits between Medicare and other
types of health coverage. Beneficiaries can also contact Medicare’s Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782.

**IMPORTANT POINT:** If a beneficiary’s employer offers health insurance, you should advise the beneficiary to talk with the human resources department at his or her place of employment about the coordination with Medicare. Some employer health insurance policies require enrollees to keep or take Medicare if they can get it, while other employers don’t have such a requirement. CWICs should be prepared to refer beneficiaries to SHIP to talk through their options.

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**Medicare Savings Programs - Financial Assistance Program #1**

As explained in the first part of this unit, there are a number of out-of-pocket expenses for Part A and B. Congress created the jointly funded (federal and state) Medicare Savings Programs (MSPs) to help low income Medicare beneficiaries pay for some or all of the Part A and B out-of-pocket expenses.

At the federal level, CMS provides regulatory oversight of the MSPs (e.g., guidance and policy interpretation). A designated state agency, that is, usually the agency administering Medicaid, is responsible for administering the MSPs. That means if a beneficiary were interested in applying for a Medicare Savings Program, he or she would generally do so the same way he or she applies for Medicaid in his or her state. The Medicaid agency is also the agency that generally conducts redeterminations to evaluate ongoing eligibility. It’s important to note that in some states this program isn’t called the Medicare Savings Program, but may instead go by a different name.

Because the federal government partially funds the MSPs, the state must follow certain federal regulations. Federal regulations require states (including 209(b) states) to use the SSI income and resource methodologies to determine countable income and countable resources. States may choose to use less restrictive rules, but aren’t allowed to use more restrictive rules than SSI. Because states have some discretion in
setting eligibility rules, CWICs must locate the state-specific details of the MSP eligibility criteria. Most states have a policy manual outlining the MSP eligibility details. CWICs are advised to locate a copy of that manual (online or paper).

To be eligible for a MSP, beneficiaries must have countable income below income limits set by the state Medicaid agency. The laws enacting the Medicare Savings Program established specific percentages of the FPL as the income limits for the MSPs, but some states have opted to use higher amounts.

**Understanding Federal Poverty Levels (FPLs)**

The U.S. Department for Health and Human Services (DHHS) establishes annual poverty guidelines that are widely used as a poverty measure for administrative purposes — for instance, when determining financial eligibility for certain federal or state programs. The poverty guidelines are often loosely referred to as the “federal poverty level” (FPL).

The FPL amounts are based on family size. For example, in 2019 the FPL for a family size of one was $12,490 ($1,040 per month) and for a family size of two it was $16,910 ($1,409 per month). Each year, there is one set of FPL figures for the 48 contiguous states and another set with higher figures for Alaska and Hawaii. The FPLs (or percentages of them) are consistently used as a standard for income eligibility for various Medicaid programs so we reference them repeatedly throughout this Module. The examples in this Module use the 2019 FPLs because DHHS doesn’t publish updated FPLs until January or February of each year. CWICs will need to research the 2020 FPLs at that time. More information about the FPLs is available at the DHHS web site (https://aspe.hhs.gov/poverty-guidelines).

In addition to countable income falling below the required limits, countable resources must be below certain limits. Beginning January 2010, as a result of the Medicare Improvements for Patients and Providers Act (MIPPA), three of the MSP resource limits aligned with the resource limits for the Low Income Subsidy (LIS) program. Some states...
have opted to use higher resource limits than those used by the LIS program, while other states have no resource limits at all. As a result, CWICs must research the details about MSP eligibility in their states.

The MSP includes four separate programs:

1. Qualified Medicare Beneficiary (QMB),
2. Specified Low-Income Medicare Beneficiary (SLMB),
3. Qualifying Individual (QI), and
4. Qualified Disabled Working Individual (QDWI).

As a reminder, a given state may use different names for some or all of these programs, so CWICs need to research the appropriate term to use.

Below is a chart summarizing the basic details of these programs for 2020.

<table>
<thead>
<tr>
<th>Program</th>
<th>Income Limit</th>
<th>Resource Limit</th>
<th>How It Helps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Medicare Beneficiary (QMB)</td>
<td>100% Federal Poverty Level</td>
<td>$7,860 single, $11,800 couple</td>
<td>Pays Part A and B premiums, deductibles, co-insurance, and co-payments</td>
</tr>
<tr>
<td>Specified Low-Income Medicare Beneficiary (SLMB)</td>
<td>120% Federal Poverty Level</td>
<td>$7,860 single, $11,800 couple</td>
<td>Pays Part B premium only</td>
</tr>
<tr>
<td>Qualifying Individual (QI)</td>
<td>135% Federal Poverty Level</td>
<td>$7,860 single, $11,800 couple</td>
<td>Pays Part B premium only</td>
</tr>
<tr>
<td>Program</td>
<td>Income Limit</td>
<td>Resource Limit</td>
<td>How It Helps</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>----------------------------------</td>
<td>------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Qualified Disabled Working Individual (QDWI)</td>
<td>200% Federal Poverty Level</td>
<td>$4,000 single, $6,000 couple</td>
<td>Pays Part A premium only</td>
</tr>
</tbody>
</table>

It's important to point out these programs don't help with the Medicare Part D out-of-pocket expenses; a separate program called Low Income Subsidy, which will be covered later in this unit, covers those. Additionally, Medicare Savings Programs don't cover Medigap or Medicare Advantage premiums.

**Qualified Medicare Beneficiary (QMB)**

Of the four Medicare Savings Programs, QMB (sometimes referred to as "quimby") provides the most support. If a Title II disability beneficiary is eligible for QMB, the State Medicaid agency will pay his or her Part B premium as well as any Part A and B deductibles and co-insurance. To be eligible, the beneficiary must:

- Have Medicare Part A;
- Have countable income at or below 100 percent of the current FPL (or a higher limit set by the state);
- Have countable resources below $7,860 for a single person, $11,800 for a couple in 2020 (or a higher limit set by the state); and
- Meet the general nonfinancial requirements or conditions of eligibility for Medicaid in his or her state (e.g., citizenship, residency)

**NOTE:** Those eligible for Medicare under Premium-HI for the Working Disabled can’t use QMB.

As noted earlier, to determine countable income the state Medicaid agency must use the SSI income methodology, unless CMS has approved a more liberal method. That means applying the $20 General Income
Exclusion to determine countable unearned income, and applying all the SSI earned income exclusions when calculating countable earned income. If the resulting total countable income is below 100 percent of the FPL (or a higher limit set by the state), then the individual would get QMB. Below is an example of how the State Medicaid agency would calculate countable income using the SSI income and resource methodology.

**Example of person who is eligible for QMB:**

Sylvia receives $874 per month of SSDI, has $2,500 in resources, and has just been notified she has completed her Medicare Qualifying Period and her eligibility for Medicare will start in three months. She explains that she can’t afford to have the Part B premium deducted from her SSDI check and doesn’t think Medicare will be useful because she won’t be able to pay the deductible and co-insurance. Could Sylvia be eligible for QMB?

Using the SSI deductions, it appears Sylvia will be below 100 percent of the FPL. Her unearned income is $874; after deducting the $20 General Income Exclusion, her countable unearned income is $854. She doesn’t have any earned income, so her total countable income is $854 per month. One hundred percent of the FPL for a single person is $1,040 per month (2019 rate). Sylvia’s countable income is below that level. Because her resources are below $7,860 she would likely be eligible for QMB, assuming she meets all the nonfinancial requirements of the State’s Medicaid program.

The Department of Health and Human Services (DHHS) publishes the FPL figures annually, usually by mid-February. Cost of Living Adjustments (COLAs) go into effect in January. As a result, COLAs for Title II benefits are disregarded in determining countable income for QMB purposes at least through the month following the month in which the annual FPL update is published. Concerning resources, the MSPs use the same resource methodology as SSI, unless CMS has approved a more liberal method. For summary information about countable resources and what resources Social Security excludes under SSI, refer to Unit 5 of Module 3.

When the State Medicaid agency finds a beneficiary eligible for QMB, the state records that information in a data system (known as the SDX) that
is shared with Social Security. Social Security will then stop deducting the beneficiary’s Part B premium from his or her Title II disability benefit check. As a QMB, the beneficiary will also get help paying his or her Part A and Part B deductibles, co-insurance, and co-payments. Generally, the State Medicaid agency will issue the beneficiary a Medicaid card. This doesn’t mean the beneficiary has full Medicaid coverage. Instead, the beneficiary receives this card to give to medical providers, so they know to bill the state for the Part A and B deductibles and co-insurance. Given this involvement by the Medicaid agency, some states refer to QMB eligible individuals as “Limited Medicaid Beneficiaries.” It’s very important to understand that MSPs don’t give beneficiaries access to the full array of Medicaid State Plan services or long-term care waivers. Instead, they have access to Medicare-covered services, and the state Medicaid agency is using the Medicaid billing system to pay the Part A and B deductible, co-payments, and co-insurance. A person must meet the criteria for a Medicaid eligibility group to get Medicaid State Plan services. See unit 1 of this module for information about Medicaid eligibility.

A determination that an individual is a QMB is normally effective for a period of 12 months. However, a state may make redeterminations more frequently than every 12 months, as long as the state doesn’t make them more frequently than every six months. This limitation on the frequency of redeterminations doesn’t apply in situations where the state becomes aware of an actual change in the beneficiary’s situation that could affect eligibility.

**QMB and Medicaid:** It’s important to understand that beneficiaries receiving QMB may also have full Medicaid coverage because they meet the eligibility criteria for a Medicaid eligibility group. In fact, many concurrent beneficiaries getting both SSI and Title II disability benefits have Medicare, Medicaid, and QMB coverage. QMB and Medicaid are similar in some ways and different in other ways:

<table>
<thead>
<tr>
<th>Program</th>
<th>Full Medicaid State Plan Services</th>
<th>Pays Part A and B deductibles and co-insurance</th>
<th>Part B Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>QMB</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Program</td>
<td>Full Medicaid State Plan Services</td>
<td>Pays Part A and B deductibles and co-insurance</td>
<td>Part B Premium</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------------</td>
<td>-----------------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Medicaid</td>
<td>Yes</td>
<td>Yes</td>
<td>Maybe (see the note below) on below</td>
</tr>
</tbody>
</table>

**NOTE:** In some states, if a person is over the income limits for the Medicare Savings Programs but is Medicaid eligible, the state will pay the Part B premium. Some states impose an income limit on providing this assistance or limit this assistance to select Medicaid eligibility groups. When a state chooses to pay the Part B premium for someone over the MSP income limit, the state is sometimes using 100 percent state funds to do so because the person isn’t eligible for the jointly funded federal and state Medicare Savings Programs. Some states have determined that it’s financially worthwhile to pay the Part B premium with state funds because it will assure the person has Medicare Part B, which reduce Medicaid costs. Other states haven’t made that determination and choose not to offer this assistance.

It’s critical that CWICs clarify if their state pays Part B premiums for dual eligible individuals (Medicare or Medicaid eligible) who are over the income limits for MSP eligibility. If that’s the case, when a beneficiary goes to work, if he or she remains or becomes eligible for Medicaid (such as through the Medicaid Buy-In), he or she will experience no loss in financial assistance for Part A and B when his or her eligibility for QMB ends. Looking at the chart above, all the financial assistance QMB provides is provided by Medicaid.

**Specified Low - Income Medicare Beneficiaries (SLMB)**

Someone eligible under SLMB (also referred to as “slimby”) will get help paying his or her Part B premium. To be eligible, the beneficiary must:

- Have Medicare Part A;
• Have countable income above 100 percent but at or below 120 percent of the current FPL (or a higher limit set by the state);
• Have countable resources below $7,860 for a single person, $11,800 for a couple in 2020 (or a higher limit set by the state); and
• Meet the general nonfinancial requirements or conditions of eligibility for Medicaid in his or her state (e.g., citizenship, residency).

**NOTE:** Those eligible for Medicare under Premium-HI for the Working Disabled can’t use SLMB.

To determine eligibility for SLMB, the states must use the SSI income methodology, unless they have been approved to use a more liberal method. That means applying the $20 General Income Exclusion to determine countable unearned income, and applying all the SSI earned income exclusions when calculating countable earned income. If the resulting total countable income were above 100 percent but at or below 120 percent of the FPL (or a higher limit set by the state), then the individual would get SLMB. Below is an example of how the states would calculate countable income, using the SSI income and resource methodology.

**Example of person who is eligible for SLMB:**

Bruce receives $1,126 per month of SSDI, has $5,500 in resources, and has just been notified Medicare will be starting. Could Bruce be eligible for SLMB?

Using the SSI deductions, it appears Bruce’s countable income will be below 120 percent of the FPL. His unearned income is $1,126; after deducting the $20 General Income Exclusion, his countable unearned income is $1,106. He doesn’t have any earned income, so his total countable income is $1,106 per month. A hundred twenty percent of the FPL for a single person is $1,249 per month (2019 rate). Bruce’s countable income is below that level. Because his resources are below $7,860, he would likely be eligible for SLMB, assuming he meets all the nonfinancial requirements of the state’s Medicaid program.
The COLA deduction explained under QMB also applies to SLMB. Additionally, when a beneficiary is eligible for SLMB, the state records that information in a data system that is shared with Social Security. Social Security will then stop deducting the beneficiary’s Part B premium from his or her Title II disability benefit check.

**Qualifying Individuals (QI)**

Someone eligible under QI will get help paying his or her Part B premium. To be eligible, the beneficiary must:

- Have Medicare Part A;
- Have countable income above 120 percent but at or below 135 percent of the current FPL (or a higher limit set by the state);
- Have countable resources below $7,860 for a single person, $11,800 for a couple in 2020 (or a higher limit set by the state); and
- Meet the general nonfinancial requirements or conditions of eligibility for Medicaid in his or her state (e.g., citizenship, residency); and
- Be ineligible for Medicaid.

*Note:* Those eligible for Medicare under Premium-HI for the Working Disabled can’t use QI.

To determine eligibility for QI, the states must use the SSI income methodology, unless CMS has approved a more liberal method. That means applying the $20 General Income Exclusion to determine countable unearned income, and applying all the SSI earned income exclusions when calculating countable earned income. If the resulting total countable income were above 120 percent but at or below 135 percent of the FPL (or a higher limit set by the state), then the individual would get QI. Below is an example of how the states calculate countable income, using the SSI income and resource methodology.

**Example of person who is eligible for QI:**

Andrew receives $1,300 per month of SSDI, has $6,000 in resources, and has just been notified Medicare will be starting. Could Andrew be eligible for QI?
Using the SSI deductions, it appears Andrew’s countable income will be below 135 percent of the FPL. His unearned income is $1,300; after deducting the $20 General Income Exclusion, his countable unearned income is $1,280. He doesn’t have any earned income, so his total countable income is $1,280 per month. One hundred thirty-five percent of the FPL for a single person is $1,406 per month (in 2019). Andrew’s countable income is below that level. Because his resources are below $7,860, he would likely be eligible for QI, assuming he meets all the nonfinancial requirements of the state’s Medicaid program.

The COLA deduction explained under QMB and SLMB also applies to QI. Additionally, when a beneficiary is eligible for QI, the state records that information in a data system that is shared with Social Security. Social Security will then stop deducting the beneficiary’s Part B premium from their Title II disability benefit check.

Many CWICs wonder what the difference is between SLMB and QI, aside from the income limit. From the beneficiary’s perspective, there is one key difference. A person who has Medicaid can use SLMB but can’t use QI. The other differences are all administrative. QI is a federal block grant program, so funding is based on availability of grant funds. If a state runs out of the block funds, it could close enrollment in QI until new grant funds are available. Another administrative difference is the match rate; the percentage the federal government pays for the QI program is different from the SLMB program.

**QMB, SLMB, QI, and Earnings**

Because QMB, SLMB, and QI are all financial needs-based programs, when a person begins working, his or her eligibility could change from one level to another or end altogether. To evaluate the effect of work on MSPs, CWICs should take the following steps:

1. Calculate total countable income (including the earning goal).
2. Compare total countable income to QMB, SLMB, and QI income levels.
3. Identify if the beneficiary will remain in same coverage level, move to a lower coverage level (QMB to SLMB or QMB to QI), or lose MSPs altogether.
4. Determine if the person will keep or become eligible for Medicaid.

Once those steps are complete, CWICs may use the charts below to help clarify how the help with Medicare Part A and B out-of-pocket expenses will change. The first chart outlines the change in coverage that will occur for beneficiaries who won’t be eligible for full Medicaid when they begin working. The second chart outlines the change in coverage that will occur for beneficiaries who will maintain or become eligible for full Medicaid when they begin working.

Scenarios for beneficiaries who aren’t, nor will become, Medicaid eligible:

<table>
<thead>
<tr>
<th>Scenario once the work goal is achieved</th>
<th>Part A and B deductibles and co-insurance will be paid?</th>
<th>Part B Premium will be paid?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has QMB, will have QMB</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Has QMB, will have SLMB/QI</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Has QMB, won’t have MSPs</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Has SLMB/QI, will have QMB</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Has SLMB or QI, will have SLMB/QI</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Has SLMB/QI, won’t have MSPs</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Scenarios for beneficiaries who will continue to be eligible for Medicaid or will become eligible when they begin working:
<table>
<thead>
<tr>
<th>Scenario once the work goal is achieved:</th>
<th>Part A and B deductibles and co-insurance will be paid?</th>
<th>Part B Premium will be paid?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has QMB, will have QMB</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Has QMB, will have SLMB</td>
<td>Yes (Medicaid)</td>
<td>Yes</td>
</tr>
<tr>
<td>Has QMB, won’t have QMB/SLMB</td>
<td>Yes (Medicaid)</td>
<td>Maybe (Medicaid)</td>
</tr>
<tr>
<td>Has SLMB, will have QMB</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Has SLMB, will have SLMB</td>
<td>Yes (Medicaid)</td>
<td>Yes</td>
</tr>
<tr>
<td>Has SLMB, won’t have QMB/SLMB</td>
<td>Yes (Medicaid)</td>
<td>Maybe (Medicaid)</td>
</tr>
</tbody>
</table>

As a reminder, someone who is Medicaid eligible can’t get QI; as a result, there is no option in the chart directly above showing the option of QI. Because this second chart reflects the beneficiaries who will maintain or obtain full Medicaid when working, the individual will have more help paying Medicare Part A and B out-of-pocket expenses. In every scenario the person is getting help paying their Part A and B co-insurance and deductibles. That’s possible because full Medicaid naturally covers those expenses if QMB isn’t available. Remember, Medicaid operates as a secondary insurance to Medicare. The only potential change in assistance is with the groups that lose eligibility for MSP altogether. In that situation, if the state won’t pay the Part B premium for dual eligible individuals (Medicare and Medicaid eligible) with income over the 120 percent income limit, then the beneficiary will need to begin paying that premium. In states that pay the Part B premium for dual beneficiaries over 120 percent FPL, the beneficiaries will see no effective change in their coverage.

Let’s look at a few examples of how earned income would affect coverage of Medicare Part A and B out-of-pocket expenses.
Example of person who is eligible for QMB, doesn’t have Medicaid, and begins working:

Sylvia receives $920 per month of SSDI, has $2,500 in resources, has Medicare, and has QMB. She has been offered a job making $1,150 per month in gross wages. What will happen to Sylvia’s eligibility for QMB?

Her unearned income is $920; after deducting the $20 General Income Exclusion, her countable unearned income is $900. Her earned income is $1,150; after deducting the $65 Earned Income Exclusion and dividing the remaining earnings in half, her countable earned income is $542.50. That means her total countable income is $1,442 per month.

Sylvia’s income isn’t only over the QMB income limit (100 percent FPL is $1,040 – 2019 rate); it’s also over the SLMB (120 percent FPL is $1,249 – 2019 rate) and QI income limit (135 percent FPL is $1,405 – 2019 rate) for a single person. She will have to begin paying her Part A and B co-insurance and deductibles, as well as her Part B premium.

As an option, Sylvia could explore her eligibility for Medicaid (e.g., Medicaid Buy-In). If she is eligible for Medicaid, that program would pay her Medicare Part A and B deductibles and co-insurance. Depending on the state she lives in, Medicaid may also pay her Part B premium. Another option is to explore Impairment Related Work Expenses (IRWEs) or Blind Work Expenses (BWEs). If Sylvia has enough of these deductions, her countable income may fall below the QI, SLMB, or even QMB limit.

Example of person who is eligible for QMB and Medicaid, and begins working:

Ericka receives $789 per month of SSDI and $14 per month in SSI, has $1,000 in resources, has Medicare and Medicaid, and has QMB. She has been offered a job making $600 per month in gross wages. What will happen to Ericka’s eligibility for QMB?
Her unearned income is $789; after deducting the $20 General Income Exclusion, her countable unearned income is $769. Ericka’s SSI will go to zero due to the earned income, but she will stay in 1619(b) status for Medicaid. Her earned income is $600; after deducting the $65 Earned Income Exclusion and dividing the remaining earnings in half, her countable earned income is $267.50. That means her total countable income is $1,036.50 per month.

Ericka’s income is over the QMB income limit (100 percent FPL is $1,040 – 2019 rate), but it’s below the SLMB limit (120 percent FPL is $1,249 - 2019 for a single person. That means she’ll continue getting help paying for her Part B premium, but through SLMB rather than QMB. While Ericka doesn’t have the QMB program to pay her Part A and B deductible and co-insurance, she does have full Medicaid coverage. If she maintains her eligibility for Medicaid when she begins working, she would continue to get help paying the Part A and B deductibles and coinsurance. In effect, Ericka will continue to have the same coverage she has now. If Ericka can’t maintain Medicaid when working, you should explore IRWEs or BWEs to see if her countable income could fall below the QMB limit.

**Qualified Disabled and Working Individuals (QDWI)**

The last Medicare Savings Program is very different from the other three. Qualified Disabled Working Individual (QDWI) only pays the Part A premium for those who are “buying-into” Medicare under “Premium HI for the Working Disabled.”

To be eligible for QDWI, an individual must:

- Be using Premium-HI for the Working Disabled to maintain Medicare;
- Have countable income below 200 percent of the current FPL;
- Have countable resources below $4,000 for a single person, $6,000 for a couple;
- Be not otherwise eligible for Medicaid; and
• Meet the general nonfinancial requirements or conditions of eligibility for Medicaid in his or her state (e.g., citizenship, residency).

As with the other MSPs, QDWI uses the SSI income and resource methodologies to determine countable income and resources. With QDWI, states aren’t allowed to use more liberal income and resource methodologies, an option they have with the QMB, SLMB, and QI program. While 200 percent of the FPL may not seem high, an individual can have a relatively high monthly income and use this program. There are two key factors that make that possible: The individual no longer has a Title II benefit check when he or she is using this program, and the earned income disregards allow him or her to have wages of more than twice the income limit. Let’s look at an example.

**Example of person who is likely eligible for QDWI:**

Frank has $3,200 per month in gross wages, and his EPMC is about to end. He’d like to maintain Medicare through Premium-HI for the Working Disabled but is concerned about affording the Part A premium. He has $3,500 in resources. Could Frank be eligible for QDWI?

His unearned income is $0, because he’s no longer receiving his SSDI benefit. His gross wages are $3,200 per month; after deducting the $20 General Income Exclusion and the $65 Earned Income Exclusion, and dividing the remaining amount in half, he has $1,557.50 in countable earned income. Because he has no unearned income, his total countable income is $1,557.50 per month.

Two hundred percent of the FPL for a single person is $2,081 per month (2019 rate). Frank’s total countable income is below that level. Because his resources are below $4,000, he would likely be eligible for QDWI, assuming he meets all the nonfinancial requirements of the state’s Medicaid program.

As this example demonstrates, an individual can have a substantial amount of earned income and still use QDWI.
Low Income Subsidy (Extra Help) - Financial Assistance Program #2

As explained in the first part of this unit, there are a number of Part D out-of-pocket expenses, which vary based on the private prescription drug plan the beneficiary chooses. For many beneficiaries, these costs are unaffordable. When Congress created Part D, it also created a financial assistance program to help low-income beneficiaries pay for the Part D out-of-pocket expenses. The formal name for this financial assistance program is Low Income Subsidy (LIS), but it’s also called “Extra Help.” LIS isn’t a state program, which is often a point of confusion. LIS is a program administered by CMS. The LIS program provides two levels of help: Full Low Income Subsidy and Partial Low Income Subsidy.

To be eligible for LIS, some groups must have income below certain FPLs. When an individual applies for LIS, Social Security will apply the FPL that corresponds to the individual’s state of residence in the month that the individual applied.

In addition to some groups having income limits, some groups must have resources below the current year’s resource limit. If a beneficiary indicates he or she would use some or all of his or her resources for funeral or burial expenses, then Social Security will allow a $1,500 exclusion for an individual and $3,000 for a couple. As a result, publications about LIS resource limits often inflate the current year’s limit by $1,500 for an individual and $3,000 for a couple, to account for this allowance. The resource limits listed in this unit don’t include the allowance for funeral or burial expenses. If a beneficiary expected those expenses, his or her resource limit, in effect, would be higher ($1,500 for an individual and $3,000 for a couple).

Full Low Income Subsidy

Full LIS provides critical support to beneficiaries. With Full LIS the beneficiary generally won’t have to pay a monthly premium. The CMS pays subsidized premiums to the prescription drug provider (PDP) or the Medicare Advantage prescription drug plan (MA-PDP) based on the service area’s regional benchmark premiums. Full LIS eligible individuals who choose to participate in a more expensive plan are responsible for the difference. Those eligible for Full LIS don’t have to pay an annual
deductible. Additionally, they aren’t subject to the initial coverage, coverage gap, or catastrophic coverage payment rules. Instead, these individuals pay small co-payments, if any.

To be eligible for the Full LIS, an individual must:

- Be entitled to benefits under Medicare Part A or entitled to Medicare Part B or both;
- Reside in one of the 50 states or the District of Columbia; and
- Have countable income at or below 135 percent of the FPL and resources at or below $7,860 for single or $11,800 for couples in 2020; **OR**
- Be deemed eligible (the following groups are deemed Full LIS eligible: Medicaid recipients, SSI beneficiaries, QMBs, SLMBs, or QIs)

**Deemed Eligible:**

Those whom CMS deems eligible don’t have to apply for Full LIS; instead, CMS automatically enrolls them. CMS determines if an individual is deemed eligible for Full LIS based on monthly data from state Medicaid agencies and Social Security’s records of SSI participation. CMS then automatically enrolls deemed eligible beneficiaries who haven’t yet enrolled with a PDP or MA-PDP. Beneficiaries whom CMS deems eligible can switch plans at any time. Many beneficiaries don’t realize that once they are eligible for Part D, Medicaid will no longer cover most, if not all, of their prescriptions, because they are the payer of last resort. To assure beneficiaries don’t inadvertently go without prescription coverage, CMS automatically enrolls Full LIS deemed eligible beneficiaries into a plan.

**Not Deemed Eligible:**

Those whom CMS deems not eligible, but instead who have income and resources below the limits noted above, have to apply for the Low Income Subsidy program. While CMS is administering the LIS program, it doesn’t have the infrastructure to accept and process applications; it doesn’t have field offices in towns across the country where beneficiaries can go and apply. As a result, CMS established an agreement with Social Security to accept and process LIS applications for those who aren’t deemed eligible. That means an individual who doesn’t fall into one of the deemed eligible
categories will need to apply for LIS at Social Security. Individuals may apply for the LIS program in three ways:

1. Submitting an online application on Social Security’s website;
2. Calling 1-800-772-1213 to apply over the phone; or
3. Submitting an application in person at a local Social Security office.

Once Social Security receives the application, the agency will need to determine if the countable income is at or below 135 percent of FPL and if countable resources are below the applicable limits.

In determining eligibility for the non-deemed group, Social Security will use the SSI income and resource methodology, with some modifications. To begin, Social Security doesn’t use deeming, but will count the following people’s income and resources in determining LIS eligibility:

- Countable income of the Medicare beneficiary and living-with spouse (if any) measured against a percentage of the annual FPL for the beneficiary’s family size (this includes dependent relatives living with the beneficiary); and
- Resources of the Medicare beneficiary and living-with spouse (if any).

In counting income, effective January 1, 2010, Social Security won’t count in-kind support and maintenance as income. The agency will also exclude interest and dividends, regardless of the source. Also worth noting, Social Security won’t approve a Plan to Achieve Self Support whose sole purpose is to exclude income and resources for LIS eligibility. Concerning resource exclusions, there are a few differences from the SSI rules:

- Social Security doesn’t consider transfers of resources when making LIS determinations. Therefore, Social Security doesn’t ask an applicant if he or she transferred resources.
- Non-liquid resources, other than non-home real property, aren’t resources for purposes of determining eligibility for the subsidy. For purposes of determining eligibility for the subsidy, the following non-liquid assets aren’t countable resources: all vehicles (autos, trucks, motorcycles, boats, snowmobiles, etc.).
household goods and personal effects, irrevocable burial trusts, and irrevocable burial contracts.

- If the individual alleges that he or she expects to use some of his or her resources for funeral or burial expenses, Social Security excludes $1,500 from that individual’s countable resources. For a married couple who live together, Social Security will exclude up to $3,000. Social Security won’t ask the individual for the actual value of the funds that he or she expects to use. Therefore, the exclusion is always $1,500 unless the individual alleges that he or she doesn't expect to use any of his or her resources for burial or funeral expenses.

In determining countable income, Social Security applies the basic SSI deductions. When determining countable unearned income, Social Security applies the $20 General income Exclusion to any unearned income first, then to earned income, if unused. The agency applies the $65 Earned Income Exclusion and divides earnings in half to determine countable earned income. Additionally, Social Security can deduct impairment Related Work Expenses (IRWE) and Blind Work Expenses (BWE). If a beneficiary indicates to Social Security he or she has IRWEs, Social Security will deduct an automatic 16.3 percent of gross wages. If a beneficiary with statutory blindness indicates he or she has BWEs, Social Security will deduct an automatic 25 percent of gross wages. Social Security will deduct the actual amount of the IRWE or BWE if it’s more advantageous than the standard percentage. To use these deductions, the Title II disability beneficiary must be under age 65. If his or her spouse is under age 65 and receiving Title II disability benefits, he or she may also use these work incentives. Below is an example calculation.

**Example of a person who is likely eligible for Full LIS:**

Sherry has $1,212 per month in SSDI, $7,000 in resources, and is single. Sherry has $200 of ISM being counted by the Medicare Savings Program that is preventing her from being deemed eligible for an MSP. She tells you she is unable to pay for her prescriptions each month.

Could Sherry be eligible for Full LIS?
<table>
<thead>
<tr>
<th>Step</th>
<th>Calculations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned Income</td>
<td>$1,212</td>
</tr>
<tr>
<td>General Income Exclusion (GIE) $20</td>
<td>– $20</td>
</tr>
<tr>
<td>Countable Unearned Income</td>
<td>=$1,192</td>
</tr>
<tr>
<td>Gross Earned Income</td>
<td>$0</td>
</tr>
<tr>
<td>Student Earned Income Exclusion</td>
<td>–</td>
</tr>
<tr>
<td>Remainder</td>
<td>–</td>
</tr>
<tr>
<td>GIE (if not used above) $20</td>
<td>–</td>
</tr>
<tr>
<td>Remainder</td>
<td>–</td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE) $65</td>
<td>–</td>
</tr>
<tr>
<td>Remainder</td>
<td>–</td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE) (16.3% of gross wages or</td>
<td>–</td>
</tr>
<tr>
<td>actual amount if higher)</td>
<td></td>
</tr>
<tr>
<td>Remainder</td>
<td>–</td>
</tr>
<tr>
<td>Divide remainder by 2</td>
<td>–</td>
</tr>
<tr>
<td>Blind Work Expense (BWE) (25% of gross wages or actual amount if</td>
<td>–</td>
</tr>
<tr>
<td>higher)</td>
<td></td>
</tr>
<tr>
<td>Step</td>
<td>Calculations</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>= $0</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td>$1,192</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>+ $0</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>- $0</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>= $1,192</td>
</tr>
</tbody>
</table>

Her unearned income is $1,212, but after deducting the $20 General Income Exclusion, her countable unearned income is $1,192. She doesn't have any earned income, so her total countable income is $1,192 per month. One hundred thirty-five percent of the FPL for a single person is $1,405 per month (2019 rate). Sherry's countable income is below that level. Because her resources are below $7,860, she would likely be eligible for Full LIS.

As a reminder, this calculation isn’t used for individuals who are deemed eligible for Full LIS and will continue to fall under a deemed eligible category when working. For example, if a beneficiary is eligible for Full LIS right now because he or she has full Medicaid coverage, and when he or she begins working, he or she will maintain Medicaid, then there is no need to do a calculation worksheet because he or she will remain deemed eligible for Full LIS. Conversely, if a beneficiary will lose his or her deemed eligible status due to a change in income, then the calculation would be appropriate. For example, if a beneficiary is eligible for Full LIS because he or she has QMB, but when he or she begin working, he or she will lose eligibility for QMB, SLMB, and QI, then the beneficiary would need a calculation worksheet to determine whether he or she meets the income criteria, unless he or she fell under one of the other deemed eligible categories (e.g., Medicaid or SSI).
Partial Low Income Subsidy

Partial LIS provides slightly less support than Full LIS. With Partial LIS the beneficiary either has no premium or will have a premium based on a sliding fee scale. As with Full LIS, CMS pays subsidized premiums to the prescription drug provider (PDP) or the Medicare Advantage prescription drug plan (MA-PDP) and base them on the service area’s regional benchmark premiums. Partial LIS eligible beneficiaries who choose to participate in a more expensive plan are responsible for the difference. Those eligible for Partial LIS have an $89 annual deductible (2020 rate). Additionally, they aren’t subject to the initial coverage, coverage gap, or catastrophic coverage payment rules. Instead, these individuals pay lower co-insurance or co-payments over the course of the year.

To be eligible for the Partial LIS, an individual must:

- Be entitled to benefits under Medicare Part A or entitled to Medicare Part B or both;
- Reside in one of the 50 states or the District of Columbia; and
- Have countable income at or below 150 percent of the FPL ($1,561 per month for an individual in 2019) and resources at or below $13,110 for single or $26,160 for married in 2020.

As with the non-deemed eligible Full LIS beneficiaries, Partial LIS beneficiaries must apply for LIS through Social Security. Individuals apply for Partial LIS in the same manner as for full LIS as described earlier. The same countable income and resource methodologies explained under Full LIS also apply under Partial LIS. The difference is merely that the income and resource limits are higher.

Example of a person who is likely eligible for Partial LIS:

Sophia has $1,425 per month in SSDI, $10,000 in resources, and is single. She tells you she is having a hard time paying for her prescriptions each month. Could Sophia be eligible for Partial LIS?

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned Income</td>
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</tr>
<tr>
<td>Step</td>
<td>Calculations</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>General Income Exclusion (GIE) $20</td>
<td>$20</td>
</tr>
<tr>
<td>Countable Unearned Income</td>
<td>$1,405</td>
</tr>
<tr>
<td>Gross Earned Income</td>
<td>$0</td>
</tr>
<tr>
<td>Student Earned Income Exclusion</td>
<td>-</td>
</tr>
<tr>
<td>Remainder</td>
<td></td>
</tr>
<tr>
<td>GIE (if not used above) $20</td>
<td>-</td>
</tr>
<tr>
<td>Remainder</td>
<td></td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE) $65</td>
<td>-</td>
</tr>
<tr>
<td>Remainder</td>
<td></td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE) (16.3% of gross wages or actual amount if higher)</td>
<td>-</td>
</tr>
<tr>
<td>Remainder</td>
<td></td>
</tr>
<tr>
<td>Divide by 2</td>
<td></td>
</tr>
<tr>
<td>Blind Work Expense (BWE) (25% of gross wages or actual amount if higher)</td>
<td>-</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>$0</td>
</tr>
<tr>
<td>Step</td>
<td>Calculations</td>
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<td>---------------------------------------------------</td>
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</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td>$1,405</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>+ $0</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>− $0</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>= $1,405</td>
</tr>
</tbody>
</table>

Her unearned income is $1,425, but after deducting the $20 General Income Exclusion, her countable unearned income is $1,405. She doesn't have any earned income, so her total countable income is $1,405 per month. One hundred fifty percent of the FPL for a single person is $1,561 per month (2019 rate). Sophia's countable income is below that level. Because her resources are below $13,110, she would likely be eligible for Partial LIS.

With Partial LIS there are no deemed eligible individuals. Instead, every Partial LIS beneficiary must meet the income and resource limits. Given that, the calculation that Social Security must use to estimate eligibility when a beneficiary begins working, unless he or she will fall under a Full LIS deemed eligible group when working (e.g., Medicaid Buy-In).

**LIS and Earnings**

To estimate the effect of earnings on a beneficiary’s LIS eligibility, the first step is to clarify which category he or she falls into: deemed eligible for Full LIS, eligible for Full LIS (not deemed eligible), or eligible for Partial LIS. Once you have identified the category, the next step is to clarify whether the individual will lose eligibility for that category once he or she is working. If the beneficiary won’t lose eligibility for the category he or she is in, then CWICs can tell the beneficiary that his or her eligibility should continue. If the beneficiary will lose eligibility for the category he or she is in, the CWICs must communicate that expected change and provide options, if any.
Example of a person the CWIC expects to maintain deemed eligibility for Full LIS:

Devin has $320 per month in SSDI, $483 per month in SSI, Medicare, QMB, and Medicaid. She has been deemed eligible for Full LIS. Devin will begin working next month making $3,000. She has several expensive prescriptions, which she relies on LIS to help her cover. What will happen to Devin’s Full LIS when she begins working?

1. The first step is to clarify which category Devin falls into, which is deemed eligible for Full LIS. She is deemed eligible because she has Medicaid, plus she has SSI and QMB.

2. The second step is to clarify whether Devin will lose eligibility for all these deemed categories once she begins working. While Devin will likely lose her eligibility for QMB, she will continue to be eligible for Medicaid and SSI (using the 1619(b) work incentive). That means the CWIC expects Devin to continue to be eligible for Full LIS as a deemed eligible beneficiary. Because the CWIC expects her to remain deemed eligible, there is no need to do the LIS countable income calculation.

Example of a person who is deemed eligible for Full LIS but whom the CWIC expects will lose that deemed status:

Tom has $1,080 per month in SSDI, Medicare, and SLMB. He has been deemed eligible for Full LIS because he gets SLMB. Tom will begin working next month making $850. He has several expensive prescriptions that he relies on LIS to help him cover. What will happen to Tom’s Full LIS when he begins working?

1. The first step is to clarify which category Tom falls into. He is deemed eligible for full LIS because he has SLMB.

2. The second step is to clarify whether Tom will lose eligibility for all these deemed categories once he begins working. After reviewing the SLMB eligibility rules, the CWIC determines he won’t be eligible for SLMB, nor will he
be eligible for QMB or QI. He will also not be an SSI recipient. The only way Tom could continue to be considered deemed eligible for Full LIS is if he became eligible for Medicaid. In many states there is a Medicaid Buy-In program, which may be a way for Tom to become eligible for Medicaid. Because Medicaid Buy-In programs have a premium, he'd need to decide if it's financially worthwhile for him. If Tom doesn't become eligible for Medicaid when he begins working, then the CWIC must use the LIS calculation to determine if he can maintain eligibility for Full LIS as a non-deemed eligible individual or for Partial LIS.

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned Income</td>
<td>$1,080</td>
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<tr>
<td>General Income Exclusion (GIE) $20</td>
<td>– $20</td>
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<tr>
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<tr>
<td>Gross Earned Income</td>
<td>$850</td>
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<td>Student Earned Income Exclusion</td>
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</tr>
<tr>
<td>Remainder</td>
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</tr>
<tr>
<td>GIE (if not used above) $20</td>
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</tr>
<tr>
<td>Remainder</td>
<td>$850</td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE) $65</td>
<td>– $65</td>
</tr>
<tr>
<td>Remainder</td>
<td>$785</td>
</tr>
<tr>
<td>Step</td>
<td>Calculations</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE) (16.3% of gross wages or actual amount if higher)</td>
<td>− $0</td>
</tr>
<tr>
<td>Remainder</td>
<td>$785</td>
</tr>
<tr>
<td>Divide by 2</td>
<td>$392.50</td>
</tr>
<tr>
<td>Blind Work Expense (BWE) (25% of gross wages or actual amount if higher)</td>
<td>− $0</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>= $392.50</td>
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<tr>
<td>Total Countable Unearned Income</td>
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<tr>
<td>PASS Deduction</td>
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<tr>
<td>Total Countable Income</td>
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</tbody>
</table>

Tom's countable income, $1,452.50, will be over 135 percent of the FPL ($1,405 - 2019 rate), which means he wouldn't be eligible for Full LIS. But, his income is below 150 percent of the FPL ($1,561 - 2019 rate), which means he would likely be eligible for Partial LIS. To support Tom in pursuing his work goal, it will be important for him to know his options. He will be able to use Partial LIS instead of Full LIS, or if Medicaid eligibility is an option for Tom in his state, he will be able to maintain Full LIS by enrolling in Medicaid.
Reporting Income and Resource Changes and LIS Redeterminations

To determine subsidy eligibility and whether the individual qualifies for a full or partial subsidy, Social Security considers all of the countable income the individual and living-with spouse receive (or expect to receive) for a period of 12 months. Although Social Security computes subsidy eligibility based on income projected for 12 months, the computation isn't linked to a particular calendar year. The subsidy determination system uses the 12-month projection of income because Social Security issues the FPL income limits as annual income limits. At the point when an individual files for subsidy, Social Security compares the 12-month projection to the current year's FPL income limit. If the individual's projected income is under the limit, he or she will continue to be eligible for subsidy until Social Security processes a redetermination or a subsidy-changing event.

Example of determining subsidy eligibility:

Ms. Smith files for subsidy in August. The subsidy determination system uses the income reported on her application in August and projects it for 12 months starting from the subsidy computation month without regard to the expected increase in her income due to the January COLA, or the expected increase in the FPL limits due to the annual FPL update (usually in February). The subsidy determination system needs this type of computation because the individual’s income for next January and next year’s FPL amount aren’t known in August when Social Security is processing the claim.

Social Security makes LIS determinations for a calendar year and won’t change them during the year unless the individual:

- Appeals the determination;
- Reports a subsidy-changing event; or
- Becomes eligible for SSI, Medicaid, or the MSP and is therefore deemed eligible for the subsidy.

Social Security doesn’t require LIS beneficiaries to report changes. There are NO mandatory reporting rules in the LIS program. In addition, there is no distinction between how the agency
processed first- and third-party reports. Beneficiaries, relatives, friends, or other agencies may report events that affect a beneficiary’s subsidy. The source of information doesn’t affect how Social Security processes the report of change.

Two types of events can affect the subsidy determination or amount:

- **Subsidy Changing Events**, which are effective the month after the month of report, and

- **Other Events**, which are events that may change the subsidy determination, but do not become effective until the January following the report (or later in some cases).

There are six Subsidy Changing Events. These events result in the re-determination of subsidy amount or eligibility for the beneficiary. Once Social Security receives and inputs a report of a subsidy changing event, the agency sends a redetermination form (SSA-1026-OCR-SM-SCE) to the beneficiary.

These changes become effective the month after the month the beneficiary reports them:

1. Beneficiary marries
2. Beneficiary and living-with spouse divorce
3. Beneficiary’s living-with spouse dies
4. Beneficiary and living-with spouse separate
5. Beneficiary and living-with spouse annul marriage
6. Beneficiary and previously separated spouse resume living together

**Example of Subsidy Changing Event:**

Mary Smith, a beneficiary, contacts Social Security in May 2019. She reports that she married in March 2019. This is a subsidy changing event or SCE. Any change becomes effective in June 2019. Mrs. Smith says that she doesn’t have time to complete the screens immediately. The 800-number agent will input the event on the Changing Event screen in MAPS, which will generate a re-determination form. The agent asks Ms. Smith if her spouse is eligible for
a subsidy as well. He is. The agent then asks if Ms. Smith is reporting the change for him as well. She says she is, so the agent enters an SCE for the spouse. He will receive a re-determination form as well. Mrs. Smith and her spouse must return both forms, even though the information on the forms should be identical. When they return the forms with the updated income and resource information, the Social Security agent will process them in MAPS. The system will then determine the new subsidy amounts, which will be effective in June 2019 for Ms. Smith and her new spouse.

Events other than the six subsidy changing events listed above may affect a beneficiary’s subsidy eligibility or amount, but any changes resulting from the report of an “Other Event” are generally effective the following January. Typically “other events” include changes in income and resources such as getting a job, becoming eligible for unemployment insurance, receiving a large insurance settlement or inheritance, etc.

**Example of an “Other Event”:**

In late August 2019, Social Security mails a scheduled re-determination to Mr. Jones. He completes the form that indicates a change in his income and sends it back to Social Security on September 19, 2019. Social Security re-determines Mr. Jones’ eligibility based on the income he reported on September 19, 2019. The subsidy determination system uses the income on this report, projects it for 12 months, and compares this annualized amount to the 2019 FPL income limits to determine his subsidy percentage. If the change he reported affects his eligibility or the amount of his subsidy, the effective date of the change will be January 2020.

There are some differences in eligibility changes for those deemed eligible for LIS. For an individual deemed eligible between January 1 and June 30 of a calendar year, the individual is deemed eligible for Full LIS for the remainder of the calendar year, regardless of changes in his or her situation. For an individual deemed eligible between July 1 and December 31 of a calendar year, the individual is deemed eligible for the remainder of the calendar year and the following calendar year.
For more information about the Part D LIS, refer to POMS HI 03001.005 Medicare Part D Extra Help (Low-Income Subsidy or LIS) (https://secure.ssa.gov/apps10/poms.nsf/lnx/0603001005).

Medicare Counseling and Referrals

Medicare beneficiaries have to make many choices that will determine how they receive their Medicare. They have the choice to keep Original Medicare or to enroll in a Medicare Advantage Plan. Beneficiaries also choose a specific provider for their Medicare Advantage Plan and their Part D plan.

CWICs need to have a basic understanding of these Medicare options, but will also need to work with organizations that provide in-depth Medicare counseling services. Some beneficiaries will have questions or problems that lie outside of the CWIC’s area of knowledge or experience. In these cases, CWICs should refer the beneficiary to an outside organization for assistance.

State Health Insurance Counseling and Assistance Programs (SHIPs)

In each of the 50 states, a State Health Insurance Counseling and Assistance Program (SHIP) provides free one-on-one Medicare counseling to seniors and people with disabilities. SHIPs help beneficiaries make informed choices about their Medicare and can answer questions about Medicare bills, appeals, and Medicare consumer rights. More information on the services that SHIPs provide and a link to state SHIP websites is available (https://www.shiptacenter.org).

Counseling Beneficiaries on Medicare

This unit covers important parts of the Medicare program that CWICs need to understand in order to assist beneficiaries. Here are some additional points to remember:

- Medicare beneficiaries may be eligible for, but not enrolled in, the Low Income Subsidy program. Some beneficiaries aren’t automatically enrolled in LIS and need to apply for this program.
- SSDI beneficiaries may not know that they could qualify for Medicaid. CWICs need to ask these beneficiaries if they have
considered Medicaid as a health coverage option, in addition to Medicare.

- Medicare beneficiaries may qualify (and need to apply) for the MSP that will help to pay their Medicare premiums and coinsurance.

- Medicare beneficiaries may have their Part B premiums paid for by the state if they are enrolled in Medicaid or in the MSP.

- Dual eligible individuals (with Medicare and Medicaid) have additional options under Medicare. For example, these individuals may change their Medicare Advantage Plan or Part D plan in any month of the year.

**Conclusion**

While many Title II disability beneficiaries are concerned about how paid employment will affect their cash payments, it’s often the medical coverage afforded by Medicare that individuals are most worried about losing. This unit provided specific information to CWICs about how the federal Medicare program operates and offers detailed explanations on how to get help paying the premiums and other out-of-pocket expenses Medicare beneficiaries incur. Finally, this unit described exactly how paid employment affects Medicare coverage and under what circumstances Medicare coverage can continue even after cash benefits cease due to SGA-level work.

**Conducting Independent Research**

**Medicare and You - CMS Publication**

**Medigap Plan Information** (http://www.medicare.gov/supplement-other-insurance/medigap/whats-medigap.html)

**Medicare and Other Health Benefits: Your Guide to Who Pays First**
(https://www.medicare.gov/Pubs/pdf/02179-Medicare-Coordination-Benefits-Payer.pdf)
Questions and Answers on Extended Medicare Coverage for Working People with Disabilities
(http://www.socialsecurity.gov/disabilityresearch/wi/extended.htm)

SSA POMS DI 40510.140 Premium Medicare for the Working Disabled – General
(https://secure.ssa.gov/apps10/poms.nsf/lnx/0440510140!opendocument)

SSA POMS HI 03001.005 Medicare Part D Extra Help (Low Income Subsidy or LIS)
(https://secure.ssa.gov/apps10/poms.nsf/lnx/0603001005)

SSA POMS HI 03020.000 Income (Low Income Subsidy)
(https://secure.ssa.gov/apps10/poms.nsf/lnx/0603020000)

SSA POMS HI 03030.000 Resources (Low Income Subsidy)
(https://secure.ssa.gov/apps10/poms.nsf/lnx/0603030000)

Medicare Coverage of Kidney Dialysis and Kidney Transplant Services. This booklet has information about Medicare coverage for people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant) (56 pages)

Additional Resources

We included templates CWICs can use to calculate countable income for the purposes of determining the effect of earned income on Medicare Savings Programs and the Part D LIS eligibility. We have also provided a decision tree CWICs can use to map out the end of a beneficiary’s EPMC.
# MSP Calculation Sheet

Beneficiary Name_____________________________ Date ___________

CWIC:_____________________________________________________

Scenario Description:

Scenario Description: (Customize chart based on any additional deductions allowed in your state)

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned Income</td>
<td></td>
</tr>
<tr>
<td>General Income Exclusion (GIE) $20</td>
<td>−</td>
</tr>
<tr>
<td>Countable Unearned Income</td>
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<tr>
<td>Gross Earned Income</td>
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</tr>
<tr>
<td>Student Earned Income Exclusion</td>
<td>−</td>
</tr>
<tr>
<td>Remainder</td>
<td></td>
</tr>
<tr>
<td>GIE (if not used above) $20</td>
<td>−</td>
</tr>
<tr>
<td>Remainder</td>
<td></td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE) $65</td>
<td>−</td>
</tr>
<tr>
<td>Remainder</td>
<td></td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE)</td>
<td>−</td>
</tr>
<tr>
<td>Remainder</td>
<td></td>
</tr>
<tr>
<td>Divide by 2</td>
<td></td>
</tr>
<tr>
<td>Blind Work Expenses (BWE)</td>
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</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>=</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td></td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>+</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>−</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>=</td>
</tr>
</tbody>
</table>

Result based on comparison of countable income to MSP income limits:

- **QMB**: No more than 100% FPL
- **SLMB**: No more than 120% FPL
- **QI**: No more than 135% FPL
- **QDWI**: No more than 200% FPL
LIS Calculation Sheet

Beneficiary Name________________________________________ Date __________

CWIC____________________________________________________________________

Scenario Description:

**Beneficiaries who are dually eligible (also have Medicaid of any type) are deemed eligible for full LIS with no additional financial assessment. Do not use this chart for those beneficiaries.**

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned Income</td>
<td></td>
</tr>
<tr>
<td>General Income Exclusion (GIE) $20</td>
<td>−</td>
</tr>
<tr>
<td>Countable Unearned Income</td>
<td>=</td>
</tr>
<tr>
<td>Gross Earned Income</td>
<td></td>
</tr>
<tr>
<td>Student Earned Income Exclusion</td>
<td>−</td>
</tr>
<tr>
<td>Remainder</td>
<td></td>
</tr>
<tr>
<td>GIE (if not used above) $20</td>
<td>−</td>
</tr>
<tr>
<td>Remainder</td>
<td></td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE) $65</td>
<td>−</td>
</tr>
<tr>
<td>Remainder</td>
<td></td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE) (16.3% of gross wages or actual amount if higher)</td>
<td>−</td>
</tr>
<tr>
<td>Remainder</td>
<td></td>
</tr>
<tr>
<td>Divide by 2</td>
<td></td>
</tr>
<tr>
<td>Blind Work Expenses (BWE) (25% of gross wages or actual amount if higher)</td>
<td>−</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>=</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td></td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>+</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>-</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>=</td>
</tr>
</tbody>
</table>

Results based on comparison of countable income to applicable LIS income limit:

Full LIS: No more than 135% FPL
Partial LIS: No more than 150% FPL
Extended Period of Medicare Coverage (EPMC) Decision Tree

Did or will cessation occur prior to the 14th month of the EPE?

- **NO**: EPMC work incentive will end 78 months after the Grace Period.

- **YES**: Did SGA occur on the 16th month of the EPE?

  - **NO**: EPMC work incentive will end 78 months from the first SGA month following the 16th month of the EPE

  - **YES**: EPMC work incentive will end 93 months after the TWP
Competency Unit 3 – Healthcare Options for Veterans

Introduction

The U.S. Department of Defense (DoD) and the Department of Veterans Affairs (VA) offer comprehensive health coverage to active members of the military and to veterans of the armed forces. The Department of Defense provides coverage through the TRICARE program. The Veterans Health Administration (VHA) administers the VA healthcare system for veterans. CWICs may encounter Social Security beneficiaries who have health coverage through one or both of these programs. Title II disability beneficiaries (SSDI, CDB, DWB) may also enroll in the Medicare program, and some veterans may be eligible for Medicaid. This unit will provide an overview of the TRICARE program and the VA healthcare system, and discuss the interactions between these systems and other healthcare programs such as Medicare and Medicaid.

IMPORTANT DEFINITIONS:

• Certain terms have specific definitions in the context of the U.S. military. “Separating” or “being discharged” means leaving the military. The only individuals who are considered “retired” from the military are: 1) Those who served for 20 years before they left military service, or 2) those who have been certified “medically retired” because they have become disabled. Note that not all injured or disabled service members are “medically retired.”

• A veteran is defined as a person who is a former member of the U.S. Armed Forces (Army, Navy, Air Force, Marine Corps, and Coast Guard), served on active duty, and was discharged under conditions other than dishonorable. This includes current and former members of the Reserves or National Guard.
Overview of Healthcare Benefits for Members of the Military and Veterans

TRICARE

All active duty service members (ADSMs) are covered by TRICARE. TRICARE, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), is a health care program of the United States Department of Defense Military Health System. TRICARE combines the health resources of the military with networks of civilian health care professionals, institutions, pharmacies, and suppliers to provide affordable access to high-quality health care services around the world. TRICARE provides health benefits for military personnel, military retirees, and their dependents, including some members of the Reserve Component.

When a service member leaves the military, he or she may or may not be able to maintain his or her TRICARE coverage. This depends on a number of factors, including if the individual is retiring, voluntarily separating, or being medically discharged. For most service members, TRICARE eligibility ends when they separate from the military.

After being discharged, some service members are eligible to apply for temporary health care through the Transitional Assistance Management Program (TAMP). TAMP can provide transitional TRICARE coverage for up to 180 days. After the 180 days (or immediately for those not eligible for TAMP), the individual can purchase extended health care coverage through a program called Continued Health Care Benefits Program (CHCBP). This program is similar to continuation of private health care coverage under COBRA and requires payment of a monthly premium. CHCBP can be used to extend health coverage for up to 18 months. When TRICARE, TAMP, or CHCBP health care benefits end, veterans may apply for VA health benefits.

The VA Healthcare System

The Veterans Health Administration (VHA) is the branch of the U.S. Department of Veterans Affairs (VA) that provides healthcare for veterans. A veteran is defined as a former member of the American Armed Forces who served on active duty and was discharged under conditions other than dishonorable. The VHA operates the United States’
largest, most comprehensive integrated health care system consisting of 150 medical centers, nearly 1,400 community-based outpatient clinics, community living centers, and Vet Centers. Together these health care facilities and the more than 53,000 independent licensed health care practitioners who work within them provide comprehensive care to more than 8.3 million veterans each year.

After a service member leaves active military service, the VHA becomes responsible for providing medical care for service-related injuries or conditions. At this point, the Department of Defense is no longer responsible for providing care for service-related conditions. The VHA offers a number of different programs as part of the Veterans healthcare system. The most important one is the Medical Benefits Package, which is a standard set of health services the VHA provides to veterans who qualify for VA healthcare benefits. Other VA programs include Readjustment Counseling services, dental care, and home healthcare for homebound veterans. In most cases, VA facilities such as VA hospitals and VA Medical Centers provide the medical services. Civilian medical facilities generally don’t provide care under the VA to veterans.

### Understanding VA Healthcare Benefits

Because CWICs primarily work with veterans rather than active members of the military, we will begin our discussion of healthcare options with the VA healthcare benefits.

#### Applying for VA Healthcare Benefits

The VA offers veterans a number of ways to apply for healthcare benefits. Veterans may apply online by filling out the online application and submitting it electronically to the VA for processing. The online application [VA Form EZ, Application for Health Benefits](http://www.va.gov/healthbenefits/apply/) is available online.

Veterans may also apply in person by going to the local VA health care facility and completing the same VA Form 10-10EZ, Application for Health Benefits. It’s also possible to apply by phone with a VA representative by calling 1-877-222-VETS (8387), 8 a.m. to 8 p.m. Mon-Fri, EST. Finally, veterans may submit applications by mail. [Detailed information about the application process for VA Health Benefits](http://www.va.gov/HEALTHBENEFITS/apply/index.asp) is available.
Eligibility

Once the VA receives the completed application, it determines whether or not the veteran meets the eligibility requirements for enrollment. The veteran must meet a number of criteria to be eligible for the VA Medical Benefits Package. First, individuals must have served in the active military service and been separated under any condition other than dishonorable. Current and former members of the Reserves or National Guard who were called to active duty by a federal order and completed the full period for which they were called or ordered to active duty may also be eligible for VA health benefits.

Second, veterans must meet minimum duty requirements (generally 24 continuous months of service) unless they were discharged because of a disability related to their service. Because there are a number of other exceptions to the minimum duty requirements, the VA encourages all veterans to apply so that it may determine their enrollment eligibility.

Additional factors determine if a veteran is eligible for VA health benefits and if the veteran is required to pay co-pays for healthcare services. Recent combat veterans are eligible for full VA health benefits for a period of five years after the date of their discharge, regardless of their income and assets. “Recent combat veterans” are veterans who were discharged from active duty after January 28, 2003. Also, veterans who were disabled in the line of duty during active service are eligible for full VA health benefits, including care for illnesses or injuries unrelated to the military service.

Some non-disabled veterans who have incomes above the income thresholds are still eligible for VA health benefits because they meet another criteria for eligibility (such as being eligible for Medicaid or having received a Purple Heart medal). For more information about eligibility for VA health care, go online (https://www.va.gov/health-care/eligibility/)

Enrollment and Enrollment Priority Groups

The VA operates an annual enrollment system that helps to manage the provision of health care. Once the VA enrolls a veteran, that veteran remains enrolled in the VA health care system and maintains access to certain VA health benefits. During the enrollment process, the VA will use the veteran’s VA disability rating and other factors to place the veteran in
one of eight Enrollment Priority Groups. Priority Group 1 is the highest priority group to receive care, and Group 8 is the lowest.

The VA uses the Enrollment Priority Groups to ensure that veterans who need healthcare the most will be covered if the VA doesn’t have enough funding to provide healthcare to all veterans. The number of veterans who can be enrolled in the health care program is determined by the amount of money Congress gives the VA each year. Because funds are limited, the VA set up Priority Groups to make sure that certain groups of Veterans can be enrolled before others.

Some veterans may be eligible for more than one Enrollment Priority Group. In that case, the VA will always place the veteran in the highest Priority Group for which the individual is eligible. Under the Medical Benefits Package, the same services are generally available to all enrolled veterans. The Enrollment Priority Groups determine how much a veteran has to pay (in co-pays) when he or she receives medical treatment and medications.

There are many other qualification rules for assignment into the Priority Groups, and this aspect of the VA healthcare system is very complex. The main qualifications are the following:

- **Priority 1:** Veterans with service-connected disabilities rated 50 percent or more; and veterans determined by VA to be unemployable due to service-connected conditions.

- **Priority 2:** Veterans with service-connected disabilities rated 30 percent or 40 percent.

- **Priority 3:** Veterans with service-connected disabilities rated 10 percent and 20 percent; veterans who are former Prisoners of War (POW) or were awarded a Purple Heart medal; and veterans whose discharge was for a disability incurred or aggravated in the line of duty.

- **Priority 4:** Veterans receiving aid and attendance or housebound benefits; veterans determined by VA to be catastrophically disabled.

- **Priority 5:** Veterans receiving VA pension benefits or eligible for Medicaid programs, and non-service-connected veterans and non-compensable, zero percent service-connected veterans.
whose gross annual household income and net worth are below the established VA means test thresholds.

- **Priority 6:** Veterans of World War I; veterans with zero percent service-connected disabilities who are receiving disability compensation benefits; and some veterans who served in a theater of combat operations after November 11, 1998.

- **Priority 7:** Veterans with income or net worth above the VA national income threshold and income below the geographic income threshold who agree to pay co-pays.

- **Priority 8:** Veterans with income or net worth above the VA national income threshold and the geographic income threshold who agree to pay co-pays.

For more information about the priority groups, refer to the VA website (https://www.va.gov/health-care/eligibility/priority-groups/).

Veterans don’t have to pay a monthly premium for VA health benefits. Instead, some veterans pay an out-of-pocket co-payment (or co-pay) for services to treat conditions not related to their military service. If a veteran doesn’t have a VA-rated disability or other special eligibility factor, he or she will be required to submit financial information to determine if he or she is eligible for free or low-cost VA health benefits. This process is called Financial Assessment (or Means Test). The results of this test determine which Enrollment Priority Group that the veteran will be placed in, and also how much their co-pays will be at the time of receiving services.

As of March 24, 2014, most veterans are no longer required to complete the annual financial assessment known as a Means Test. Instead, VA will receive income information from the IRS and Social Security, and will contact the veterans only if the information it receives indicates a change in their VA health benefits may be appropriate. The elimination of the annual means test frees enrolled veterans to enjoy their VA health care benefits without worrying about completing annual income assessment forms. Under the new process, veterans will be required to have one financial assessment on file — their current file if they’re already enrolled, or the assessment they provide when they apply. **The VA will maintain and monitor that assessment** and update it only as substantial income changes occur. (https://www.va.gov/health-care/about-va-health-benefits/cost-of-care/).
There are four types of co-pays in the VA health system:

1. Outpatient co-pays
2. Inpatient co-pays
3. Long-term care co-pays, and
4. Medication co-pays.

Some low-income veterans are eligible for reduced co-pay rates for inpatient care, and veterans in Priority Group 1 are exempt from all co-pays. Primary care services and specialty care services have co-pays of $15 and $50 respectively. Medications veterans fill at VA pharmacies cost $5 to $11 for a supply of up to 30 days with a $700 medication co-pay cap. For the most up-to-date information on co-pays and other out-of-pocket expenses associated with the VA healthcare benefits (http://www.va.gov/healthbenefits/cost/copays.asp).

**Medicare and VA Health Benefits**

Veterans with both Medicare and VA health benefits can choose which health coverage to use when they receive care. The veteran can either receive care at a VA facility or choose to use Medicare by seeing a provider outside of the VA system. In general, the two healthcare programs are independent and don’t coordinate benefits. Medicare can’t pay for the same service that was covered by veterans’ benefits, and the VA can’t pay for the same service that Medicare covered.

When a veteran uses Medicare, he or she is responsible for all Medicare premiums, deductibles, and coinsurance. When the veteran receives care through the VA, Medicare won’t pay anything. The only instance in which both Medicare and the VA can pay for services is when the VA authorizes services in a non-VA hospital. In this case, if the VA doesn’t pay for all of the medical services received during the stay, then Medicare can pay for the Medicare-covered part of the services that the VA doesn’t pay for. Also, if a doctor or hospital that isn’t part of the VA system bills a veteran for VA-authorized care, Medicare may pay all or part of the co-pays for these services.

When veterans are considering whether to decline or dis-enroll from Medicare Part B, they should explore all options carefully before making a decision. If a veteran doesn’t enroll in Medicare Part B when it’s first
available, he or she may have to pay a late enrollment penalty if he or she later decides to enroll in Part B. Having VA health coverage won’t make the veteran exempt from this penalty. However, if a veteran declines Part B coverage because he or she is covered by a group health plan based on current employment, there will be no late enrollment penalty if the veteran enrolls in Part B later.

The Part B late enrollment penalty is 10 percent of the current Part B premium for every 12-month period that the veteran delays enrollment. In addition, the veteran may have to wait to enroll in Part B. As a rule, beneficiaries can only enroll in Part B during the General Enrollment Period (January 1 to March 31). Part B coverage will then become effective on July 1 of that year. For this and other reasons, the VA strongly encourages veterans with VA health benefits to maintain other type of health insurance, including Medicare and Medicaid. Funding set aside by Congress for the VA changes each year. It’s possible that veterans in lower priority groups could lose their eligibility for VA health benefits when this funding decreases. Veterans should be careful about choosing to end other health insurance solely because they have VA health benefits.

VA Prescription Drug Benefits and Medicare Part D

The VA provides prescription drug benefits to all veterans enrolled in VA health benefits. Under the VA prescription drug program, VA physicians write prescriptions for medications that are on a national list of covered medications (called the VA formulary). Veterans using VA drug coverage can only fill prescriptions at a VA pharmacy or through the VA’s prescription drug mail order program, which is called CMOP (Consolidated Mail Outpatient Pharmacy). Note that if the veteran has Medicare Part D, he or she may fill a VA-written prescription at a non-VA pharmacy using his or her Medicare Part D coverage.

Medicare Part D coverage and VA Prescription Drug Benefits are completely separate programs and don’t affect each other in any way. Veterans enrolled in both programs effectively have two prescription drug programs that they can use. Veterans access VA drug benefits through VA physicians and VA pharmacies. Veterans may use Medicare Part D through non-VA providers and fill prescriptions at non-VA pharmacies. The VA generally provides comprehensive drug coverage at a low cost to veterans. In some cases, however, the out-of-pocket costs for a drug will be cheaper at a non-VA pharmacy through Medicare than through the VA.
In these situations, veterans can save money by using their Part D coverage. If a veteran has Medicare Part D and qualifies for the Low Income Subsidy (LIS) program, he or she will have minimal out-of-pocket costs when using his or her Part D coverage. This is another reason for some veterans to use Medicare Part D coverage instead of VA drug coverage. Veterans who don’t qualify for the LIS may pay less for medications if they obtain them through the VA instead of through Medicare. Neither Medicare nor the VA will pay for medications that the other program has paid for.

**Choosing Whether or Not to Enroll in Medicare Part D**

Veterans with VA health benefits will have to decide whether or not to enroll in a Medicare Part D plan. CWICs should discuss with a veteran the pros and cons of having Part D coverage in addition to VA prescription drug coverage. Veterans may have to pay a monthly premium when they enroll in a Medicare Part D plan. Some veterans will decide not to enroll in Medicare Part D and only obtain their medications through the VA.

Veterans who have had continuous VA health benefits don’t have to pay a late enrollment penalty for Medicare Part D at any later date. A veteran can decline Part D coverage and enroll later without having the penalty of higher monthly Part D premiums. This is because Medicare considers VA prescription drug coverage as creditable coverage for Medicare Part D purposes. Creditable coverage means that Medicare considers the VA drug benefits as good as or better than Part D drug plans (VA health benefits aren’t creditable coverage for Medicare Part B. If a veteran declines Part B coverage, he or she will have a late enrollment penalty if he or she enrolls in Part B later).

When deciding whether or not to enroll in Medicare Part D, veterans need to assess how important it is for them to have Part D coverage in addition to VA prescription drug coverage. Factors to consider include the cost of Part D premiums and the additional flexibility of being able to get prescriptions from non-VA doctors and facilities. Veterans can also use their Medicare Part D coverage to obtain medications that aren’t on the VA formulary. Another way to receive non-formulary drugs through the VA is to request them through a waiver process. This process, however, can be time consuming and challenging for many veterans. A veteran can sometimes use VA prescription drug coverage to obtain drugs that are too expensive or not available through Medicare.
Two additional considerations may be important to veterans. A veteran who lives in or moves to a geographical area that has limited access to VA facilities may want to maintain his or her Medicare prescription drug coverage to facilitate access to a pharmacy. If a veteran becomes a patient or inmate in a government agency (such as a jail, prison, state veterans home, or state mental institution), the veteran may not be eligible for VA health benefits. While the veteran is in that institution, he or she may not have creditable coverage for Medicare Part D from the VA. Because of this, it may be important to maintain Medicare Part D coverage in order to avoid a break in coverage and a Part D late enrollment penalty. It’s important to note that veterans who are incarcerated are ineligible for Medicare Part D. This is because they don’t meet the requirement of permanently residing in the service area of a Part D plan.

**TRICARE**

TRICARE is the Department of Defense (DoD) health care program for active duty service members (ASDMs) and their family members. TRICARE evolved during the 1990s from the existing military health care program, CHAMPUS (Civilian Health and Medical Program of the Uniformed Services). The DoD provides all members in all branches of the U.S. military with health coverage through TRICARE. TRICARE provides health care through a combination of military and civilian medical facilities and providers. TRICARE is designed so that ASDMs and family members can get health care at civilian medical facilities when they are unable (too far away, for example) to get treatment at a military hospital or clinic. The name TRICARE comes from the existence of its three primary programs:

1. **TRICARE Prime** (a managed care plan for all active duty service members);

2. **TRICARE Standard** (a fee-for-service plan for non-active duty beneficiaries, including family members, living in the United States); and

3. **TRICARE Extra** (a savings program that works with TRICARE Standard).

Additional TRICARE programs include:
• **TRICARE For Life** (for Medicare-eligible TRICARE beneficiaries);

• **TRICARE Reserve Select** (for Reservists and National Guard Members);

• **TRICARE Prime Overseas**; and

• **US Family Health Plan** (available only in six areas of the country).

All active duty service members are covered under either TRICARE Prime or TRICARE Prime Remote. Family members and other TRICARE beneficiaries choose between several other TRICARE options. The DoD bases eligibility for the different TRICARE programs on a number of factors, including whether the individual or his or her TRICARE sponsor is on active duty or retired, where he or she lives, and whether he or she is Medicare eligible. Each program differs in terms of out-of-pocket costs and which medical providers and facilities its members can use (military, civilian, or both). In general, TRICARE provides comprehensive health coverage at a low cost to its members.

When a service member leaves the military, eligibility for TRICARE will end unless the individual is retiring from the military. Retirees and their dependents maintain eligibility for TRICARE. Service members can retire after 20 years of service or if they become permanently or temporarily disabled, referred to as medical retirement. It’s possible for a beneficiary to have both TRICARE and VA healthcare benefits.

Most Title II disability beneficiaries who have TRICARE and Medicare will be enrolled in TRICARE for Life (TFL). Two other possible TRICARE options for beneficiaries with Medicare are TRICARE Plus and TRICARE Prime. TRICARE Prime is only available to beneficiaries who live in a TRICARE Prime service area. TRICARE Plus is available at some Military Treatment Facilities, and it gives enrollees priority access to primary care appointments at these facilities.

TRICARE Prime care uses a managed care system similar to a civilian HMO. Under TRICARE Prime, a primary care manager coordinates care, and members need referrals and prior-authorizations to access specialty care. For veterans with TRICARE Prime, a Military Treatment Facility (MTF) provides most care. One advantage of choosing TRICARE Prime over TFL is that Prime gives the beneficiary priority access to treatment at
MTFs. The disadvantage of choosing TRICARE Prime over TFL is that the beneficiary won’t be able to use the wider network of providers that accept Medicare. Also, with TRICARE Prime, the beneficiary will need a referral and authorization to see a specialist. The majority of Medicare-eligible TRICARE beneficiaries that CWICs will encounter will be enrolled in TRICARE for Life.

**TRICARE for Life**

TRICARE for Life is the TRICARE program option for Medicare-eligible uniformed services retirees, their eligible family members and survivors, and certain former spouses. TFL is available to all Medicare-eligible TRICARE beneficiaries, regardless of age, provided they have Medicare Parts A and B. TFL is wraparound coverage for Medicare. This means that for most medical services, TRICARE will pay all out-of-pocket costs that the beneficiary would have incurred with Medicare alone. For medical services covered by both Medicare and TRICARE, TRICARE will cover the full Medicare deductible and coinsurance amounts. Veterans with TFL have a wide choice of providers and minimal out-of-pocket costs. TRICARE for Life is similar to the Original Medicare (that is “fee-for-service” Medicare) in that the veteran can use any Medicare-certified healthcare provider or facility.

[Complete information about TRICARE](https://www.tricare.mil/) is available.

**TRICARE and Medicare**

When beneficiaries have TRICARE and Medicare, Medicare coverage will generally be the primary payer (will pay bills first). TRICARE is secondary payer for medical services that are covered by both Medicare and TRICARE. Medicare will pay its portion of the claim, and then TRICARE will pay the remaining amount of the bill. TRICARE will pay any Medicare co-insurance and deductible amounts for the Medicare beneficiary. The only exception to this rule is when the beneficiary has used up a Medicare benefit for a medical service. In this case, TRICARE will also make payment as the primary payer. The beneficiary will be responsible for applicable TRICARE deductibles and cost shares.

The beneficiary will usually have no out-of-pocket costs for services covered under both TRICARE and Medicare. For example, if a veteran
has both types of health coverage, and needs to stay in a hospital for four months, the veteran will have no out-of-pocket costs. TRICARE will cover all Part B out-of-pocket costs as well, as long as the veteran uses providers that accept Medicare. CWICs should remind veterans to use providers that accept Medicare. If they use a provider that doesn’t accept Medicare, then Medicare won’t pay anything. In this case, TRICARE will pay only 20 percent of its allowed rate for the services, and the beneficiary will be responsible for the remainder of the bill.

If Medicare covers a medical service but TRICARE doesn’t, then TRICARE won’t pay anything. Medicare will be the primary payer. The veteran will have to pay any remaining portion of the bill after Medicare has paid. In this case, the veteran will pay Medicare co-insurance and deductible amounts. When TRICARE covers a medical service but Medicare doesn’t, TRICARE will be the primary payer. The veteran will have to pay any TRICARE cost shares and the TRICARE Standard annual deductible (unless the veteran has other health insurance that will pay).

**Medicare Part B Enrollment and TRICARE**

Title II disability beneficiaries with TRICARE need to understand the importance of enrolling in and maintaining their Medicare Part B coverage. Under federal law, if an individual is a TRICARE beneficiary eligible for premium free Medicare Part A, he or she must enroll in Medicare Part B and pay the monthly premiums in order to remain eligible for TRICARE benefits. There are a few exceptions to this rule, which are discussed below. If a beneficiary doesn’t enroll in Part B when it becomes available to him or her, he or she can enroll in Part B later but he or she may have a break in his or her TRICARE coverage and he or she may be required to pay the Part B late enrollment penalty.

There are two main exceptions to the requirement of having Medicare Part B in order to be eligible for TRICARE. The first exception is for active duty service members (ADSMs) and their family members. ASDMs aren’t required to purchase Medicare Part B in order to remain TRICARE eligible. ASDMs can enroll in Part B anytime they are on active duty or within the first eight months following the month they separate or retire from the service. This eight-month period is called a Special Enrollment Period for Medicare Part B. The DoD strongly encourages ASDMs to keep Part B while active so that there is no break in TRICARE coverage after they leave the military. If the SSDI beneficiary is a family member of an ASDM (who is called his or her sponsor), the beneficiary doesn’t need to
purchase Part B until his or her sponsor retires or separates. The family member will have a Special Enrollment Period: He or she can enroll any time the sponsor is on active duty and the eight months period after the sponsor separates or retires from service.

**TRICARE and Medicare Prescription Drug Benefits**

TRICARE provides veterans with low-cost comprehensive prescription drug coverage. TRICARE has a standardized list of covered medications called the Uniform Formulary. TRICARE classifies all medications into three cost tiers:

- **Tier 1**: Formulary – Generic
- **Tier 2**: Formulary – Brand Name
- **Tier 3**: Non-Formulary

TRICARE bases the beneficiary’s out-of-pocket costs on the drug’s Tier level and on how the beneficiary obtains the drug. If the beneficiary obtains the prescription drug at a Military Treatment Facility pharmacy, there is no cost to the beneficiary. If he or she obtains the medication through the mail or at a “Network” pharmacy, then co-pays apply. TRICARE has more than 56,000 Network pharmacies throughout the U.S. and its territories.

How Medicare and TRICARE coordinate benefits between prescription drug coverage is similar to how they coordinate for other types of medical services. Medicare is the primary payer when both TRICARE and Medicare cover the prescription drug. There is no cost to the beneficiary for drugs that both plans cover, up to an annual coverage limit of $2,250. After the beneficiary reaches this limit, he or she is responsible for standard TRICARE co-pays for medication. This means that initially veterans with both types of health coverage will have no out-of-pocket prescription drug costs. After they have reached $2,250 in total drug costs, veterans will have to pay the TRICARE Standard co-pays. If a veteran uses MTF pharmacies for drugs on the Uniform Formulary, he or she will have little or no out-of-pocket costs for medications, even after reaching his or her annual coverage limit.

Joining a Medicare Part D plan is voluntary for TRICARE beneficiaries. TRICARE drug coverage is creditable coverage for Medicare Part D purposes. Beneficiaries won’t be subject to a Part D late enrollment penalty as long as they have had no break in TRICARE coverage. The
primary advantage for veterans with TRICARE to enroll in a Medicare Part D plan occurs if the veteran is low-income. Low-income veterans may be able to obtain some medications at a lower out-of-pocket cost by using their Medicare instead of TRICARE. For most TRICARE beneficiaries, there is almost NO advantage to enrolling in a Medicare prescription drug plan. More information about the interaction between TRICARE and Medicare is available online (https://tricare.mil/Plans/Eligibility/MedicareEligible.aspx).

**Conducting Independent Research**

**Veterans Health Administration Home Page**
(http://www.va.gov/health/)

**Veterans Health Care information**
(http://www.military.com/benefits/veterans-health-care)

**VA Health Benefits Reference Library**
(http://www.va.gov/healthbenefits/resources/publications.asp)

“Comparison of Outpatient Prescription Drug Coverage: Medicare, VA, VA-ChampVA, DoD-Tricare Pharmacy” Centers For Medicare & Medicaid Services

**Important Information for TRICARE (Military Health Benefits): Beneficiaries Entitled to Medicare Based on Social Security Disability:** Social Security Administration, SSA Publication No. 05-10020, June 2014. (https://www.ssa.gov/pubs/EN-05-10030.pdf)
Competency Unit 4 – Understanding Private Health Insurance Coverage

Introduction

Until recently, many Social Security disability beneficiaries have been unable to access private health insurance. Historically, private health insurance companies could deny coverage due to pre-existing conditions. Because most beneficiaries eligible for Social Security disability benefits have pre-existing conditions, these private health insurance plans were out of reach. Because of the Affordable Care Act (ACA) of 2010, private health insurance companies may not deny eligibility for a healthcare plan or access to covered services because of pre-existing conditions (effective January 1, 2014). For children, the ACA removed this barrier in September 2010.

Generally, individuals access private health insurance plans through the following means:

- Employer-sponsored health insurance;
- The Marketplace (also known as the Insurance Exchange);
- Individual or family plans purchased directly from private health insurance companies; or
- Union, association, and professional organization sponsored plans.

**NOTE:** This unit will provide details about each of these pathways to private health insurance as they currently stand. Legislative changes to the ACA could occur in the coming year which would make some information in this unit inaccurate. When in doubt, seek assistance from your VCU NTDC TA Liaison.
Healthcare Terms and Concepts

Healthcare Terms
There are certain terms a CWIC must understand to master the information in this unit.

Initial Enrollment Period:
The first time health coverage is made available is called the initial enrollment period. If the person doesn’t sign up during the initial enrollment period, he or she will need to wait for the open enrollment period or a special enrollment period to enroll.

Open Enrollment Period:
With most pathways to private healthcare, after the initial enrollment period expires, there will likely be a designated time frame during which a person can enroll, called an open enrollment period. This is often once a year and will span multiple weeks or months. During open enrollment, an individual can accept or change health plans.

Special Enrollment Period:
When a pathway to health insurance has an initial and open enrollment period, it’s common to also have a special enrollment period. This provides a way for people, who meet certain exceptions, to enroll after the initial enrollment period but before the open enrollment period. Take, for example, an individual who opts out of employer-sponsored health insurance because he or she was already on his or her spouse’s employer health plan. If that person lost coverage under his or her spouse’s employer health plan, he or she could enroll in his or her own employer’s health plan (assuming they have and allow this under a special enrollment period), even if the coverage ended before open enrollment.

Premium, Deductibles, Co-Payments, Co-Insurance, and Out-of-Pocket Maximum

- Premium is a monthly amount the individual must pay to be enrolled in a plan.

- Deductible is the amount of money an individual is responsible for paying before the health plan will start helping to pay for covered services.
Co-insurance is the percentage of a medical bill that the individual pays.

Co-payment is a fixed fee that subscribers to a health plan pay for their use of specific medical services covered by the plan.

Out-of-pocket maximum is the maximum amount an individual pays for healthcare services in a calendar year before the insurer begins to pay for services at 100 percent.

The amount of the premium, deductible, co-payments, and co-insurance can vary dramatically from one plan to another.

**Example of how each of these expenses comes into play:**

Alex has seldom been sick and never spent time in the hospital. Last December Alex broke his leg skiing and was rushed to the local hospital. The break was so bad that he needed surgery. Afterwards he endured several months of physical therapy. The bill for the hospital stay, surgery, and physical therapy amounted to $60,000.

Alex’s health plan is through his employer; he has $250 deducted from his paycheck each month for the premium. Because Alex had rarely been ill, he hadn’t yet paid the required deductible. After the hospital stay and surgery, Alex was responsible for:

- The first $500 of his medical bills (deductible);
- Twenty percent of the remaining medical expenses up to the out-of-pocket maximum of $2,000 (co-insurance);
- and
- Continued payment of the health insurance premium ($250/month).

The total expenses, not including premiums, Alex will have during any calendar year will be $2,500.

**Broad Insurance Reforms**

Under the Affordable Care Act (ACA) of 2010, a number of broad insurance reforms changed some of the rules set by health insurance companies.
Elimination of Pre-Existing Conditions: As of January 1, 2014, insurance companies can no longer deny coverage or deny issuing an insurance plan to individuals because of a pre-existing condition. The elimination of pre-existing conditions for children under the age of 19 went into effect in September 2010. The pre-existing condition rule does not apply to some policies purchased before September 2010.

Community Rating: Community rating is a reform that affects how health insurance companies can set their rates. Historically, health insurance companies have been able to take into consideration the individual’s personal health when determining the rate. Under the ACA, health insurance companies can vary their rates but only based on certain characteristics including family size, geographic location, use of tobacco, and age.

Lower Insurance Costs: Health insurance companies are no longer able to have annual or lifetime limits on the amount of covered health care services. This rule does not apply to some plans that the ACA grandfathered in and to some covered services. Additionally, health plans must create limits for the amount a consumer will pay in out-of-pocket costs and provide certain preventative services at no cost.

Extended Access to Parents’ Heath Insurance: In the past, health plans often dropped children from their parents’ plans when they turned 19 or finished college. As of September 2010, children can stay on (or be added to) their parents’ insurance policies until they turn 26. This applies to insurance plans that provide dependent coverage, including employer-sponsored health coverage.

Mental Health Parity: The ACA didn’t establish Mental Health Parity protections but does extend the applicability of parity to many new insurance plans. Under parity requirements, health plans can’t put more restrictive criteria on behavioral health services than on physical or acute care services. This allows greater, and equitable, access to behavioral health services when compared to physical health.

Common Types of Healthcare Plans

Health Maintenance Organization (HMO)

This type of health insurance plan usually limits coverage to care from doctors who work for or contract with the HMO. It generally won’t cover out-of-network care except in an emergency. An HMO may require you
to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

**Exclusive Provider Organizations (EPO)**

These are managed care plans in which services are covered only if you use doctors, specialists, or hospitals in the plan’s network (except in an emergency).

**Preferred Provider Organization (PPO) Plans**

With this type of health plan you pay less if you use providers in the plan’s network. You can use doctors, hospitals, and providers outside of the network without a referral for an additional cost.

**Point of Service (POS) Plans**

With the type of plan you pay less if you use doctors, hospitals, and other health care providers that belong to the plan’s network. POS plans require you to get a referral from your primary care doctor in order to see a specialist.

**Employer-Sponsored Health Insurance**

For many Social Security disability beneficiaries, accessing employer-sponsored healthcare is a work incentive that remains largely untapped. Many individuals consider employment merely as a way to improve their quality of life through increased income. However, accessing employer-sponsored benefits such as health coverage, short-term or long-term disability insurance coverage, and life insurance can allow individuals to support their healthcare needs as well as those of a spouse or dependents. Many employers offer benefits to an individual who works a specified number of hours and remains employed for a specified period of time.

**Active Work Requirements:** Employers usually require an employee to work a minimum number of hours per week to be eligible for employee benefits. This active work requirement ranges from 20 to 40 hours per week depending on the employer and health coverage provider.

**Service Wait:** When an individual accepts employment that offers health coverage, he or she may be required to wait between one to six months to enroll. This period is known as the service wait. The service wait may be different for each benefit the employer offers.
Once the individual meets the eligibility requirement, there will be an initial enrollment period during which time he or she can enroll. Depending on the plan(s) offered by the employer, the individual would likely have a monthly premium. In many cases the employer pays a portion of the premium and the employee pays another portion. In some situations the employer will pay the entire premium.

**Types of Employer-Sponsored Healthcare Coverage**

Employers may choose to provide a variety of private health plans. Each type provides coverage in different ways with advantages and disadvantages. Individuals should consider the cost associated with the coverage. Although some coverage will enable an individual to have greater access to medical providers, the individual must be able to afford the cost associated with this choice. Most employer-sponsored healthcare benefits use a form of healthcare explained under the “Common Types of Healthcare” above.

It’s possible for an employer to use a self-insured trust or self-funded plan as an alternative. These are plans in which a large company or labor union covers an individual’s medical expenses with funds set aside to pay claims. Because this type of coverage is less regulated, the policies vary greatly. Individuals who are members of a self-insured trust should thoroughly review the benefits to determine what the self-insured trust covers.

**Using Medicaid or Medicare with Employer-Sponsored Health Coverage**

Beneficiaries can use private employer-sponsored coverage in conjunction with Medicaid and Medicare. Adding private health coverage can expand access to providers and extend healthcare benefits to family members. Unfortunately, many individuals believe that use of, or eligibility for, private health coverage will make them ineligible for Medicaid or Medicare, when this is generally not the case. As a result, many individuals needlessly deny themselves and their dependents access to employer-sponsored health coverage.

When using employer-sponsored health benefits in conjunction with either Medicaid or Medicare (or both), it’s critically important that beneficiaries inform current and new medical providers of multiple types of health coverage to ensure proper billing and to avoid patient liability.
When an individual is eligible for Medicaid and private health coverage simultaneously, the private coverage always becomes primary (pays first) and Medicaid becomes secondary. There are no exceptions to this rule. Medicaid is always the payer of last resort when other forms of health insurance are available.

Medicaid beneficiaries should report to their eligibility worker when they are offered employer-sponsored health insurance. Some states will require the beneficiary to take the employer-sponsored health insurance if it’s “cost effective.” If it’s “cost effective,” the Medicaid agency will likely pay the individual’s health insurance premium. If it’s not “cost effective,” the individual won’t be required to take the new coverage but will also not receive any assistance in paying for the premium.

When an individual is eligible for both Medicare and employer-sponsored health coverage simultaneously, the employer’s coverage becomes primary (pays first) and Medicare becomes secondary, if the individual is under age 65 and the employing company has more than 100 employees. However, Medicare only pays the difference between the employer coverage and the cost of the covered expense up to what Medicare would usually pay for the covered expense.

Employer-sponsored health insurance becomes the secondary payer with Medicare paying first for individuals under age 65 who work for companies with fewer than 100 employees, or for people aged 65 and older who work for companies with fewer than 20 employees.

While Medicare will let a beneficiary opt out of Medicare Part B and D if the beneficiary has employer-sponsored healthcare, it’s important that beneficiaries know some employer-sponsored health insurance plans will require the beneficiary to get or keep all parts of Medicare if they are eligible.

If employment ends and the individual has COBRA coverage or retiree coverage with Medicare, then Medicare is the primary payer. We provide more detailed information on COBRA further on in this unit.

**NOTE:** If a beneficiary already has COBRA when he or she becomes Medicare-eligible, in most cases he or she will want to enroll in Part B to avoid paying a late enrollment penalty. The beneficiary won’t have a Special Enrollment Period (SEP) to enroll in Medicare Part B when COBRA
ends. See the unit on Medicare for more information on Medicare Part B and late enrollment penalties.

Social Security Title II disability beneficiaries have eight months after employer coverage stops, regardless of COBRA, to enroll in Medicare Part B without a premium surcharge. For more detailed information about the premium surcharge for Medicare Part B, refer to Unit 2 of this module, “Understanding Medicare.”

**Example of using Medicare with employer-sponsored health coverage:**

Gus has been working for the same small company for 40 years. He enjoys his work, likes his employer, and at age 70 has no intention of retiring. In addition to his employer’s health insurance, he has Medicare. Gus had an emergency appendectomy two weeks before his 71st birthday. He was admitted to the hospital, where doctors performed surgery. Instead of billing his primary insurer, Medicare paid for the majority of the surgery and hospital stay. Because Gus received coverage from a small employer (fewer than 20 employees), Medicare covered the surgery as the primary payer, with the private coverage becoming secondary.

**Example of using Medicaid with employer-sponsored health coverage:**

Michael is an SSI recipient who is now working, making $20,000 annually, and is enrolled in his employer-sponsored health coverage with a deductible and copayments. He is also still eligible for Medicaid under 1619(b) provision, which is explained in detail in Unit 1 of this module.

Michael received bills for lab work and consultations that he thought his health insurance covered, so he called the lab and asked to speak to the billing department. The representative explained that he was being billed for copayments that his primary insurer required. He said he understood, though he didn’t. He then called his primary care physician’s office and asked to speak to the billing department there. Again, he questioned the bill. After a
moment the billing representative agreed with him and assured him that the billing department will remind the lab and the physician’s office that not only does Michael have private insurance but also that Medicaid that will take care of the co-payments that the lab billed.

He was relieved until the following month when he received a bill from the same lab. He angrily tore into the envelope and yanked out the bill. His concerns were immediately alleviated when he saw at the bottom of the bill, “BALANCE DUE: $0.”

Beneficiaries should take into account some important considerations when combining Medicare or Medicaid with employer-sponsored insurance:

- Determining whether the employer’s plan will cover the beneficiary’s current physician(s) and specialists.
- Informing new health insurance carrier of Medicare eligibility to establish payment order and avoid patient liability.
- Taking into account special provisions for continued Medicaid and Medicare coverage while working (see Units 1 and 2 of this module).

**COBRA Health Coverage Protection between Jobs or Continuation Coverage**

Federal and state law allows continued access to employer-sponsored health coverage after employment ends, whether it ends voluntarily or involuntarily. These legal protections apply to health coverage through an employer. The protections are commonly called COBRA, or continuation coverage protections. The acronym COBRA stands for the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986. With the passage of the Affordable Care Act (ACA) of 2010, pre-existing conditions are no longer a barrier to individual health insurance plans, and new pathways exist (e.g., Marketplace) to obtain health insurance. As a result, it’s expected that fewer people will use this COBRA option. Because this law still exists, it’s important CWICs understand when and how it can help.
Individuals who are working and have health coverage through their employer might lose that coverage for a number of reasons, such as being laid off, quitting, or reducing their work hours. When individuals lose employer-sponsored health coverage for these or similar reasons, the COBRA laws may allow them to keep that coverage for up to three years. Continuation coverage laws, in most situations, also protect spouses and dependents of those on an employer-sponsored health plan.

**IMPORTANT NOTE:** Under COBRA provisions, employers don’t pay for any part of the premium for continuation coverage. The individual who receives coverage entirely pays for COBRA coverage.

To be eligible for continuation coverage, the individual must have lost his or her employer-sponsored group coverage because of a qualifying event. Many events that cause an individual to lose his or her original coverage are qualifying events. For employees, qualifying events include:

- Quitting,
- Being fired for a reason besides gross misconduct,
- Being laid off, or
- Having work hours reduced to a point where the employer doesn’t provide health coverage.

To be eligible for continuation coverage, the individual must be on the employer-sponsored health plan on the day before a qualifying event happens. After the qualifying event, the employer has to notify the health plan within 30 days of that event. If the covered individual divorces or legally separates from the spouse, or is someone who reaches an age where he or she is no longer considered a dependent child, those individuals have to notify the health plan within 60 days.

The health plan then has 14 days to send out a notice informing the key people in these cases that continuation coverage is available. They will send an application along with the notice that explains how much the COBRA continuation coverage premium will be. The cost will generally be the entire amount of the premium, including what the employer used to pay, plus a small cost for administrative fees.

A covered individual has 60 days from the day of the qualifying event to enroll in continuation health coverage. If an individual gets a notice after
the qualifying event, he or she has 60 days from the day he or she receives the notice. If the individual doesn’t get a notice, he or she will need to contact both the employer and the health plan.

In some states, if Medicaid covers beneficiaries, the state’s Medicaid health insurance premium payment program may be able to help pay COBRA continuation coverage premiums. CWICs are encouraged to investigate whether this option is available in their home state.

Two laws relate to this continued coverage. They apply to different people for different amounts of time. It can be confusing as to when coverage under one law begins and when another one ends.

- **COBRA is a federal law that covers employees of businesses with 20 or more employees.** It allows up to 18 months of continuation coverage for an employee who loses coverage because of a qualifying event. The premium for these 18 months is up to 102 percent of the premium for current employees with the same plan. The coverage time periods are sometimes different for spouses and dependents. COBRA will last for 36 months if the individual qualifies for continuation coverage because of the employee’s Medicare enrollment, legal separation or divorce, loss of dependent status, or death of the employee.

- **OBRA (Omnibus Budget Reconciliation Act of 1987) is a federal law meant to extend COBRA for a longer period of time to people with disabilities.** If the individual is on COBRA for 18 months and Social Security determines that the individual is disabled within the first 60 days of the COBRA continuation coverage, the individual can extend the coverage for an additional 11 months. The purpose of this law is to protect health coverage during the period between becoming disabled and qualifying for Medicare. The premium can increase to up to 150 percent of the premium for current employees with the same plan.

With continuation coverage, the individual is on the same health coverage policy he or she was on previously and will have the same benefits as other employees on the plan. If the employer increases premiums for those currently on that plan, the continuation coverage premiums will increase accordingly. If the employer offers current employees an
opportunity to switch plans, those on continuation coverage will have that opportunity as well. With COBRA, the individual can also choose to continue coverage for dental and vision benefits.

The Marketplace (Insurance Exchange)

The Marketplace, also known as the Insurance Exchange, was a centerpiece of the Affordable Care Act (ACA). The purpose of the Marketplace is to ensure the availability of and access to health insurance for Americans. The heart of the Marketplace is a website that provides a place for people to compare and shop for private health insurance plans. The model fosters competition and facilitates access. The website also provides a way for people to apply for non-disability or non-elderly related Medicaid eligibility groups and the Children’s Health Insurance Program (CHIP), as well as the Advanced Premium Tax Credit (APTC), which helps pay health insurance premiums.

Some states have created their own state-specific Marketplace, whereas other states chose not to create a Marketplace; instead, its citizens use the Marketplace run by the federal government: www.healthcare.gov. A handful of states pursued a hybrid model. To find out what your state is using for the Marketplace, go online and select your state: (https://www.healthcare.gov/marketplace/individual/). CWICs should become familiar with these resources to be able to refer beneficiaries when the time arises.

For individuals who don’t have Internet access or who need support in comparing plans, shopping for plans, or applying for Medicaid or the APTC, both phone and in-person assistance is available. Details such as the appropriate phone number and how to find in-person assistance are available on the Marketplace website for each state.

Eligibility and Who Can Use the Marketplace

To use the Marketplace, an individual must:

- Live in the Marketplace service area, and
- Not be incarcerated, and
- Be a U.S. citizen or national, or
• Be a non-citizen who is lawfully present in the U.S. for the entire period for which he or she is seeking enrollment

Important Notes About Medicare and Medicaid Beneficiaries:

**Medicare Beneficiaries:** It’s illegal to sell and issue duplicate coverage to Medicare beneficiaries. As a result, Medicare beneficiaries can’t use the Marketplace. The exception is beneficiaries whose employer purchases Small Business Health Options Program (SHOP) coverage, as they are treated the same as any other people with employer coverage.

**Medicaid Beneficiaries:** While Medicaid beneficiaries aren’t prohibited from purchasing a plan on the Marketplace, there doesn’t appear to be any situation in which it would make financial sense to purchase a plan on the Marketplace and have Medicaid. The individual would have to pay the monthly premium, because he or she would be ineligible for the Marketplace financial assistance programs.

Now that you understand the eligibility criteria for purchasing a private plan on the Marketplace and the fact that Medicaid and Medicare beneficiaries are unlikely to benefit from such a plan, it’s helpful to look at who could benefit from a Marketplace plan:

• Individuals receiving SSDI who don’t qualify for Medicaid and are in the 24-month Medicare Qualifying Period.

• Uninsured individuals currently applying for Social Security.

• SSI beneficiaries who have earned income that exceeds 1619(b) and other options for Medicaid in the state.

• Social Security disability beneficiaries who medically improve.

• Title II disability beneficiaries who were terminated due to SGA-level work and whose Medicare coverage under the EPMC will soon expire.

**Enrollment Periods**

• **Open Enrollment Period:** Generally this period is November, December, and potentially one or more months in the beginning
of the following year. The Marketplace website will specific dates for a state’s open enrollment period. **Special Enrollment Period:** When a qualifying life event occurs (e.g., moving to a new state, certain changes in income, marriage, divorce, birth of a child), a Special Enrollment Period will be available.

**Qualified Health Plans**

Plans on the Marketplace are called Qualified Health Plans (QHPs). The entity running the Marketplace (the state agency or federal government) must review all plans to assure they meet certain requirements. One of the major requirements of QHPs is that they must offer Essential Health Benefits (EHBs). Essential Health Benefits are a minimum package of services that all QHPs have to offer. They create a baseline for plans on the Marketplace. Essential Health Benefits include at least these 10 categories:

1. Ambulatory patient services,
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorders services (including behavior health treatment)
6. Prescription drugs
7. Rehabilitation and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services, and chronic disease management
10. Pediatric services (including oral and vision care)

The essential health benefits package may vary slightly from state to state. Each state creates a benchmark plan, which provides more specific details about coverage including specific benefit limits, state required benefits, and a list of covered prescription drug categories and classes. **State benchmark plans** (http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html)
To make it easier for consumers to compare plans on the Marketplace, the plans are categorized using a metal grouping: platinum plans, gold plans, silver plans, and bronze plans. The difference between these categories of plans is the actuarial value, which is the overall healthcare cost that each plan covers. Plans with higher actuarial value (the health plan covers more healthcare costs) have a higher monthly premium. The lower the actuarial value, the lower the premium will be.

<table>
<thead>
<tr>
<th>Levels of Coverage</th>
<th>Plan Pays On Average</th>
<th>Enrollees Pay On Average* (in addition to monthly premium)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>60 percent</td>
<td>40 percent</td>
</tr>
<tr>
<td>Silver</td>
<td>70 percent</td>
<td>30 percent</td>
</tr>
<tr>
<td>Gold</td>
<td>80 percent</td>
<td>20 percent</td>
</tr>
<tr>
<td>Platinum</td>
<td>90 percent</td>
<td>10 percent</td>
</tr>
</tbody>
</table>

*Based on average cost of an individual under the plan and may not be the same for every enrolled person.

In looking at the plans, for example, an individual may have more out of pocket costs associated with the provision of health care services with a silver plan than he or she would with a gold plan. But, the individual would have less in premium costs with a silver plan than he or she would with a gold plan. Choosing a health plan is a financial decision based in large part on the individual’s expected health care needs. The monthly premiums will vary not only by metal category, but also by geographic area, age, family size, and tobacco use.

Two financial assistance programs help those with low income afford coverage through the Marketplace:

- Advanced Premium Tax Credit (APTC)
- Cost Sharing Reduction
Advanced Premium Tax Credit (APTC)

ACA created the Advanced Premium Tax Credit to help those with low income offset the cost of health insurance. A tax credit generally means getting money back during tax time each year. This tax credit works in a very different way. If a person’s Modified Adjusted Gross Income (MAGI) is low enough, he or she can get this tax credit in advance, getting a little bit each month. The monthly amount of the tax credit is paid directly to the health insurance company beneficiaries choose on the exchange, to cover a portion of the monthly premium. The end result is that the person gets a portion of their premium paid, reducing what has to come directly out of his or her pocket each month. It’s also important to note that this tax credit is “refundable,” which means it’s available to a person even if he or she has no tax liability.

Who can get APTC?

The ACA bases eligibility for the APTC, in part, on income. Families with income between 100 percent and 400 percent of the FPL who purchase coverage through an insurance exchange could be eligible for a tax credit. There is no asset test. Income is determined using the MAGI standard. To determine income using the MAGI standard, the first step is to determine taxable income less any allowable IRS deductions, which is what the person reports to the IRS. Add in any Title II Social Security income that you didn’t count as taxable income. Unlike the Medicaid eligibility groups who use a MAGI-based income methodology, there isn’t a 5 percent disregard of income. For example, George has $1,200 of SSDI and $850 of gross wages. He doesn’t have Medicare yet and has no tax deductions. His total income, $2,050, is below 400 percent of the FPL for a single person ($4,163 – 2019 rate).

A critical concept to understand, in terms of eligibility, is that even if a person’s income falls within that range, he or she can’t get this tax credit if he or she is eligible for minimum essential coverage. Minimum essential coverage includes public health insurance such as Medicare Part A, Medicaid, the CHIP program, TRICARE, and VA Heath Care Benefits. The logic is the federal government is already sponsoring, at least in part, health insurance for those individuals. Minimum essential coverage also includes employer-sponsored health insurance, unless the employer-sponsored plan doesn’t cover at least 60 percent of health care expenses or unless the person’s share of the premium exceeds 9.5 percent of his or her income. People who have affordable employer-sponsored health
insurance can enroll in a health insurance plan through the exchange and may receive tax credits to reduce the cost. During the application process on the Marketplace, the person would have to “attest” to having unaffordable employer-sponsored health insurance. The Marketplace then verifies that statement.

If a person is interested in applying for the APTC, he or she will need to do so through the Marketplace for his or her state, whether it’s a state-run exchange or the federally run version. During the application process, the person will provide his or her estimated income for the year. If his or her income is low enough, he or she can choose the specific amount of advanced credit he or she wants applied to his or her premiums each month, up to a maximum amount based on his or her income. If the amount of the advanced credit he or she takes for the year is less than the tax credit he or she ends up being due, then he or she will get the difference as a refundable credit when completing his or her tax return at the beginning of the following year. If the advanced payments for the year are more than the amount of credit the person ends up being due, then the extra tax credit will reduce his or her overall refund (if any) or he or she must pay it back when filing the tax return the following year. If a person’s income is variable, he or she will potentially want to choose an advanced tax credit amount that is less than the maximum to avoid or minimize having to pay at tax time.

**How much does APTC help?**

The amount of the tax credit that a person can receive is based, in part, on the premium for the second lowest cost silver plan on the exchange where the person is eligible to purchase coverage. A silver plan covers about 70 percent of health care expense. The amount of tax credit is also based on the household’s income. On the lower end of the scale, those with income up to 133 percent of the FPL will pay 2 percent of their income on the premium. On the higher end of the scale, those with income up to 400 percent of the FPL will pay 9.5 percent of their income on the premium.

**Example of eligibility for a silver plan:**

Debra is 45 years old and has income in 2019 that she expects to be 250 percent of the FPL, which is $31,225 (2019 rate). Given her income, Debra wouldn’t be required to pay more than 8.05 percent of income for a premium,
which equals $2,427 for the year. The second lowest cost silver plan in her area costs $5,733. Because she’s only required to pay $2,427, she would be eligible for an advanced tax credit of $3,306.

When applying for a health plan on the Marketplace, the individual will also be able to apply for the APTC. The Marketplace will calculate the APTC the person is estimated to be eligible for. If an individual is interested in an estimate, the Kaiser Family Foundation has created an estimator tool that can be found online (https://www.kff.org/interactive/subsidy-calculator/).

Cost Sharing Reduction

The purpose of cost sharing subsidies is to protect those with lower income from the high out-of-pocket costs that can occur when accessing health care services. The ACA provides for reduced cost sharing for families with incomes at or below 250 percent of the FPL by making them eligible to enroll in health plans that pay more of the health care costs. There is no asset test for this assistance.

The way it works is the person must sign up for a silver level plan and must also be eligible for the APTC. If he or she meets those criteria and his or her income is at or below 250 percent of FPL, then he or she can get the out-of-pocket savings similar to a gold or platinum plan at the price of a silver plan. As noted earlier, the out-of-pocket expenses for a silver plan are around 30 percent, whereas the out-of-pocket costs are only 20 percent with a gold plan and down to 10 percent with a platinum plan. By giving someone the equivalent of a gold or platinum plan at the price of a silver plan, it will reduce his or her out-of-pocket costs.

If the person applying is a member of a federally recognized Indian Tribe, he or she won’t have to pay any cost-sharing if his or her household income is less than 300 percent of the federal poverty level. A summary of health reforms for Native Indians and Alaska Natives can be found online (https://www.aihfs.org/pdf/IHS-ACA-Fact_Sheet.pdf).

Catastrophic Plans

The Marketplace may also offer catastrophic plans. Catastrophic plans generally require the person to pay all of his or her medical costs up to a certain amount, usually several thousand dollars. If a person has any costs for essential health benefits that exceed that amount, then the
insurance company generally pays those expenses. These policies usually have lower premiums than a comprehensive plan but cover the person only if the person needs a lot of care. They provide protection in worst-case scenarios. In the Marketplace, catastrophic policies cover three primary care visits per year at no cost and cover preventive benefits for free, such as blood pressure screening or alcohol misuse screening.

These plans will only be available on the Marketplace for people under 30 years of age or people over 30 who have received a hardship exemption from the individual mandate fee (explained below). To get a hardship exemption, the person must have household income less than 100 percent of the Federal Poverty Level. For someone with very low income and few health care costs, this could potentially be a useful option.

**Individual and Employer Mandate**

A highly contested part of the ACA includes the individual and employer mandates. The individual mandate was the part of the law that requires individuals to pay a tax penalty if they don’t have health insurance. The idea behind the individual mandate was that when someone without health coverage gets urgent, often expensive medical care and doesn’t pay the bill, it affects the cost of health care for everyone. Starting with the 2019 tax year, the individual mandate no longer applies.

The ACA also includes a provision for an employer mandate, which imposes a tax penalty if employers with at least 50 full-time employees or full-time equivalents don’t offer health insurance coverage that is affordable and meets minimum standards set by the ACA. Affordable means the employee’s share of the premium costs for employee-only coverage is less than 9.5 percent of the yearly household income. “Minimum standards” means that the employer-sponsored health plan must cover at least 60 percent of total health care costs. Enforcement of this tax penalty, which is called the Employer Shared Responsibility Payment, began applying in 2016. The amount of the tax penalty is based partly on whether the employer offers insurance or not.

The penalties for not providing affordable coverage aren’t triggered unless an employee accesses the tax credit on the Marketplace. If just one employee accesses the credit, then it triggers the penalty for all relevant FTEs.

When working with a beneficiary who has questions about his or her employer’s responsibility under this mandate, you should refer him or her
to the Marketplace’s toll-free number or the organizations providing in-person assistance.

**Other Pathways to Private Health Insurance**

In addition to accessing private health insurance through an employer or through the Marketplace, it may also be possible for an individual to access coverage through:

- Individual or family plans purchased directly from private health insurance companies
- Union, association, and professional organization sponsored plans

Private health insurance companies will continue to offer individual and family health insurance plans outside the Marketplace. They will likely target those plans to people who are interested in a different benefit package than the state’s benchmark plan allows. It’s important for individuals to know that the APTC and the Cost Sharing Reduction aren’t available to anyone who purchases a plan outside the Marketplace.

Some people get health coverage through unions and professional organizations, or associations such as an association of realtors, artists, or trades people. The laws governing these types of plans depend on a number of factors, including the type of policy, who the participants are, and other variables, so it’s impossible to make general statements about which laws apply. But, what can be said is that the broad reforms under the ACA (elimination of pre-existing conditions, community rating, etc.) apply to any new health insurance plan an individual purchases, including those purchased directly from private health insurance companies, through unions, professional organizations, or associations.

**Conclusion**

The passage of the ACA has changed the landscape of the private health insurance market. CWICs should be knowledgeable about the Marketplace to help beneficiaries without health coverage explore those options. Additionally, CWICs should be knowledgeable about the interface between employer-sponsored health insurance and public
benefits. Addressing those questions is a key part of supporting individuals with disabilities in recognizing the many benefits of work, without worrying about the effect on their benefits.

**Conducting Independent Research**

**Department of Labor COBRA website**  
(http://www.dol.gov/dol/topic/health-plans/cobra.htm)

**An Employee’s Guide to Health Benefits under COBRA, U.S. Department of Labor**  

**Medicare and Other Health Benefits**: Your Guide to Who Pays First, CMS Publication No. 02179  

**Kaiser Family Foundation** serves as a non-partisan source of facts, information, and analysis for policymakers, the media, the health care community, and the public (http://www.kff.org/).

**The National Health Law Program (NHeLP)** is a national public interest law firm that seeks to improve health care for America’s working and unemployed poor, minorities, the elderly, and people with disabilities (https://healthlaw.org/).

**Families USA is a consumer focused website** on health care, Medicaid, Medicare, private insurance, and prescription drugs, as well as state and national health policy analysis. It’s a nonprofit, non-partisan organization dedicated to the achievement of high-quality, affordable health care for all Americans (https://www.familiesusa.org/).

**Prescription Drug Patient Assistance Programs (PhRMA)** is a site that contains a directory of prescription drug patient assistance programs. Users can find out which pharmaceutical companies participate and how to access low-cost and no-cost medications (https://www.phrma.org/).

**Georgetown University Health Policy Institute** publishes information, which helps consumers understand health care protections provided under federal and state law, including HIPAA  
(http://ihcrp.georgetown.edu).
Federally administered Marketplace (https://www.healthcare.gov/).

The Centers for Medicare and Medicaid website provides information for community organizations on how they can support people in accessing the Marketplace (https://marketplace.cms.gov/).
Competency Unit 5 – Supporting Individuals with Disabilities in Assessing Healthcare Needs and Options

Introduction

All SSI and Title II disability beneficiaries have significant disabilities or medical conditions. In many instances, these disabilities require a regular course of medical care. Depending on the disability, the individual may need a fairly wide range of medical services and products. The costs associated with these services and products will vary greatly.

In some cases, an individual can obtain all the healthcare and related services needed for under $200 per year. Other beneficiaries with more significant disabilities may have healthcare needs that will cost in excess of $10,000 per year. In fact, some individuals who work and have physical disabilities may require several hours of home healthcare services per day. Their annual costs for healthcare may exceed $50,000. Hopefully, with good healthcare coverage options and high-quality healthcare counseling from a skilled CWIC, beneficiaries can receive the services they need with limited out-of-pocket expenses. In some cases, CWICs will need to make a referral to an agency that can provide expert advocacy and counseling on a specific healthcare program or plan.

This unit will provide a framework for assessing the healthcare needs of beneficiaries and providing counseling to them to guide their decisions related to healthcare. Eligibility details provided in previous units in this module will be referenced, but not explained. To clarify eligibility requirements or obtain more information on the various programs and strategies mentioned in this section, the reader should refer to other sections of this manual or to the resources referenced at the end of this unit.
Counseling on Healthcare Issues: Defining the Role of the CWIC

Social Security beneficiaries often make decisions about seeking work, accepting a job, or working more hours based on the anticipated effect that work and wages will have on their continuing eligibility for Medicaid or Medicare. Similarly, beneficiaries may make these decisions based on the availability of other health insurance options, including private insurance plans, insurance plans sponsored by the Department of Veterans Affairs (VA), or state-specific insurance plans that are publicly funded or subsidized.

Unfortunately, these employment-related decisions made by beneficiaries often are based on incorrect or incomplete information about either the effect of their work on Medicaid or Medicare, or rights they may have to the wide range of other third-party insurance options. Some beneficiaries may wrongly assume that benefits (i.e., insurance coverage) will be terminated, while others may wrongly assume that benefits may continue. Still others may lack the sophistication or insight to realize that these are important issues to consider when planning a move into competitive work or higher-paying work.

A well-trained CWIC works with the beneficiary in a benefits-planning context to guide his or her decisions as related to securing or retaining coverage for his or her healthcare needs. While the experienced CWIC should be competent to deal with the majority of issues presented in this section, every CWIC should have minimum levels of expertise on these topics depending on the topic and the nature of the issues.

Levels of Competency for CWICs

The subject areas for healthcare planning listed below are sorted into primary and secondary categories. In-depth expertise in the primary subject areas will be a challenge during the first six to 12 months after a CWIC is newly certified. However, with close supervision, regular mentoring, and access to technical assistance from the NTDC, the newly certified CWIC should be able to provide competent healthcare planning and counseling services in all the primary subject areas.

Within these subject areas, CWICs should be able to accurately analyze complex beneficiary scenarios with the use of reference materials (such as this manual and relevant websites). In cases involving individualized
WIPA services, the Benefits Summary and Analysis (BS&A) report and the Work Incentives Plan (WIP) should comprehensively address each of these issues as relevant.

The following represent primary subject areas related to healthcare planning and counseling:

- The basic framework of the state’s Medicaid program, including an understanding of the services covered, the application process, and the appeal process;

- Each Medicaid eligibility group available to people with disabilities, including each group’s income limit, resource limit, and the income/resource methodology;

- Thorough knowledge of the Medicaid work incentives, including Section 1619(b) and the state’s Medicaid buy-in (MBI) program, if the buy-in is available;

- The basic framework of Medicare, including an understanding of the differences between Parts A, B, C, and D, and an understanding of the Medicare 24-month waiting period;

- The Extended Period of Medicare Coverage (EPMC), allowing Title II disability beneficiaries to retain premium-free Medicare Part A and optional Part B and Part D coverage during the nine-month trial work period and for a minimum of 93 months thereafter;

- The Medicare Savings Programs (MSPs), including what they can help pay for, how to apply, income limits, resource limits, and the income and resource methodology used;

- The Low-Income Subsidy (LIS) Program, including what they can pay for, who has to apply and who is deemed eligible, the income limits, the resource limits, and the income and resource methodology used;

- How SSI’s Plan to Achieve Self-Support (PASS) can provide access to Medicaid coverage in many states;

- The Medicaid appeals process and any resources available for handling those appeals, including the state’s Protection and Advocacy program;
• Healthcare options available to veterans including TRICARE and the VA healthcare system;

• The basic concepts of employer-sponsored healthcare;

• The basic framework of the Marketplace and which beneficiaries are likely to benefit from a private health insurance plan through this exchange; and

• The interaction of Medicare, Medicaid, TRICARE, VA healthcare benefits, and private health insurance, including primary payer rules.

• The following represent secondary subject areas related to healthcare planning and counseling:

• Any Medicaid waivers available that can provide expanded eligibility criteria or expanded services to beneficiaries;

• The framework for selecting a Medicare Part D prescription drug plan including the online resources available to beneficiaries for assisting with plan selection;

• The key provisions of COBRA healthcare continuation coverage as they relate to the right to continued private insurance coverage following an event that results in the termination of that coverage;

• The healthcare-related services, including assistive technology, available through the state’s vocational rehabilitation agency or agencies allowing some transition-aged youth and adults some medical services and equipment to support their vocational goal when not otherwise available through Medicaid or a private insurance plan;

• Any state-funded or state-subsidized health insurance plans, including the CHIP program, that may be available to meet the needs of beneficiaries in the state;

• The health insurance benefits offered by the U.S. military and the Department of Veterans Affairs to disabled veterans and their families; and
Any charitable resources available in your state or regions of the state that the beneficiary can access to meet healthcare needs for individuals not otherwise insured, to meet those needs.

Given the complexity of the many healthcare provisions and considerations, some programs have assigned multiple CWICs the responsibility of developing special healthcare counseling expertise.

Making Referrals

On occasion, beneficiaries will encounter problems and questions about their health coverage that are outside of the CWIC’s experience or current level of knowledge. The beneficiary may need expert help with a Medicaid appeal, or help to determine which Medicaid category best meets his or her needs. The state Protection and Advocacy program is an excellent source of help with complex Medicaid problems or appeals. There may also be local legal aid organizations that provide expert assistance with Medicaid. The State Health Insurance Assistance Programs (SHIPs) provide free, expert counseling on Medicare program options, appeals, and other Medicare rules to and for all Medicare beneficiaries in all states regardless of age. To locate a SHIP, go to: www.shiptacenter.org

For CWICs who are new and still learning about public healthcare programs (such as Medicaid and Medicare), referrals to specific experts and organizations can help the beneficiary get answers to complex questions when he or she needs the help.

Assessing the Healthcare Needs of a Beneficiary

It’s crucial that CWICs assess a beneficiary’s healthcare needs, including identifying needs that aren’t currently being met. Armed with this information, the CWIC can work with the beneficiary to develop both short-term and long-term plans to meet the beneficiary’s healthcare needs.

A sample assessment tool that outlines the key information to be gathered is available at the end of this unit. Even if the beneficiary isn’t getting services in one of these areas, it’s important to assess whether these are unmet healthcare needs. For each category on the
questionnaire or checklist, the CWIC should address a number of key areas, including:

- **Estimated monthly or annual costs.** This helps to establish what is at stake if, for example, the beneficiary lost eligibility for Medicaid. If the actual cost of medication were $200 per month, the beneficiary would need $2,400 per year to cover this cost if he or she lost Medicaid and no other source of prescription drug coverage is identified.

- **How is the item covered?** This will help identify whether there needs to be a plan for continued eligibility for Medicaid or Medicare after starting work. For example, this may prompt the CWIC to explore either 1619(b) or the Medicaid buy-in as part of a long-range benefits plan.

- **What are the total out-of-pocket expenses for the service or product on a monthly and yearly basis?** This is really the bottom-line inquiry for each of the key healthcare areas. By answering these questions for each service or product, the CWIC begins to see a picture of just what it’s costing the beneficiary for healthcare. Armed with this information, the CWIC can then work with the beneficiary to develop a plan to cover as much of the out-of-pocket expenses as possible.

No matter how detailed the interview questionnaire or checklist may be, it can’t anticipate every potential healthcare need. CWICs should share with the beneficiary the purpose of the questions and encourage him or her to offer any additional relevant information. If any of the identified healthcare needs are either not covered through some type of insurance or payment source or require significant deductibles or co-payments, this should be a red flag to explore other coverage options.

Keep in mind that the information you gather through the initial interview is just one “snapshot” in the healthcare assessment process. When providing services over an extended period of time, it will be necessary to update the information periodically. For example, the beneficiary may have started taking a new Medicaid-funded medication that is very expensive, making the retention of Medicaid while working a higher priority than it was at the initial interview. To ensure important changes to healthcare needs and coverage aren’t missed, CWICs should make a
proactive contact with the beneficiary at least every six months to fully review and update all information collected during the initial interview.

**Example of a healthcare issue that goes beyond the typical questionnaire or checklist:**

Using an interview checklist containing questions about home healthcare, the CWIC learns that Sally, who has cerebral palsy and uses a wheelchair, receives four hours of personal care services per day (two hours in the morning and two hours in the evening). Although not suggested by the interview checklist, Sally’s CWIC, knowing that she is attending college, asks if these services are sufficient to prepare her to leave for school in the morning. Sally explains that her new morning aide, supplied by the ABC Home Health Agency (a Medicaid contractor), is often unreliable, arriving 15 to 30 minutes late, which results in Sally being late for her morning college classes.

The CWIC provides Sally with self-advocacy tips for addressing the issue with a supervisor at ABC. Additionally, after some follow-up investigation of resources, the CWIC refers Sally to a self-directed home care program run through the local Center for Independent Living. This program will enable Sally to hire and supervise her own Medicaid-funded home health aides.

**Assessing Current, Long-Term, and Potential Eligibility for Third-Party Insurance**

After completing an assessment of a beneficiary’s healthcare needs, it’s important to explore existing or potential payment sources that will help cover the identified costs. This section will discuss third-party insurance plans, which, for the majority of beneficiaries, will involve Medicaid, Medicare, or a private insurance. CWICs need to be aware, however, that some beneficiaries will have coverage through lesser-known third-party insurance plans, such as CHIP, the VA healthcare system, or TRICARE.
Medicaid

If the beneficiary is a Medicaid recipient, it’s important to verify the Medicaid eligibility group. Eligibility could be through the receipt of SSI, through the medically needy or spend down group, through the Medicaid Buy-in, or through the Home and Community Based Services waiver group. By identifying the source (or sources) of Medicaid eligibility, it will be possible to help the beneficiary plan for the retention of Medicaid when he or she goes to work or increases monthly earnings if retention of Medicaid is critical to him or her.

Example of moving from the Medicaid Spend-Down program to the Medicaid Buy-in program:

Let’s go back to Sally, who is 22 years old, has cerebral palsy, and is starting her senior year in college majoring in Spanish education. Sally receives $820 in CDB and must pay $100 per month for a spend-down to receive Medicaid, based on the financial criteria unique to her state. The CWIC is meeting with Sally as she begins her last year in college.

Sally explains that her prospects for a teaching job upon graduation are good and that she expects to earn $24,000 to $30,000 as starting pay, plus a comprehensive health insurance plan. At her CWIC’s urging, Sally has checked around, and it appears that none of the health insurance plans provided by school districts offers coverage for four hours of daily personal care services, which she will continue to need. Based on these facts, both Sally and her CWIC agree that she will need to maintain Medicaid coverage for the indefinite future.

The CWIC explains to Sally that as she starts working, her spend down amount will increase. The CWIC also explains to Sally that she should be eligible for the Medicaid Buy-in, as her state is one of the many states implemented this optional Medicaid eligibility group. The CWIC shares with Sally their state’s buy-in criteria: (1) Countable income can be up to 250 percent of the federal poverty level after applying SSI-related income disregards (allowing for earnings of around $60,000 gross per year if there is no
unearned income); (2) Countable resources of up to $10,000 are allowed — higher than the resource limit for the state’s spend down program; and (3) She’ll be required to pay a monthly premium of around $100. Sally agrees to apply for the buy-in as soon as she starts working. The CWIC summarizes this information in an updated BS&A report.

Based on the stated facts, Sally’s need for personal care services may be modest enough that she can have a long-term plan to pay these costs herself once he pays off her student loans and she sees her pay increase. Keep in mind that her personal care services would cost nearly $1,500 per month if we assume a $12 per hour rate. As part of long-range planning, the CWIC should urge Sally to look into potential tax savings, through the flexible spending account or medical deductions, as a way to partially subsidize this cost should she assume it at some point in the future.

**Retaining Medicaid through 1619(b) provisions**

Continued Medicaid under 1619(b) is available to former SSI recipients who lost SSI due to earnings and who currently meet all the criteria for 1619(b) eligibility. Although 1619(b) has been available nationwide for over 30 years, many people are unaware of it. CWICs must be vigilant to make sure that SSI beneficiaries and the agencies that serve them are aware of 1619(b).

One potential pitfall in establishing both initial and continuing eligibility is the “Medicaid use test.” To meet this test, the beneficiary must:

- Have used Medicaid in the last 12 months;
- Expect to use Medicaid in the next 12 months; or
- Or would be unable to pay unexpected medical bills in the next 12 months without Medicaid.

Most beneficiaries will meet one of the first two alternatives as active Medicaid users. As a practical matter, everyone should meet the third test as well, as it would be rare to have a private health insurance plan that would pay for any and all unexpected medical bills no matter what intervening events occurred.
Example of using the PASS work incentive as part of a long-range plan to retain Medicaid:

Let’s go back to Sally and change the facts slightly. Her state hasn’t opted for the Medicaid Buy-in (MBI) program. Although Medicaid is automatic for SSI recipients in her state, because her level of CDB benefits, $820, is well over her state’s SSI rate, she can’t qualify for SSI and can’t access 1619(b) Medicaid, which is only available to former SSI recipients who lose SSI due to work and earnings. This creates a major dilemma for Sally, who needs Medicaid and is planning to go to work. To Sally, it appears as if there is no means to retain Medicaid upon securing employment.

When the CWIC meets with Sally during her final year of undergraduate school, she determines that Sally is a good candidate for a Plan for Achieving Self-Support (PASS). Sally can set aside her CDB benefits in a PASS to save toward the purchase of a van to be modified for her use as a wheelchair user. This would support Sally’s goal to become a Spanish teacher, as nearly all of the potential school districts that would employ her aren’t located near any public transportation line, with some more than 20 miles from her home.

The CWIC explains that an approved PASS would allow Sally to set aside $800 of her CDB benefits into a dedicated account to save for the down payment on the van, resulting in that income being excluded for SSI purposes. With countable income reduced to $0, Sally will now be eligible for an SSI check at the full Federal Benefit Rate (FBR) per month and automatic Medicaid, with no spend down. Assuming the PASS is effective in October, with a plan to purchase the van in late July and start teaching in September of the following year, Sally will be able to save more than $7,000 for a down payment on the van.

**NOTE:** The CWIC would typically go on to discuss the PASS finances in greater detail, explaining what would happen when Sally loses CDB benefits following her trial work period.
As part of the long-term plan, the CWIC explains: If Social Security approves, Sally can set aside a portion of her wages through the PASS when she goes to work to pay for van insurance and make van payments. The state Vocational Rehabilitation agency will be able to pay for approximately $20,000 in modifications to allow Sally to drive the van as a wheelchair user. Sally can expect to lose her CDB benefits because she will have performed SGA following a nine-month trial work period and three-month grace period. Her PASS can continue, following the loss of CDB benefits, with her wages being the only income going into the PASS. Finally, upon losing her SSI at the completion of the PASS, Sally will be eligible for Medicaid through section 1619(b) as she will have lost SSI payments due to having earnings over the allowable limit for an SSI cash payment.

Under her unique circumstances, PASS will enable Sally to reach her employment goal and also retain Medicaid as a payment source for personal care services in her state. Keep in mind that many beneficiaries will need more hours of personal care services than the four hours per day that Sally needs with resulting monthly costs of $5,000 or more.

As stated previously, CWICs must be familiar with the Medicaid waiver programs available in their state, not just Medicaid eligibility groups. Given the role of CWICs in supporting work, it’s particularly important to be aware of any waiver that may allow for vocational services, including job coaching, that could support a beneficiary’s work goal. In many states, waivers are available that will provide a range of assistive technology and home modifications, among other things not ordinarily available through the regular Medicaid program. This could greatly help Sally, from the earlier examples, as she moves into her own apartment upon completing college.

Upon graduation, Sally’s grandparents, who are moving to Florida, agree to rent to Sally their small, two-bedroom ranch home. The two entrances to the home are already wheelchair-accessible, as Sally’s grandmother needed similar access to come and go in either her walker or a three-wheeled scooter.

The CWIC, having researched the current waiver Sally is using, identified a number of other services that may benefit her, including home modifications and a range of assistive technology to maximize independence or to support work goals. Sally identifies the following special items that may increase her independence as she moves into the
ranch home: an environmental control unit, allowing her to answer the phone, open or lock the doors, or operate the TV and appliances from a central unit on her wheelchair; a ceiling track lift, allowing Sally to safely and efficiently travel from the bedroom to the bathroom and back to take care of hygienic needs with minimal assistance from a third person; and a one-time allowance to make her kitchen more accessible to her by lowering countertops and redesigning the kitchen to make it more usable by her. Sally agrees to contact her Medicaid caseworker to determine whether she can take advantage of the home modifications as a renter of the property.

**Medicare**

Some important Medicare issues that will come up in the CWIC or beneficiary relationship include:

- An understanding of Medicare Savings Programs as a means of paying for Medicare Part A and B premiums and other out-of-pocket expenses;
- The effect of work on eligibility for Medicare Savings Programs;
- An understanding of the Low Income Subsidy Programs as a means of paying for Medicare Part D out-of-pocket expenses;
- The effect of work on eligibility for Low Income Subsidy Programs; and
- The potential eligibility for Extended Medicare Coverage for eight years or more after the Social Security disability beneficiary starts working.

**Medicare Savings Programs**

As noted above, the Medicare Savings Programs can pay for Part B premiums and, in the case of the QMB program, can also pay for the Part A and Part B co-payments and deductibles. When counseling beneficiaries, it’s important to ask questions about Part B premiums, investigate potential eligibility for the Medicare Savings Programs, and identify any co-payments they are paying.

**Example of how Medicare Savings Programs can assist:**

George currently receives $960 per month of SSDI, has Medicare, and is enrolled in the Qualified Medicare
Beneficiary (QMB) programs (one of the Medicare Savings Programs). George has 4-5 medical appointments each month, which are covered under Part B. The QMB program pays the 20 percent coinsurance for him, which adds up to $250. The QMB program is also paying the Part B premium. George has been offered a job making $950 per month, which he’d like to take, but he’s questioning whether it would financially make sense given he’d lose all coverage through the Medicare Savings Programs.

At the meeting, the CWIC explains that if George were to apply for the Medicaid Buy-In program, he’d have Medicaid to cover his Part B deductible and co-insurance. The CWIC also explains that in their state the Medicaid agency would pay his Part B premium if he were to become Medicaid eligible, noting George would have to pay approximately $83 per month to use this program. George, seeing he would financially get ahead and have more healthcare coverage, took the job and enrolled in the Medicaid Buy-In program.

It’s important to emphasize that the CWIC was able to help George think through these options by using an interview tool that prompts questions about Part B premium payments and potential eligibility for Medicaid Buy-In. By taking these steps, George’s CWIC is able to direct him to a solution that supports him in working, financially getting ahead, and continuing his needed healthcare coverage.

**Example of how beneficiaries dually eligible for Medicaid and Medicare must use Part D for Prescription Drug Coverage:**

When the CWIC first meets with Sally, she is 19 years old, in her second year of college, and has been receiving CDB benefits since age 18. Sally also explained that she takes two anticonvulsants to control a seizure disorder, which are covered by Medicaid. At the time of their meeting, Sally wasn’t yet eligible for Medicare.

In helping Sally to plan for her long-term healthcare needs, the CWIC explains that at age 20, after she has received CDB benefits for 24 months, she will be eligible for
Medicare. It’s further explained that when Sally becomes eligible for Medicare she will be required to have her prescription drugs covered by the Medicare Part D prescription drug program, even if she remains eligible for Medicaid.

The CWIC documents this information in Sally’s BS&A report. The CWIC also advises Sally that she will need to start the process of choosing a Part D prescription drug plan a few months before her Medicare eligibility begins, and provides links to online resources and tools for doing this.

Wherever possible, the CWIC should help the beneficiary plan for upcoming changes to minimize loss in coverage.

When Sally becomes eligible for Medicare, the CWIC will then provide counseling about eligibility for the Low Income Subsidy program. The CWIC will also help Sally understand the effect of work on LIS and explore strategies for ways to get help paying her prescriptions.

**Private Insurance Coverage**

Beneficiaries are most likely to be eligible for a private health insurance plan if they are working and coverage is available as an employee benefit, or through their spouse or parents’ health insurance plan through work. It’s possible a beneficiary may have coverage through the Marketplace, but that would generally only be the case with Title II disability beneficiaries in the 24-month Medicare Qualifying Period who aren’t eligible for Medicaid. In regards to private health insurance coverage, CWICs are most likely to encounter beneficiaries who face issues relating to:

- Understanding coordination of benefits (who pays first, second, etc.);
- When private insurance is or isn’t financially worthwhile; and
- Rights under private health insurance plans.

While it’s simply not possible to maintain expertise regarding private health insurance plans as they relate to Medicaid and Medicare, the
CWICs can take steps to help beneficiaries explore their options and understand their rights in this area.

- CWICs should be prepared to explain how it’s possible to have employer-sponsored healthcare in addition to Medicare or Medicaid.

- CWICs should be able to help beneficiaries explore when employer-sponsored health insurance may be financially worthwhile (e.g., when state Health Insurance Payment can be available, access to larger pool of medical providers, access to alternative care services).

- CWICs should be able to explain the basic rights beneficiaries have in accessing private health care coverage and refer beneficiaries to the state’s health insurance commissioner for details questions.

- If a beneficiary is already covered by a private health insurance plan, the CWIC can urge him or her to obtain a copy of the policy or a summary of what the plan covers. The plan typically provides these summaries to a beneficiary as a routine matter, or the employee can ask his or her human resource department to help him or her get a copy. Often these summaries will make it very clear whether a particular service is covered and under what conditions. If the insurance company declines to cover a particular item or service, the summaries the company provides to the employee generally describe any appeals available through the plan itself.

**Assessing Current and Potential Eligibility for Non-Traditional Payment Sources or Strategies for Healthcare**

There are numerous non-traditional sources of funding for healthcare (i.e., sources other than Medicaid, Medicare, private health insurance, or lesser known programs that act like third party insurance). This section will briefly comment on the role the CWIC can play with regard to two of these funding sources or program: special education programs and state Vocational Rehabilitation agencies.
Special Education Programs

When working with a transition-aged special education student, generally 16 to 21 years of age, don’t overlook the special education system as a means for funding a wide range of services that we might typically think of as falling into the healthcare area. For example, if necessary to support a student in a special education program, a school could provide: mental health counseling, a private duty nurse, a one-to-one aide, physical therapy, occupational therapy, or speech therapy. A school can also provide a range of equipment under the designation of assistive technology including augmentative communication devices.

While very few CWICs can be expected to be special education experts, nearly every state’s Protection and Advocacy agency will devote considerable resources to special education advocacy. It’s incumbent on CWICs to establish working relationships with the special education advocates at the Protection and Advocacy agency so that they can call on these contacts for information about special education rights and guidance on when it’s appropriate to refer a beneficiary for assistance.

State Vocational Rehabilitation (VR) Agencies

Many of the beneficiaries receiving WIPA services will have active cases with their state VR agency or a separate VR agency for the blind (in many states). Although we don’t typically think of the VR agency as a funding source for healthcare services, they are authorized to fund a wide range of services for the “diagnosis and treatment” of physical or mental impairments to reduce or eliminate impediments to employment, to the extent that these services aren’t available from other sources such as Medicaid, Medicare, or private health insurance. Just a few examples of these items or services include: therapeutic treatment, dental care, eyeglasses and visual services, personal assistance services while receiving VR services, and rehabilitation technology (including vehicle modifications and telecommunication devices).

Typically, the role of the CWIC on VR issues will be to identify the potential for assistance with healthcare needs and refer the individual to the VR agency. If the beneficiary encounters a dispute over coverage of an item or service or if he or she anticipates a dispute, the CWIC can also refer the individual to the Client Assistance Program (CAP) advocate who covers their state or region of the state. The CAP program exists in every state and is authorized to assist individuals in their disputes with the VR
agency. In many states, the CAP program is located within the Protection and Advocacy agency.

**Assessing Case Scenarios to Determine When a Beneficiary Will or Won’t Have a Long Term Need to Retain Medicaid**

Some beneficiaries will have significant disabilities but no apparent need for expensive healthcare services on a regular basis. For example, an individual whose only disability is profound deafness may incur no regular healthcare expenses related to the disability. Like all Americans, those individuals should have health insurance to cover the unexpected illness or injury, but the employer-funded health insurance plan may be enough, when available. The decision on whether long-term Medicaid eligibility is important will always depend on individual circumstances, and the CWIC should be able to provide guidance to the beneficiary in making this decision.

**Example in which a beneficiary will need long-term Medicaid:**

Eric, age 28, has a traumatic brain injury and started receiving SSI benefits at age 18. About three months ago, he became eligible for $520 in monthly CDB in addition to a reduced SSI benefit. He lives in a state where Medicaid eligibility is automatic for SSI recipients. Eric has no regular healthcare costs and, except for routine medical or dental appointments, doesn’t see a doctor unless he is ill. His parents check in with him daily at his apartment, but he is otherwise independent.

Eric starts a job at a local warehouse where he will make $11 per hour working 15 hours per week. His gross pay will be $715 in most months (higher in three-paycheck months), meaning he will lose his right to SSI cash benefits but retain CDB benefits. As a 15-hour-per-week employee, he won’t be covered by his employer’s health insurance plan.
During the CWIC’s visit with Eric and his father, they discuss how his wages will affect his SSI and CDB benefits. The CWIC explains that Eric should be eligible for 1619(b) Medicaid upon his loss of SSI eligibility (i.e., his annual wages will be below his state’s 1619(b) threshold of $30,000, his resources will be below SSI’s limits, and he will meet 1619(b)’s Medicaid use test as he has used Medicaid in the past year). Eric and his father still wonder if he should bother to keep Medicaid because he so rarely uses it.

While the ultimate decision to retain Medicaid through 1619(b) will always be the beneficiary’s to make, the CWIC should advise Eric and his father that there are several good reasons for keeping 1619(b). Keeping Medicaid will insure him against unexpected medical expenses, as he has no other health insurance coverage. Coverage will be cost-free (subject to any modest co-payments if his state has them). If he loses his job or his wages go down significantly while he is eligible for 1619(b), he can transition back to SSI cash benefits without a new application.

**Example in which keeping Medicaid may be more important than it first appears:**

After Eric worked 15 hours per week at the warehouse for six months, Eric’s employer increased his hours to 30 per week and his hourly pay to $12 per hour. His gross pay will be $1,500 in most months (higher in three-paycheck months), meaning he will still be ineligible for SSI but can continue his eligibility for 1619(b) assuming he continues to meet all other eligibility criteria. Even though his monthly wages will be well above the current substantial gainful activity amount, he can retain CDB benefits throughout a nine-month trial work period and three-month grace period.

As a 30-hour per week employee, he will now be covered by his employer’s health insurance and dental plans as long as he opts for the plan and pays a $75 per month health insurance premium. The insurance plan is comprehensive, covering doctor visits ($10 co-payment) and prescription drugs ($10 co-payment) among its many benefits. Dental
insurance is available as well, with a $5 per month payment toward the premium if he opts for the coverage.

In a follow-up meeting with the CWIC, Eric and his father are looking for guidance on whether Eric should sign up for the health insurance or dental plan. They indicate that Eric’s doctor does accept Medicaid but that the nearest dentist who accepts Medicaid is more than 20 miles away. They also discuss the trial work period and expected loss of CDB benefits thereafter. Finally, Medicare eligibility will commence in about 12 months, and they have questions about Medicare Part D coverage and whether the premium for Medicare Part B coverage is worth paying.

Among other things, the CWIC explains:

- That with $1,500 in monthly gross earnings and no significant impairment-related work expenses or subsidies to bring countable wages below the SGA level, Eric can expect his CDB cash benefit to be suspended after a nine-month trial work period and three-month grace period;

- If he retains Medicaid through 1619(b), he can return to SSI cash benefits status upon losing his CDB benefits;

- Private health insurance coverage and dental coverage at these modest payment rates is a good deal if Eric can work it into his budget;

- He is responsible for reporting to the Medicaid agency that he has the option to take this employer-sponsored health insurance plan. If the Medicaid agency finds it cost-effective, it may pay the premium for him;

- His Medicaid should be able to pay some co-payments on doctor visits and prescription drugs that the employer-sponsored plan doesn’t cover;

- Because his Medicare eligibility will begin in about 12 months, he will need to decide whether to enroll in Parts B and D, because he will likely have comparable coverage through the private health insurance plan. He will need to check with his employer to clarify if they will require he
take Medicare. If not, he will then need to decide whether to opt out of Part B or D.

Based on this information, Eric and his father decide that he will enroll in the employer-sponsored health insurance and dental plans; he will contact the Medicaid agency to report this private health insurance and find out if Medicaid will pay the monthly premium; he will take whatever steps are necessary to retain Medicaid through 1619(b); and they will meet again in six months to review Eric’s updated work status and sort out the issues affecting whether he should enroll in either Medicare Part B or Part D.

In these scenarios, the CWIC has guided Eric and his father through some complex scenarios to enable them to make informed decisions.

**Staying Current in Healthcare Policy**

CWICs must regularly update their resource materials and attend new trainings to keep up with changes in healthcare policy. In recent years, the Marketplace was started, many states have initiated Medicaid Buy-in (MBI) programs, many states started new Medicaid waiver programs, and the Medicare Part D program was started. Eligibility thresholds for 1619(b), which vary state-by-state, typically go up every year. Similarly, the eligibility levels in state medically needy or spend down programs may change from year to year.

CWICs can expect this manual to be edited on a regular basis as changes occur, but that editing may be no more often than once per year. For this reason, it’s essential to regularly reference resources on the VCU NTDC website, review email updates distributed by the NTDC, and attend new and refresher trainings as appropriate. Finally, CWICs must be alert to changes that are specific to their state and regularly check with key resources to keep up with state-related changes.

**Conducting Independent Research**

The Kaiser Family Foundation’s “State Health Facts” site is a perfect example of a relevant resource to supplement CWICs’ knowledge on state and federal health care rules and ongoing changes to them. Its website,
www.statehealthfacts.org, provides links, state-by-state, and state-specific links to a range of programs within the state, including Medicaid, Medicaid waivers, and the CHIP program.

Additional Resources

On the following page, we have attached a form that CWICs may use to assess a beneficiary’s current healthcare coverage and areas of unmet need.
Planning for Health Care Coverage

Name: ________________________________

Date: ______________________________________

What do you currently use your healthcare coverage for? (check all that apply)

☐ Doctor visits
☐ Mental health counseling
☐ Other therapies (e.g., physical therapy, occupational therapy, and speech therapy)
☐ Medication
☐ In-home services
☐ Residential services (e.g., foster home, group home)
☐ Day Habilitation (e.g., supported employment)
☐ Durable Medical Equipment
☐ Other:

Current healthcare coverage (check all that apply): 

☐ Medicaid
☐ Medicare
☐ MSP
☐ LIS
☐ Private
☐ VA

Average monthly or annual healthcare costs and premiums: 
__________________________

Description of healthcare needs currently unmet: 
__________________________________________________________
__________________________________________________________
__________________________________________________________
Module 5 – Understanding Other Federal Benefits and Associated Work Incentives
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Module 5 – Understanding Other Federal Benefits and Associated Work Incentives

Introduction

Many Social Security disability beneficiaries use additional programs such as HUD housing subsidies, SNAP (formerly known as food stamps), veterans benefits, ABLE accounts, or other federal, state, or local benefits. Many of these additional benefits are means-tested, and paid employment or self-employment may affect them. Social Security requires CWICs to gain competency in understanding how paid employment affects a variety of other benefit programs, and this module covers the most common forms of benefits individuals may receive in addition to Social Security disability benefits. It’s essential that CWICs recognize these as core competency areas, not optional areas of study.

This module consists of seven distinct units, with each unit covering a different program. These programs are: Temporary Assistance to Needy Families (TANF), the Supplemental Nutrition Assistance Program or SNAP (formerly referred to as the Food Stamp Program), federal housing assistance provided by the U.S. Department of Housing and Urban Development (HUD), the Unemployment Insurance Program, Workers’ Compensation benefits, benefits provided to veterans by the U.S. Department of Veterans Affairs (the VA) and the U.S. Department of Defense (DoD), and financial stability programs.

CWICs must understand that the material presented in the module reflects only the federal rules governing each program or benefit. Some programs permit state variance and even encourage it. This means that the development of competency in these areas doesn’t stop with this manual but merely begins here. CWICs must conduct independent research into each of the programs presented in this module to gain a functional knowledge of the state-specific variations that may apply.
CWIC Core Competencies

- Demonstrates knowledge of other federal benefit programs and associated work incentives, including TANF, SNAP, HUD housing subsidies, Workers’ Compensation, Unemployment Insurance benefits, Veterans benefits, and other benefit programs, as well as the interaction of these programs with Social Security disability benefits.

- Demonstrates an understanding of state-specific regulations and policies that affect publicly funded benefits programs and the administration of these programs in the home state.

- Demonstrates the ability to analyze the effect of employment on program eligibility, cash-payment status, and benefit levels for TANF, SNAP, HUD housing subsidies, Workers’ Compensation and Unemployment Insurance benefits, Veterans benefits, and other benefit programs.

- Demonstrates an understanding of the key components of ABLE accounts and other financial stability programs.
Competency Unit 1 – Temporary Assistance for Needy Families (TANF) Program

Introduction

Congress enacted The Temporary Assistance for Needy Families (TANF) Program in 1996 under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). A block-grant program designed to make dramatic reforms to the nation’s welfare system, TANF aims to move recipients into work and turn welfare into a temporary assistance program. TANF replaced the previous national welfare program known as Aid to Families with Dependent Children (AFDC), the related program known as the Job Opportunities and Basic Skills Training (JOBS), and the Emergency Assistance (EA) program.

TANF has a two-fold mission:

1. To assist families with dependent children in meeting transitional financial needs; and
2. To help these families become self-sufficient.

The TANF program has four specific purposes:

- Provide assistance to needy families so that children receive care in their own homes or in the homes of relatives;
- End the dependence of needy parents by promoting job preparation, work, and marriage;
- Prevent and reduce the incidence of out-of-wedlock pregnancies; and
- Encourage the formation and maintenance of two-parent families.

Congress reauthorized the program under the Budget Reconciliation Act of 2005. Legislators didn’t make changes at this time regarding eligibility, but they did make some administrative changes in the work participation rules and increased the focus on the importance of healthy
marriages and responsible fatherhood. Since 2010, Congress has authorized the Temporary Assistance for Needy Families (TANF) block grant under a series of short-term extensions.

A Federal Program that States Administer

Every state in the nation offers the TANF program for people who need cash assistance and meet certain income and eligibility tests. States may refer to their TANF programs by a different name. For example, in Kentucky, the TANF program is referred to as the Kentucky Transitional Assistance Program (K-TAP). Florida calls its TANF program the Work and Gain Economic Self-Sufficiency (WAGES) program. To receive federal funds, states must also spend some of their own funds on programs for needy families. The TANF program refers to this requirement for spending by the states as the “maintenance of effort” (MOE) requirement. States have used their TANF funds for a variety of services and supports, including income assistance, child care, education and job training, transportation, aid to children at risk of abuse and neglect, and a variety of other services that help low-income families.

The TANF regulations provide states with a clear and balanced set of rules for meeting the law’s performance goals. They reflect PRWORA’s strong focus on moving recipients to work and self-sufficiency to ensure that welfare is a short-term, transitional experience. The regulations encourage and support flexibility, innovation, and creativity as states develop programs that can reach all families and provide support to working families. They don’t tell states how to design TANF programs or spend funds. At the same time, the regulations hold states accountable for moving families toward self-sufficiency. Congress has given the Department of Health and Human Services (DHHS) authority to assess penalties if states fail to meet certain criteria, such as work participation rates.

Core Federal Requirements of TANF Programs

TANF is a federal program administered by the states. Therefore, instead of having detailed federal guidelines, states receive block grants that have a few core federal requirements. States write their own regulations and submit them for approval to the Office of Family Assistance (OFA),
part of the Department of Health and Human Services (DHHS). State programs vary greatly, because many of the requirements that are part of the TANF program are state-specific or even county-specific.

The core federal requirements are:

- A family that includes an adult who has received assistance is limited to 60 months of TANF funds in a lifetime (with some exceptions); and
- A parent or caretaker in the household must pursue work in order to continue receiving benefits.

**Time Limits**

States establish their own time limits for TANF within broad federal parameters. The 60 months of assistance may be consecutive, or they can accumulate over time. States also have the ability to establish a shorter timeframe. Virginia, for example, set a limit of 24 consecutive months of benefits. The federal government recognized that states would have a number of people who need this assistance for longer than 60 months. As a result, federal guidelines allow states to exclude up to 20 percent of their average number of monthly TANF recipients from this 60-month time limit. States may use separate state-only funds to provide assistance to families they wish to exempt from the limit or to families that have reached the federal limit, without counting against the 20 percent cap. These exceptions include:

- The hardship exception (states may define what constitutes a hardship); or
- Families that include a member who has been battered or subjected to extreme cruelty.

Although it isn’t a federal requirement, most states include individuals with disabilities in their 20 percent exemption. TANF program personnel can assist people with disabilities in filing applications for the Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) programs. Once Social Security awards disability benefits, the individual would no longer be included in the 20 percent exemption group.

When calculating the 60-month lifetime limit of benefits, the TANF program doesn’t count any months in which a minor child who isn’t the
head of household or married to the head of household receives assistance, or during which an adult who lives on an Indian Reservation or in an Alaskan Native Village that has more than 50 percent unemployment rate gets assistance. Lastly, the TANF program doesn’t count any months in which an individual receives only non-cash assistance provided under the Welfare to Work program. This generally involves someone who has lost the benefit due to earnings but remains eligible for Medicaid or other benefits tied to the Welfare to Work program.

Work Requirements

The core federal requirement that the parent or caretaker in the household must pursue work in order to continue receiving benefits states that work activity should begin within 24 months of receiving TANF. Again, states have some latitude, and they can make that 24-month period shorter. At least 35 states have done so. This work requirement applies to work-eligible individuals — adults or minors who are head of household and receiving assistance under TANF. The regulations exclude some groups from being work-eligible, such as:

- A minor parent who’s not the head of household;
- A non-citizen ineligible due to immigration status;
- A parent caring for a disabled family member;
- Some individuals in Tribal TANF; and
- At the state’s option on a case-by-case basis, Social Security disability beneficiaries.

States must offer people with disabilities an equal right to participate in programs instead of automatically exempting them from the participation requirements. They must provide services in the most integrated setting appropriate to the needs of people with disabilities. The regulations also stipulate that state TANF programs must not discriminate against individuals on the basis of disability, and they have to comply with relevant civil rights laws by providing reasonable accommodations to allow individuals with disabilities to participate.

The TANF regulations define 12 “work activities” that include job training, volunteer work, or actual paid employment. No more than 20 percent of the required number of work participants can qualify because they
underwent vocational training or were a teen head of household in secondary school. Different work participation rules apply to one-and two-parent families and states can make exceptions for single parents with small children who are unable to find childcare. States must provide transitional Medicaid coverage to families that become ineligible for cash assistance due to increased earnings from work.

Most states use something called an Individual Responsibility Plan (IRP) to help track work activities. The IRP is an individualized plan written with the recipient that outlines the strategies and timelines associated with going to work. If the recipient refuses to put together an IRP or doesn’t follow it, he or she can receive a “sanction,” which means the TANF program will withhold some or all of his or her benefit.

**Financial Eligibility for TANF**

TANF recipients must meet a financial eligibility test in order to receive benefits. For this eligibility test, states consider both income and resources. Different states exempt different amounts and types of income, as well as different resources. For instance, all states exempt portions of earned income, but how much they exempt changes significantly from state to state. Some states exempt all earned income up to the federal poverty level. Others exempt some portion of it that may change over time.

In addition, states vary on the different resources they exempt. One important exemption is a vehicle. Many states exempt one vehicle in the household as part of the effort to help people go to work, but not all states do so. Some states use an Individual Development Account (IDA) in place of a resource exemption. TANF programs exclude money that individuals deposit into an IDA from the resources test. Individuals may only withdraw money deposited into the account to use for specified expenses, including post-secondary education, a first-home purchase, or business start-up capitalization. Individual Development Accounts vary greatly from state to state, and some states don’t have them. States that do have IDA programs may put a cap on how much they exempt, ranging from $1,000 to no cap at all. For more information on IDA programs, see Unit 7 of this module.

Some states have emergency TANF payments they can make available under certain circumstances. Certain individuals on SSI or Social Security
disability benefits who have temporary unemployment may be able to take advantage of this feature. Some states have a core set of basic requirements but leave it up to each county to decide on income eligibility and other benefit issues. This is true in California.

How Social Security Disability Benefits and TANF Interact

People receiving SSI or Social Security disability benefits or their family members may also be eligible for TANF. For this reason, it’s important for CWICs to include information about this program in the Benefits Summary & Analysis (BS&A) report and to carefully explain the effect earned income will have on this benefit.

TANF and SSI

CWICs need to understand how SSI and TANF interact. Remember that the SSI program bases eligibility on that person’s individual circumstance, whereas TANF is a benefit to a family. The programs use different types of income tests. States vary greatly on how they treat SSI benefits when calculating a family’s eligibility for TANF. An individual who is a household of one can’t receive both TANF and SSI. If an individual qualifies for SSI, he or she will receive SSI rather than TANF. However, one member of a family may receive SSI while the rest of the family gets TANF. This is often the case when a child receives SSI under the children’s eligibility test, while a TANF check comes to the household based on the entire family’s income.

Because TANF programs use income as a factor of eligibility, and because a TANF family grant is partially funded by Federal block grants, TANF family grant payments are considered “income based on need” (IBON) in the SSI program. When Social Security is determining eligibility for SSI or calculating how much the SSI cash payment should be, the agency counts the SSI claimant’s share of a TANF grant dollar for dollar as unearned income and the $20 general income exclusion does not apply to this income. For more information about how TANF may affect SSI benefits, refer to the POMS (https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830403).

If someone applies for TANF and the caseworker suspects that he or she may be eligible for Social Security disability benefits, the caseworker will
refer the individual to the Social Security Administration and may provide some case-management services to assist in applying for Social Security benefits. There are a couple of reasons for that. First, TANF benefits have a limit of 60 months and include a work requirement. Social Security benefits may be a better fit if the applicant has a disability that may prevent them from working at the level required to live without benefits. Second, state workers will try to help an individual apply for and receive Social Security benefits, if possible, to save space on the 20 percent exemption discussed earlier.

**TANF and Title II Disability Benefits**

A Title II Social Security disability benefit, on the other hand, has no income eligibility requirement. Instead, Social Security bases this benefit on the individual’s work history and credits earned under the disability insurance program. In addition to the Social Security disability check coming into the household, a child (or a child and caregiving spouse) may receive a Social Security benefit as well. Therefore, if a family applies for TANF, and several members of that family receive Social Security benefits, often their combined household income will disqualify the family from TANF. Basically, TANF counts every penny of unearned income, so it doesn’t take much in Social Security benefits to make a family or individual financially ineligible for TANF.

However, there are cases in which an individual is receiving a lower Social Security benefit amount, and for whatever reason, the person may not be eligible for SSI (e.g., he or she has excess resources). If that particular state’s TANF office has a more lenient resource requirement, then the family may remain eligible for TANF while, at the same time, one or more of the family members receives rather low amounts of Social Security benefits.

**Conclusion**

It’s critically important that CWICs remember to ask beneficiaries about whether or not they or any members of their household receive TANF benefits before offering benefits counseling. CWICs should also verify a TANF payment with the local welfare agency to make certain they capture all relevant information. Finally, it’s essential that CWICs carefully research TANF implementation in their home state, as well as the
counties in their catchment area, to ensure that they have a solid understanding of state and local rules. CWICs must remember that their job isn’t to determine eligibility for the TANF program, but rather to offer information and resources that help individuals understand what role TANF plays in an overall benefits plan.

**Conducting Independent Research**

**Administration for Children and Families Main TANF Webpage**
(http://www.acf.hhs.gov/programs/ofa/programs/tanf)

**Welfare Rules Data Book**
(http://www.acf.hhs.gov/sites/default/files/opre/welfare_rules_databook_final_v2.pdf)


**Department of Health and Human Services, Office of Civil Rights Summary of Policy Guidance: Prohibition against Discrimination on the Basis of Disability in the Administration of TANF.**
(http://www.hhs.gov/ocr/civilrights/resources/specialtopics/tanf/summeryofpolicyguidancetanf.html)

**Online Services for Key Low-Income Benefit Programs**: What States Provide Online with Respect to SNAP, TANF, Child Care Assistance, Medicaid, and CHIP (http://www.cbpp.org/research/online-services-for-key-low-income-benefit-programs?fa=view&id=1414).

**Executive Summary of TANF Rules**
Competency Unit 2 – Supplemental Nutrition Assistance Program (SNAP)

What Happened to the Food Stamp Program?

Congress created the original Food Stamp Program in 1939 to assist families during the Great Depression. A pilot project modernized the program in 1961, and it became a permanent program in 1964. In 1974, Congress required all states to offer food stamps to low-income households. The Food Stamp Act of 1977 made significant changes to the program regulations by creating more stringent eligibility requirements and administration, as well as removing the requirement that food stamp participants purchase food stamps.

Congress passed legislation in 2008 that changed several rules related to the former Food Stamp Program. They enacted Public Law 110-246, the Food Conservation and Energy Act of 2008, on June 18, 2008. Two of the changes that went into effect on October 1, 2008, have to do with the name of the program. Congress changed the program’s name from The Food Stamp Program to the Supplemental Nutrition Assistance Program, or SNAP. Congress also changed the name of Food Stamp Act of 1977 to the Food and Nutrition Act of 2008. State agencies may continue to use state-specific program names.

Introduction to the Supplemental Nutrition Assistance Program or SNAP

SNAP is a federal program administered by the U.S. Department of Agriculture that helps low-income people purchase food. Individuals eligible to receive SNAP may include those who work for low wages, the unemployed or part-time workers, recipients of welfare or other public-assistance payments, the elderly or disabled who live on a small income, or the homeless. In most states, public-assistance agencies administer SNAP through a local network of city or county offices. These public assistance agencies sometimes referred to as “welfare agencies,” also administer TANF and often Medicaid.
SNAP benefits are typically awarded to “households”. For the purposes of receiving SNAP, a household consists of a person or a group of people living together, not necessarily related, who purchase and prepare food together. In some situations, it’s possible to have more than one food-stamp household per dwelling. Some people who live together, such as husbands and wives and most children under age 22, are included in the same household, even if they purchase and prepare meals separately. Normally people are not eligible for SNAP benefits if an institution gives them their meals. However, there is one exception for elderly persons and one for disabled persons:

- Residents of federally subsidized housing for the elderly may be eligible for SNAP benefits, even though they receive their meals at the facility.

- Disabled persons who live in certain nonprofit group living arrangements (small group homes with no more than 16 residents) may be eligible for SNAP benefits, even though the group home prepares their meals for them.

SNAP provides a type of debit card for food purchases, called the Electronic Benefit Transfer system, or EBT. The state agency electronically deposits the monthly SNAP allotment onto the card, based on the number of people in the household and the amount of monthly income remaining after certain deductions. The recipient can then use the EBT card at participating retailers to purchase eligible food items. The Food and Nutrition Act of 2008 defines eligible food as any food or food product for home consumption, and it also includes seeds and plants that produce food for consumption by SNAP households. The Act precludes people from purchasing the following items with SNAP benefits: alcoholic beverages, tobacco products, hot food, and any food sold for on-premises consumption. Nonfood items such as pet foods, soaps, paper products, medicines and vitamins, household supplies, grooming items, and cosmetics are also ineligible for purchase with SNAP benefits. In some areas, SNAP offices can authorize restaurants to accept the benefits from qualified homeless, elderly, or disabled people in exchange for low-cost meals.
SNAP Supports Work

While Congress intended SNAP to ensure that no one in our land of plenty should fear going hungry, it also reflects the importance of work and personal responsibility. In general, people must meet work requirements in order to be eligible for SNAP benefits. These work requirements include registering for work, not voluntarily quitting a job or reducing hours, taking a job if offered, and participating in employment and training programs assigned by the state. Failure to comply with these requirements can result in disqualification from the Program. Some special groups may not be subject to these requirements including: children, seniors, pregnant women, and people who are exempt for physical or mental health reasons.

Some SNAP beneficiaries are “able-bodied adults without dependents” or ABAWDs. An ABAWD is a person between the ages of 18 and 49 who has no dependents and is not disabled. These individuals can only get SNAP for 3 months in 3 years if they do not meet certain special work requirements. This is the time limit. To be eligible beyond the time limit, an ABAWD must work at least 80 hours per month, participate in qualifying education and training activities at least 80 hours per month, or comply with a workfare program. Workfare means that ABAWDs can do unpaid work through a special State-approved program. For workfare, the amount of time worked depends on the amount of benefits received each month. Another way one to fulfill the ABAWD work requirement is through a SNAP Employment and Training Program.

Basic Eligibility Requirements for SNAP

Some basic federal SNAP eligibility rules apply in almost every state, but states have the authority to establish their own rules beyond federal requirements. Therefore, CWICs need to become familiar with their state’s specific rules in order to fully understand how SNAP works and who is eligible for benefits. Some states have very unique SNAP rules, so CWICs shouldn’t assume that because SNAP works in a particular way in one state that it will function the same way in another.
In order to qualify for SNAP benefits, all members of the household, including children, must have a Social Security number. A household member who doesn’t have a Social Security number can choose not to apply for benefits. Even though non-applicants are ineligible for SNAP benefits, the program will still count their income and resources to determine eligibility for the remaining household members. Students over the age of 18 are generally not eligible for SNAP, with some exceptions noted in the regulations. Most legal immigrants and certain non-citizens may also be eligible.

**SNAP Resource Limits**

Households may have $2,250 in countable resources, such as a bank account, or $3,500 in countable resources if at least one person is age 60 or older, or is disabled. However, certain resources are NOT counted, such as a home and lot, the resources of people who receive Supplemental Security Income (SSI), the resources of people who receive Temporary Assistance for Needy Families (TANF), and most retirement (pension) plans.

The procedures for handling vehicles are determined at the state level. States have the option of substituting the vehicle rules used in their TANF assistance programs for SNAP vehicle rules when it results in a lower attribution of household assets. A number of states exclude the entire value of the household’s primary vehicle as an asset. In states that count the value of vehicles, the fair market value of each licensed vehicle that is not excluded is evaluated. Currently 32 state agencies exclude the value of all vehicles entirely while 21 state agencies totally exclude the value of at least one vehicle per household. The 2 remaining states exempt an amount higher than the SNAP’s standard auto exemption (currently set at $4,650) from the fair market value to determine the countable resource value of a vehicle. For more information concerning state specific vehicle policy, check with the State agency that administers the SNAP program.

**SNAP Income Rules**

To qualify for SNAP benefits, households have to meet certain income tests unless all members are receiving TANF, SSI, or in some places general welfare assistance. Most households must meet both the gross and net income tests. Gross income means a household’s total, non-excluded income, before any deductions have been applied. Net income means gross income minus allowable deductions. Gross monthly income
limits, before any deductions, equal 130 percent of the poverty level for the household size, while net monthly income limits equal 100 percent of the poverty level. A household with an elderly person or a person who is receiving certain types of disability payments only has to meet the net income test.

After adding up all of the household’s countable income, the SNAP worker will subtract certain deductions. All households receive a “standard deduction” from gross income to cover basic, essential expenses unrelated to medical care, work, or childcare. The standard deduction varies according to household size and adjusts annually for inflation. In addition to the standard deduction, states must apply other deductions when determining net income eligibility for SNAP. We list them here in the order in which SNAP personnel deduct the expenses:

- A 20 percent deduction from earned income;
- A standard deduction of $167 for households sizes of 1 to 3 people and $178 for a household size of 4 (higher for some larger households and the standard deduction is higher in Alaska, Hawaii and Guam);
- A dependent care deduction when needed for work, training, or education;
- Medical expenses for elderly or disabled members that are more than $35 for the month if they are not paid by insurance or someone else;
- Legally owed child support payments;
- Some states allow homeless households a set amount ($152.06) for shelter costs; and
- Excess shelter costs that are more than half of the household's income after the other deductions. Allowable costs include the cost of fuel to heat and cook with, electricity, water, the basic fee for one telephone, rent or mortgage payments and taxes on the home. (Some states allow a set amount for utility costs instead of actual costs.) The amount of the shelter deduction cannot be more than $569 unless one person in the household is elderly or disabled. (The limit is higher in Alaska, Hawaii and Guam.)
It’s important to understand that the deductions described here are only the most common ones. There are many other income exclusions and some types of income don’t count at all. The SNAP income rules are quite complex and may vary significantly by state.

**IMPORTANT:** Federal law requires SNAP program personnel to disregard all funds set aside in an approved Plan to Achieve Self-Support (PASS) when they determine eligibility for SNAP.

The United States Department of Agriculture (USDA) adjusts SNAP income and resource standards at the beginning of each federal fiscal year (October 1) based on certain cost-of-living (COLA) adjustments. Figures provided in this unit reflect the amounts that the USDA established as of October 1, 2019 that will be applied through September 30, 2020.

**SNAP Allotments**

The amount of SNAP benefits the household gets is called an allotment. The net monthly income of the household is multiplied by 0.3, and the result is subtracted from the maximum allotment for the household size to find the household’s allotment. This is because SNAP households are expected to spend about 30 percent of their resources on food. The USDA adjusts SNAP maximum allotments, at the beginning of each federal fiscal year based on cost of living adjustments (COLA). COLAs take effect each year in October. If a household applies after the first day of the month, it will receive benefits from the day the household applies.

The SNAP program calculates maximum allotments based on the Thrifty Food Plan for a family of four, priced in June that year. The Thrifty Food Plan estimates how much it costs to buy food to prepare nutritious, low-cost meals for a household, and it changes every year to keep pace with food prices. SNAP determines the maximum allotments for households larger and smaller than four persons using formulas that account for economies of scale. Smaller households get slightly more per person than the four-person household. Larger households get slightly less.
CWIC’s Role in SNAP Income and Resource Determinations

While CWICs don’t have the authority to make SNAP eligibility or allocation determinations, you can provide some important information and support to beneficiaries.

1. Empower SNAP beneficiaries with basic information about how the SNAP benefit is calculated and the way earnings affect SNAP. When you provide that explanation, be sure to point out that 20 percent of earned income is excluded when calculating the SNAP amount.

2. In some states, the state agency that administers SNAP or a local human service agency has created a calculator to estimate a SNAP benefit amount. If you have access to state-specific SNAP calculator, you may be able to use that to estimate a beneficiary’s SNAP when working.

3. If you do not have access to a state-specific SNAP calculator to estimate changes in a beneficiary’s SNAP amount, and the beneficiary is concerned about the effect of earnings on their SNAP, offer to help the beneficiary contact the agency administering SNAP to determine the likely change when working.

You will need to conduct research in your state to determine if a state-specific SNAP calculator is available. You may be able to locate this information by contacting the agency administering SNAP in your state, searching online, or networking with colleagues.

Applying for SNAP Benefits

Individuals apply for SNAP at the local welfare office and, more frequently now, online. CWICs can find the agency that administers the SNAP program in each state online at the state directory (https://www.fns.usda.gov/snap/state-directory).

If the applicant or a member of the applicant’s household is applying for or receiving Supplemental Security Income (SSI) benefits, he or she can apply for SNAP at the local Social Security office.
After the individual submits an application, the SNAP office will contact him or her to set up an interview. States can waive the requirement of a face-to-face interview for certain elderly or disabled persons who may be “homebound.” If eligible, the individual will receive food stamps no later than 30 days from the date the office received his or her application. In the event that the household needs immediate assistance, the office can release the SNAP benefits within seven days. During the interview, the SNAP worker will explain the program rules. The worker can also assist in completing the application.

The applicant must show proof of certain information such as U.S. citizenship, or other documents for certain non-citizens and legal immigrants. Other required verification includes Social Security numbers, unearned and earned income, and resources.

**Rights and Responsibilities under SNAP**

It’s important to help beneficiaries understand their rights under the SNAP program. They have the right to:

- Receive an application and have SNAP accept it on the same day.
- Designate another adult to make the request on the applicant’s behalf.
- Receive food stamps within seven days if there is an immediate need for food.
- Receive service without regard to age, gender, race, color, disability, religious creed, national origin, or political beliefs.
- Be told in advance if the SNAP office would reduce or end benefits during the certification period because of a change in the recipient’s circumstances that they did not report in writing.
- Access their case file and be provided a copy of SNAP rules.
- Appeal any decision.

Along with these rights come responsibilities. SNAP applicants and beneficiaries must answer all questions completely and honestly, provide proof they are eligible, and promptly report changes to the SNAP office. Applicants must not put money or possessions in someone else’s name;
make changes on any SNAP cards or documents; sell, trade, or give away their SNAP benefits; or use SNAP to buy ineligible items. People who break SNAP rules may lose their right to participate in the program. They may also be subject to fines or face legal consequences.

It’s also the recipient’s responsibility to report changes in a timely manner to avoid needing to pay back SNAP for erroneously issued benefits. CWICs should research how the local SNAP office expects participants to report changes to their household circumstances. Some households need to report changes in circumstances every month, others must report changes when they occur, and still other households must report changes once a quarter.

**Special Rules for People Who Are Elderly or Have Disabilities**

SNAP includes a number of special rules for people who are disabled or elderly. To be eligible for these special rules, the person must meet the definition of “elderly or disabled household member.” According to the Food Stamp Act, an elderly person is one who is 60 years of age or older. Generally, the SNAP program considers a person to be disabled if he or she:

- Receives federal disability or blindness payments under the Social Security Act, including Supplemental Security Income (SSI) or Social Security disability or blindness payments;
- Receives state disability or blindness payments based on SSI rules;
- Receives a disability retirement benefit from a governmental agency because of a disability considered permanent under the Social Security Act;
- Receives an annuity under the Railroad Retirement Act and is eligible for Medicare or is considered to be disabled based on the SSI rules;
- Is a veteran who is totally disabled, permanently housebound, or in need of regular aid and attendance; or
• Is a surviving spouse or child of a veteran who is receiving VA benefits due to a permanent disability.

One rule that applies only to people with disabilities has to do with living arrangement. Generally, people living in institutional settings that provide food aren’t eligible for SNAP. However, under certain circumstances, people living in nonprofit residential settings of 16 or fewer individuals can qualify for SNAP even if they need someone within that setting to help them prepare the food.

In addition, individuals who are categorically eligible if they already receive SSI or TANF aren’t subject to the SNAP resource test, because they have already met the resource tests to qualify for SSI or TANF. For more information about how the SSI program interacts with SNAP, see the following Social Security publications online (http://www.ssa.gov/pubs/EN-05-10101.pdf).

The work requirements of the SNAP program don’t apply to people who receive Social Security disability benefits. This means people with disabilities don’t need to be working to receive SNAP for more than three months, nor does the program require them to seek employment, including registering for work.

As noted earlier, families with elderly or disabled members receive an extra deduction when SNAP calculates net income. For elderly members and disabled members, allowable medical costs that are more than $35 a month may be deducted unless an insurance company or someone who is not a household member pays for them. Only the amount over $35 each month may be deducted. Allowable costs include most medical and dental expenses, such as doctor bills, prescription drugs and other over-the-counter medication when approved by a doctor, dentures, inpatient and outpatient hospital expenses, and nursing care. They also include other medically related expenses, such as certain transportation costs, attendant care, and health insurance premiums. The costs of special diets are not allowable medical costs. Proof of medical expenses and insurance payments is required before a deduction for these expenses may be allowed.

Another important difference in SNAP for elderly and disabled individuals has to do with the shelter deduction. The shelter deduction is for shelter costs that are more than half of the household’s income after other deductions. Allowable shelter costs include the costs of rent or mortgage,
taxes, interest, and utilities such as gas, electricity, and water. For most households, there is a limit on the amount of the deduction that can be allowed, but for a household with an elderly or disabled member all shelter costs over half of the household’s income may be deducted.

For more information about [SNAP rules that apply to individuals who are elderly or disabled](https://www.fns.usda.gov/snap/eligibility/elderly-disabled-special-rules), refer to the USDA Food and Nutrition website.

**Conclusion**

In this unit, we have reviewed the basic federal parameters for SNAP. CWICs must remember that states have some discretion in terms of eligibility requirements, as well as income and resources tests. Within broad federal parameters, states vary significantly in how they design and operate their SNAP programs. It’s very important that CWICs stay abreast of their state’s requirements, as they may change periodically. Ask the offices administering SNAP in your state for literature, policies, and procedures in order to be specific with beneficiaries and recipients who come to you for information. We have provided resources below for conducting research into the federal rules, along with a link to individual state SNAP plans.

**Conducting Independent Research**


**The SNAP Website** ([http://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap](http://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap))

**SNAP Regulations for Income** ([https://www.govregs.com/regulations/title7_chapterII_part273_subpartD_section273.9](https://www.govregs.com/regulations/title7_chapterII_part273_subpartD_section273.9))

**SNAP Regulations for Resources** ([https://www.govregs.com/regulations/title7_chapterII_part273_subpartD_section273.8](https://www.govregs.com/regulations/title7_chapterII_part273_subpartD_section273.8))
Competency Unit 3 – Federal Housing Assistance Programs

Introduction

The U.S. Department of Housing and Urban Development (HUD) funds a variety of programs designed to provide “decent, safe and sanitary” housing for families with low incomes. HUD’s rental-subsidy programs make housing affordable by allowing families to pay a percentage of their adjusted income (usually 30 percent) for housing, while HUD funds make up the difference between the family’s contribution and the total rent. Generally, when a family’s income increases, so does their portion of the rent. Conversely, if family income decreases, their share of the rent usually goes down as well.

HUD funds a variety of rental-subsidy programs. The three primary programs are:

1. Public housing
2. Project-based Section 8
3. Housing Choice Voucher (also known as “tenant-based Section 8”)

All three programs apply very similar rules to determine the amount a family will pay for housing. The major difference among the programs involves whether the family must live in a particular housing project or may choose where to live. Public housing and project-based Section 8 provide “project-based” assistance — families must live in particular housing projects, and if they move out, they lose their housing subsidies. Housing Choice Vouchers provide “tenant-based” assistance — families can choose where to live, and they may take their subsidies with them if they move.

Local agencies called “public housing agencies” (PHAs) generally administer HUD programs at the local or state level, using HUD funds. HUD rules govern the programs, but PHAs may set some rules as well.

HUD programs don’t have sufficient resources to serve all families who need and want assistance. As a result, programs usually have long
waiting lists. Families often need to wait even to be included on waiting lists, and they should take certain measures to ensure they will be admitted to HUD programs once they have been added to the lists.

**IMPORTANT NOTE ABOUT UPCOMING CHANGES IN HUD POLICY:**

On July 29, 2016, President Obama signed into law the Housing Opportunity through Modernization Act of 2016 (HOTMA). This legislation made sweeping changes to Sections 102, 103 and 104 of the United States Housing Act of 1937, particularly those affecting income calculation and reviews. Section 102 changes requirements pertaining to income reviews for public housing and HUD's Section 8 programs. Section 103 modifies the continued occupancy standards of public housing residents whose income has grown above the threshold for initial eligibility. Section 104 sets maximum limits on the assets that families residing in public housing and Section 8 assisted housing may have. Additionally, section 104 provides that HUD must direct public housing agencies to require that all applicants for and recipients of assistance through HUD's public housing or Section 8 programs provide authorization for public housing agencies to obtain financial records needed for eligibility determinations.

The final regulations for implementing the provisions of HOTMA, including the elimination of the Earned Income Disregard, were not released by the time the 2020 WIPA manual was produced. The information provided in this unit is based on current HUD regulations prior to full implementation of HOTMA. The VCU-NTDC will disseminate an explanation of the new rules when the final regulations are published. The [proposed regulations are available online at federalregister.gov](https://www.federalregister.gov/documents/2019/09/17/2019-19774/housing-opportunity-through-modernization-act-of-2016-implementation-of-sections-102-103-and-104).

**Basic HUD Rental Subsidy Programs and Eligibility Requirements**

The three basic HUD rental subsidy programs are:

1. Public housing;
2. Project-based Section 8 rental subsidies; and
3. Housing Choice Voucher (and Project-Based Voucher)

**Public Housing**

PHAs own and operate public housing, although the funding comes from HUD. It takes a variety of forms, including high-rise apartment buildings, smaller groups of apartments, or even detached single-family homes. Families can only use the rental subsidies that come with public housing in public housing; if a family moves out, they lose the subsidy.

To be eligible for public housing, a family must have “low income.” However, 40 percent of public housing units newly rented each year must go to “extremely low income” families.

More information about public housing is available at HUD’s website (https://www.hud.gov/program_offices/public_indian_housing/programs/ph)

**Project-Based Section 8 Rental Subsidies**

Project-based Section 8 rental subsidies make housing affordable in privately owned and operated housing projects. The subsidy applies to a specific unit in the project, so if the family moves, they usually lose the subsidy.

A family must have “very low income” to be eligible for a project-based Section 8 subsidy, although projects that began receiving rental assistance before October 1, 1981 may admit families with “low income.” Forty percent of new admissions each year to project-based Section 8 subsidies must go to “extremely low income” families.

More information about Project-Based Section 8 Rental Subsidies is available on HUD’s website (https://www.hud.gov/program_offices/public_indian_housing/programs/hcv/project).

**Housing Choice Voucher (also known as “Tenant-Based Section 8”)**

Housing Choice Vouchers subsidize rent in privately owned housing units other than housing projects. Generally, a family may use a Housing Choice Voucher to rent an apartment or house if the landlord is willing to participate in the program. Housing Choice Vouchers are portable. This
means that a family may move and bring the subsidy with them, and can live anywhere in the United States.

Only families with “very low income” may qualify for Housing Choice Vouchers. Each year, “extremely low income” families must receive 75 percent of the vouchers.

More information about **Housing Choice Vouchers** is available on HUD’s website (https://www.hud.gov/program_offices/public_indian_housing/programs/hcv/about/fact_sheet)

PHAs can use up to 20 percent of their Housing Choice Voucher funding to provide Project-Based Vouchers, which apply to particular units in privately owned housing projects. A family that receives a Project-Based Voucher must live in the unit for at least a year, or else they will lose their subsidy. If the family moves out of the unit after a year, they may request a tenant- based rent subsidy in the unit to which they move.

**HUD Income Definitions:**

1. **Low income:** At or below 80 percent of the median income for a family of a given size in the local area.

2. **Very low income:** At or below 50 percent of the median income for a family of a given size in the local area.

3. **Extremely low income:** At or below 30 percent of the median income for a family of a given size in the local area.

Because median income in a local area determines income eligibility for HUD programs, actual income dollar limits will differ widely from one area to the net. **Find income limits** online (http://www.huduser.gov/portal/datasets/il.html).

In addition to meeting income limits, a family must meet these criteria:

- Constitute a “family,” as defined by the PHA;

- **Prove that at least one member is a U.S. citizen or eligible immigrant** (see https://www.law.cornell.edu/uscode/text/42/1436a#a);

- Provide Social Security numbers for all members of the family aged 6 or older; and
Complete a satisfactory background check that considers rental history and criminal background.

**Who Is Included in a “Family”?**

To be eligible for HUD rental subsidy programs, the household members must meet the definition of a “family.” Each PHA provides its own definition of “family,” using HUD guidelines. Generally, a family is a single person or a group of people, with or without children. A child who is temporarily out of the home due to placement in foster care remains a member of the family. All residents of a single dwelling count as part of the family, except live-in aides.

HUD also provides these definitions:

**Disabled or elderly family:** A family whose head, co-head, spouse, or sole member is disabled or at least age 62; two or more persons living together who are all disabled or at least age 62; or one or more persons living together who are all disabled or at least age 62 and who live with one or more live-in aides.

**Person with a disability:** A person who:

- Meets Social Security’s adult definition of disability (see Section 223, Social Security Act); or
- Is determined by HUD regulations to have a physical, mental, or emotional impairment that:
  a. Is expected to be of long, continued, and indefinite duration;
  b. Substantially impedes his or her ability to live independently; and
  c. Is of such a nature that such ability could improve with more suitable housing conditions; or
  d. Has a developmental disability as defined in Section 102 of the Developmental Disabilities Assistance and Bill of Rights Act.

The disability must not be based solely on drug or alcohol dependency. HUD programs may exclude a person who would pose a direct threat to the health or safety of others, or who would cause substantial damage to the property of others.
A student in higher education can’t qualify for HUD Section 8 assistance if she or he:

- Is under age 24;
- Isn’t a U.S. military veteran;
- Is unmarried;
- Doesn’t have a dependent child;
- Isn’t a person with a disability who was receiving Section 8 assistance as of November 30, 2005; and
- Isn’t otherwise individually eligible, or has parents who aren’t eligible for Section 8 on the basis of income (24 CFR 5.612)

Basic Rent and Utility Payment Calculation

A family in a HUD rental subsidy program generally pays the highest of the following for rent and utilities (“total tenant payment”):

- 30 percent of adjusted family income;
- 10 percent of gross family income;
- If the family receives welfare assistance payments, the amount of that assistance designated for housing; or
- The minimum rent for some programs ($25/month to $50/month), unless the family is exempt from the minimum rent due to financial hardship.

For most families, the rent and utility payment is 30 percent of adjusted income. PHAs can choose different calculation methods to set total tenant payment, so long as they don’t yield amounts higher than the standard method.

**NOTE:** If a family with a Housing Choice Voucher rents a unit whose gross rent exceeds the “payment standard” – an amount set by the PHA based on average market rental costs for a unit with a given number of bedrooms – they must pay the difference between the gross rent and the payment standard PLUS the amount they would otherwise pay (usually 30% of adjusted income). When the family
first chooses the unit, they will only be allowed to rent it if 
their total payment is no greater than 40% of adjusted 
income. However, if rent rises after initial occupancy, a 
group with a Housing Choice Voucher may pay more than 
40% of adjusted income.

Calculating Adjusted Income
To compute adjusted income, the PHA:

1. Adds all included income;
2. Doesn’t include any excluded income; and

Included Income
Income includes, but isn’t limited to:

- Earned income of employees (before taxes or other payroll 
deductions).

- Self-employment earnings, after subtracting:
  a. Business expenses (but not expenses used to expand the 
business or capital improvements);
  b. Interest paid on loans for the business (but not loan 
principal, or interest on loans used to expand the business 
or make capital improvements);
  c. Depreciation computed on a straight-line basis; and
  d. Interest and dividends.

- Most periodic payments, including Social Security, SSI, public 
assistance, annuities, insurance payments, pensions, retirement 
funds, disability and death benefits, unemployment and workers 
compensation, alimony and child support received, etc.

- Income deriving from assets.

- Assets.

HUD programs don’t have asset limits. However, HUD counts any income 
that a family derives (or could derive) from assets during income 
determinations. If total assets are $5,000 or less, HUD counts only the
actual income (interest, dividends) the family receives from the assets. If total assets are more than $5,000, HUD counts the larger of:

- The actual income received from the assets, or
- A percentage of the value of the assets based on the current passbook savings rate established by HUD.

Excluded Income

HUD doesn’t count some types of income under HUD mandatory rules. The following types are especially relevant to family members who are working for pay and for people with disabilities:

- Earnings from work of children under age 18.
- Earnings in excess of $480 per year for each full-time student 18 years or older (excluding the head of household and spouse).
- Amounts received in training programs funded by HUD, and in qualifying state or local employment training programs, including payments for job-related expenses.
- Reimbursement for expenses incurred to participate in publicly assisted programs.
- Resident service stipends up to $200 per month.
- Income used to pay expenses under a Plan to Achieve Self Support (PASS).
- Payments received for providing foster care.
- Income of a live-in aide.
- Funds paid by state agencies to a family to offset services needed to keep a family member with a developmental disability living at home.
- Reimbursements for medical expenses.
- Lump sum SSI and Social Security benefits.
- Amounts withheld from public benefits to recover overpayments.
- SNAP and other food assistance program benefits.
- Earned Income Tax Credit (EITC) refunds.
• Personal needs allowances received by people in intermediate care facilities for people with developmental disabilities and assisted living units.

**Mandatory Income Deductions**

HUD deducts these amounts from family income under mandatory HUD rules:

• $480 per year ($40 per month) for each dependent who is under age 18, disabled, or a full-time student.

• $400 per year ($33.33 per month) for a disabled or elderly family.

• Child care expenses for a child under age 13 to enable a family member to work, seek work, or further his or her education.

• The amount of the following two expense types that exceed 3 percent of gross family income:
  
  a. Unreimbursed medical expenses for all members of a disabled or elderly family.
  
  b. Unreimbursed reasonable attendant care and assistive technology costs needed by a family member with a disability to enable any family member to be employed. Attendant care “includes but isn’t limited to reasonable expenses for home medical care, nursing services, housekeeping and errand services, interpreters for hearing-impaired, and readers for persons with visual disabilities.”

**Optional Income Deductions**

PHAs may adopt optional deductions for public housing, but only if they are willing to absorb the costs (i.e., the PHA must provide funds to offset the reductions in rent resulting from the optional deductions). As a result, most PHA’s don’t offer optional deductions.

**Utility Allowance**

If a family pays for utilities separately from their rent, the PHA or project owner will determine a utility allowance to deduct from their payment for rent and utilities. The amount that remains after deducting the utility allowance is the amount the family pays for rent.
The PHA or project owner calculates the utility allowance based on the family and unit size, the types of utilities the family pays, the average cost of those utilities in the area in which the family lives, and other factors. Utilities include gas, electricity, heating fuel, water, trash collection and sewerage, but not telephone or cable TV. If the utility allowance is greater than the total tenant payment, the PHA or project owner provides a payment (utility reimbursement) to the family or utility supplier to make up the difference. In some cases, a higher utility allowance may be provided as a reasonable accommodation for a family that includes a member with a disability. A family whose rent includes utilities doesn’t receive a utility allowance.

**Programs that Promote Employment and Financial Independence**

Several HUD programs encourage certain family members to pursue employment and greater financial self-sufficiency. These include the Earned Income Disregard (EID), the Family Self-Sufficiency (FSS) program, and Individual Savings Accounts (ISAs). Another — the Homeownership Voucher Program — enables a family to convert its Housing Choice Voucher to help the family buy a home, rather than rent one. Finally, HUD’s Moving to Work (MTW) demonstration program allows selected PHAs to test innovative, locally-designed strategies that use federal dollars more efficiently, help residents find employment and become self-sufficient, and increase housing choices for low income families. Moving to Work gives PHAs exemptions from many existing public housing and voucher rules, and more flexibility with how they use their federal funds.

**Earned Income Disregard (also known as “Earned Income Disallowance”)**

The Earned Income Disregard (EID) enables certain family members with certain HUD rental subsidies to go to work without having the family’s rent increase immediately. HUD phases in the rent increase.

**Who Is Eligible?**

- Adults with and without disabilities in public housing; and
- Adults with disabilities who receive assistance from the:
When Does It Apply?
The EID applies in any of three situations:

1. When an adult family member is newly employed and the family’s income increases as a result. The member must have been previously unemployed or minimally employed (earning no more than the equivalent of 500 hours at the local minimum wage) during the year before the new employment starts; or

2. When an adult family member has an increase in earnings during participation in a self-sufficiency or other job training program (which may include employment counseling, work placement, basic skills training, education, English proficiency, workfare, financial or household management, apprenticeship, community college, substance abuse or mental health treatment program, etc.), and the family’s income increases as a result; or

3. When an adult family member is newly employed or increases his or her earnings during (or within 6 months after) receiving TANF-funded assistance (including one-time payments, wage subsidies and transportation aid totaling at least $500 in a 6-month period), and the family’s income increases as a result.

The EID also applies to a family member who reaches age 18 and meets one of the above three conditions.

How Does It Work?
When a family member qualifies for the EID, the PHA disregards the increase in family rent resulting from the new or increased earnings in two phases:

- Housing Choice Voucher program,
- HOME Investment Partnerships program,
- Housing Opportunities for Persons with Acquired Immune Deficiency Syndrome (AIDS) (HOPWA) program, or
- Project-Based Section 8 Voucher (but not other project-based Section 8 programs).
1. During the first 12 months of the EID, the PHA excludes 100 percent of the increase in family income resulting from the new or increased earnings. As a result, the family’s rent doesn’t increase due to the earnings for the first 12 months of work. The 12 months continue to be counted even if the family member stops working during that time period.

2. During the second 12 months of the EID, the PHA excludes at least 50 percent of the increase in family income resulting from the new or increased earnings. PHAs may opt to exclude more than 50 percent. The family’s rent increases during this second 12 month period, but only half as much as if HUD counted all the increase in income. Again, the second 12 months of the EID continue to be counted even if the family member stops working during that time period. It’s important to understand that once the family member is found eligible for the EID and the EID 24-month period begins, there is no way to stop it. At the end of the 24-month period, eligibility for the EID ends even if the family member didn’t work the entire time and wasn’t able to use the benefit of the disregard for all 24 months. Furthermore, the EID benefit is only afforded once per life time. When the 24-month period ends, there is no additional EID benefit.

After the beneficiary has used up the EID, the exclusion of earnings ends. HUD computes the family’s rent based on family income, including all of the earnings.

**Examples of How the EID is Applied**

**Example of someone who works all 24-months of the EID period:**

*Mephisto* is 37 years old. He receives $783 per month in SSI and lives alone with a Housing Choice Voucher. He hasn’t worked in more than 12 months. He pays $215 per month for rent including utilities ($783 SSI – $33.33 disabled family deduction = $749.67 \times 30\% = $224.90). He starts a job earning $10 per hour working 30 hours per week (an average of $1,300 per month gross wages). On average, his SSI payment reduces to $175.50 per month.
Mephisto qualifies for the EID. During the first 12 months, the PHA fully excludes the increase in his income resulting from his earnings. His rent and utility payment remains $221 per month.

During the second 12 months, the PHA excludes 50 percent of the increase in his income. His income increase is $692.50 ($1,300 wages + $175.50 reduced SSI = $1,475.50 − $783 original SSI = $692.50). Fifty percent of $692.50 is $346.25. Mephisto’s rent increases to $317.08 ($1,300 wages + $175.50 reduced SSI − $346.25 excluded income increase − $33.33 disabled family deduction = $1,095.92 × 30% = $328.77) after his next rent reexamination.

Mephisto uses up his EID after 24 months. Now the PHA includes all his earnings in the rent calculation. After his net redetermination, his rent increases to $422.75 ($1,300 wages + $175.50 SSI − $33.33 disabled family deduction = $1,442.17 × 30% = $432.65).

Example of someone who only works for part of the 24-month EID period:

Alex is 23 years old. He receives $900 per month in SSDI and lives alone. He has a Housing Choice Voucher. He hasn’t worked in more than 12 months. He pays $260 per month for rent including utilities ($900 SSDI − $33.33 disabled family deduction = $866.67 × 30% = $260). He starts a seasonal job earning $10 per hour working 22 hours per week (an average of $953 per month gross wages).

Alex qualifies for the EID. During the first 12 months, the PHA excludes 100 percent of the increase in his income resulting from his earnings. His rent and utility payment remains $260 per month.

However, Alex did not actually work all 12 months since his job is seasonal. He only worked for 6 of those months. Even though Alex didn’t work for all 12 months, the 12-month EID period continued to be used up. Alex’s rent
remains the same for the entire year because 100% of the increased income he had when he worked was disregarded. For the other 6 months, he had no increased income because he didn’t work, therefore his rent was the same as it was before he started working. The EID exclusion isn’t applied in these months because Alex didn’t have any increased income, but the EID 12-month period is still being used – that initial 12-month clock is ticking.

During the second 12 months, the PHA excludes 50 percent of the increase in Alex’s income. His income increase is $953 ($953 wages + 900 SSDI = $1,853 − $900 original SSDI). Fifty percent of $953 is $476.50. Alex’s rent increases to $402.95 ($953 wages + $900 SSDI − $476.50 excluded income increase − $33.33 disabled family deduction = $1,343.17 × 30% =$402.95) after his next rent reexamination.

Again, since Alex’s job is seasonal, he only actually worked for 6 months of this second 12-month period. Because of this, he only received the benefit of the disregard for those 6 months. In the months Alex didn’t work, his rent went back down to the original amount because he didn’t have earnings for those months. The EID exclusion isn’t applied in these months because Alex didn’t have any increased income, but the EID second 12-month period is still being used – that second 12 month clock is still ticking.

Alex uses up his EID after 24 months even though he didn’t have increased income due to work for all of those months. Now the PHA includes all his earnings in the rent calculation for the months Alex works. After his net redetermination, his rent increases to $545.90 ($953 wages + $900 SSDI − $33.33 disabled family deduction = $1,819.67 × 30% = $545.90).

**Family Self-Sufficiency Program**

The Family Self-Sufficiency (FSS) Program provides case management and an escrow fund to families who agree to a plan to achieve self-sufficiency. When the head of the family goes to work, the family’s rent increases. However, the local PHA deposits the amount of the rent
increase into an escrow account for the family to withdraw after they have reached their goal.

**Who Is Eligible?**

Families are eligible for the FSS who receive rental assistance through:

- Public housing, or
- Housing Choice Voucher, or
- Indian housing through the Native American Housing Assistance and Self-Determination Act.

**How Does It Work?**

The family enters into a service plan and a contract with the local PHA to pursue self-sufficiency objectives. The head of the family agrees to seek and maintain paid work. The goal of the plan is to end the family’s dependence on public assistance or rental subsidies by achieving the plan objectives, or by increasing family income enough that HUD is no longer subsidizing their rent (i.e., 30 percent of their adjusted income equals or exceeds the total rent and utilities for their unit). The family receives case management to help them achieve their goal. They may receive assistance including education, job training, counseling, childcare, and transportation aid.

The family also receives an escrow account. The PHA deposits funds into the account that are equal to the increase in rent the family pays after the head of the family becomes employed (for very low-income families). Low-income families receive a lesser contribution, based on what their rent increase must have been if their income were 50 percent of the area median income. The family receives all the funds in the account once they have reached their FSS goals. The PHA may release some funds to the family if they have reached interim goals and need money to pay for education, work-related expenses, or other needs related to the goal. The FSS typically lasts for five years.

In some cases, the head of a family may be eligible for both FSS and the Earned Income Disregard (EID) at the same time. HUD applies the EID first. Because HUD doesn’t increase the family’s rent for the first 12 months of earnings, the PHA makes no contribution to the FSS escrow account for those 12 months. During the second 12 months of earnings, the EID causes the rent to increase only half as much as if HUD counted all earnings. The PHA deposits the amount of the increase into the FSS
account. After the second 12 months, when the EID has expired, HUD increases the rent based on all of the earnings. The PHA deposits the full amount of the increase into the FSS account for up to the remaining three years of the FSS contract.

A family that receives a Housing Choice Voucher and participates in the FSS Program must live in a unit in the area served by the PHA that administers the FSS Program for at least 12 months, but may then move out of the jurisdiction and continue the FSS Program.

A fact sheet describing the FSS program is available at the HUD website (https://www.hud.gov/sites/documents/FSSFACTSHEET.PDF)

**Individual Savings Accounts**

As an alternative to the Earned Income Disregard, PHAs may offer a family in public housing the option to have their rent increase due to employment deposited into an Individual Savings Account (ISA) for the family to use for certain self-sufficiency purposes.

**Who Is Eligible?**

Only families in public housing who pay an income-based rent are eligible. A family may choose between the Earned Income Disregard and an ISA; PHAs can’t require a family to use an ISA. PHAs may offer ISAs, but HUD doesn’t require them to. Most PHA’s don’t offer them.

**How Does It Work?**

When an adult family member goes to work, the family pays an increased rent. The local PHA deposits the rent increase into an interest-bearing account. The family may withdraw funds from the account, but only for:

- Buying a home;
- Paying a family member’s education costs;
- Moving out of public housing; or
- Other expenses the PHA approves to support greater self-sufficiency.

An ISA can last for up to 24 months. Although this is the same time limit as for the EID, an ISA can provide a family with a greater benefit. The ISA receives deposits of the full rent increase for the family resulting from new earnings for 24 months. The EID prevents rent from increasing for
only the first 12 months, and then provides a rent increase based on no more than half the increased income resulting from the new earnings.

**Moving to Work (MTW)**

Moving to Work (MTW) is a HUD demonstration program that provides PHAs the opportunity to design and test innovative, locally-designed strategies that use Federal dollars more efficiently and help residents find employment and become self-sufficient. HUD allows PHAs selected for the demonstration to seek exemption from many existing Public Housing and Housing Choice Voucher program rules found in the United States Housing Act of 1937 in pursuit of the three MTW statutory objectives:

- Reduce cost and achieve greater costs effectiveness in Federal expenditures;
- Give incentives to families with children where the head of household is working, is seeking work, or is preparing for work by participating in job training, educational programs, or programs that assist people to obtain employment and become economically self-sufficient; and
- Increase housing choices for low-income families.

HUD expects MTW PHAs to use the opportunities presented by MTW to inform HUD about ways to better address local community needs. Some of the innovative strategies MTW PHAs are testing include:

**Cost Savings**

- Using the MTW block grant to leverage funds
- Streamlining HUD processes
- Redesigning HUD forms
- Risk-based inspections
- Rent simplification

**Self Sufficiency**

- Self-sufficiency requirements
- Linking rental assistance with supportive services
- Escrow accounts
- Earned income exclusions
- Increased case management services

**Housing Choices**

- Developing mixed-income and tax credit properties
- Foreclosure prevention, mortgage assistance and homeownership programs
- Increasing the percentage of project-based vouchers

PHAs in the MTW Demonstration also have the flexibility to combine Federal funds from the public housing operating and modernization programs and Housing Choice Voucher program into a "block grant" to help them better meet the purposes of the demonstration and the needs of their communities.

Congress authorized the MTW Demonstration under Section 204 of the Omnibus Consolidated Rescissions and Appropriations Act of 1996. The original MTW Demonstration statute permitted up to 30 PHAs to participate in the demonstration program. Additional MTW ‘slots’ have been added by Congress over time through appropriations statutes. Currently there are 39 PHAs participating in the MTW demonstration program. You can find a [map online showing all of the current MTW sites](https://www.hud.gov/program_offices/public_indian_housing/programs/ph/mtw/mtwagencies).

An important thing to be aware of is that MTW PHAs may choose NOT to provide the Earned Income Disregard, or may modify the EID. In some cases, MTW PHAs provide a more generous exemption for earned income than is provided by the EID. CWICs must conduct research to determine if the local PHAs in their area are part of the MTW demonstration, and if so, whether they have eliminated or modified the EID as part of that program.

While MTW agencies have considerable flexibility, they must still abide by all other federal rules and regulations, including the Fair Housing Act, the Civil Rights Act, labor standards, environmental rules, procurement guidelines, demolition and disposition procedures and relocation regulations. For all activities that affect their residents' rent payments, PHAs must also conduct an impact analysis that recognizes the unforeseen circumstances that may affect their residents and develop an
appropriate hardship policy. These safeguards help minimize any potentially negative impact of MTW on residents and communities.

**Plan to Achieve Self Support (PASS)**

A Plan to Achieve Self Support (PASS) is a SSI work incentive designed to help a person with a disability to reach a work goal that makes him or her less dependent on cash benefits from Social Security. If the beneficiary achieves the goal, the earnings will reduce or stop SSI payments, or stop Social Security disability payments. The PASS enables the user to pay for a variety of expenses to reach the work goal. Social Security subtracts the expenses from “countable” income, which provides the user with a higher SSI payment than she or he would receive without the PASS. See Module 3, Unit 7 for details about PASS.

While PASS isn’t a HUD work incentive, HUD programs deduct PASS expenses when computing a family’s adjusted income, thereby reducing the family’s rent and utility payments. PASS users are better able to afford to pay for PASS expenses when their family’s rents in HUD programs are lower.

**Homeownership Voucher Program**

HUD’s Homeownership Voucher Program enables some Housing Choice Voucher recipients to use their vouchers to help them purchase homes, instead of renting.

**Who Is Eligible?**

The HUD Homeownership Voucher Program is optional. PHAs may choose whether to offer it, so many don’t. However, HUD may require a PHA to provide homeownership assistance as a reasonable accommodation to a family that includes a member with a disability.

**A list of PHAs that participate in the HUD Homeownership Voucher** program can be found online (http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/hcv).

To be eligible for the program, a family must have a Housing Choice Voucher and must live in the area served by a PHA that participates in the Homeownership Voucher Program. The family may convert their newly acquired Housing Choice Voucher to a Homeownership Voucher and use it exclusively for homeownership. In most cases, however, families that
have been using their Housing Choice Vouchers in rental properties will later convert them to Homeownership Vouchers.

For a family with a disabled member, annual income of each adult member who will own the home must be at least as high as the SSI Federal Benefit Rate (FBR) for an individual ($783 per month in 2020), unless the PHA chooses to make it higher.

**How Does It Work?**

A family with a Housing Choice Voucher contacts the PHA and requests to participate in the Homeownership Voucher Program. If the PHA participates in the program and approves the request, the PHA converts the voucher, and the family uses it to pay for expenses to buy a home, rather than to rent one. Homeownership expenses may include:

- Mortgage payments
- Mortgage insurance
- Property taxes and insurance
- Utilities
- Maintenance, repairs, and replacements

The PHA, its contractor, or a HUD-approved agency must provide the family with homebuyer counseling. The PHA may set a down payment requirement (e.g., at least 1 percent of the purchase price from the family’s personal resources).

The housing assistance payment (the amount HUD will pay toward homeownership expenses) is the lesser of: (a) the payment standard minus the total tenant payment, or (b) the monthly homeownership expenses minus the total tenant payment.

Homeownership assistance may last indefinitely for a family with a disabled member. Families may use Homeownership Vouchers in combination with other public homeownership programs, such as mortgage or loan guaranty programs. Unlike other homeownership assistance programs, the Homeownership Voucher can help avert foreclosure by providing more financial assistance if a family’s income drops due to unemployment, loss of public benefits, or other reasons.
Re-examinations of Income

PHAs must reexamine a family’s income at least once every 12 months if the family pays an income-based rent. A PHA must adopt a policy detailing whether families must report increases in income between annual reexaminations, or whether the families need only to report changes annually. If a PHA requires families to report income increases between annual reexaminations, then the PHA will conduct interim reexaminations when the families report changes, adjusting families’ rents accordingly.

If a family’s income decreases between annual reexaminations, or another change occurs that would reduce the family’s income-based rent (e.g., a new dependent joins the family, childcare or medical expenses increase, etc.), the family can report the change to the PHA and trigger an interim reexamination to reduce the rent. This is true even if the PHA doesn’t require families to report income changes between annual reexaminations.

Flat Rates in Public Housing

Flat rent is an option for families in public housing that prevents them from paying more than the market rent for their unit when their income rises. If a family chooses to pay a flat rent, the amount they pay is based on the housing unit’s actual market value in the private rental market. The flat rent is approximately the amount the landlord could rent the unit for without a public subsidy.

Why Would a Family Choose a Flat Rent?

If a family’s income increases enough, their income-based rent (usually 30 percent of adjusted income) may be higher than the market rent for the unit they occupy. If the family chooses a flat rent instead, they pay only the market rent, and not more.

When Can a Family Choose a Flat Rent?

Each year, families can select between income-based and flat rent at the time of annual reexamination. The PHA must inform the family of the actual amount of their income-based rent and the flat rent applicable to their unit.
Flat Rent Adjustments
A PHA must reexamine the family composition and housing unit size of a family in public housing at least once a year, even if the family pays a flat rent. The PHA may choose to reexamine the income of a family paying a flat rent as rarely as once every three years, though the PHA may choose to conduct reexaminations annually. PHAs must review the amounts of flat rents at least annually to ensure they still reflect actual market rents.

Flat Rents — When To Do Interim Adjustments
PHAs must allow families to immediately switch from flat rent to income-based rent in the event of financial hardship that prevents the family from paying the flat rent. PHAs must establish policies on hardships that warrant switching from flat rent to income-based rent, which must include:

- Decreases in income;
- Loss or reduction of employment;
- Death in the family;
- Reduction in or loss of earnings or assistance;
- Increase in medical, childcare, transportation, education, or other expenses;
- Demonstrated financial hardship; and
- Other situations the PHA defines.

When a family’s rent reduces due to their changing from flat rent to income-based rent, they must wait for their net annual reexamination to switch back to flat rent if their income increases again.

Flat rent is an important option for families in public housing whose incomes increase substantially due to employment.

Minimum Rates and Hardship Exemptions
A PHA may set a minimum rent for particular programs. The minimum will be between $0 and $50 per month for public housing and some Section 8 programs (moderate rehabilitation, tenant-based, and project-based voucher). For other Section 8 programs, the minimum rent is set
at $25 per month. The minimum rent generally applies even if the usual rent or utility calculation (30 percent of adjusted family income) shows the family should pay a lesser amount. However, there are exceptions when the family may pay less than the minimum rent.

Common reasons why families pay minimum rent:

- Family’s major source of income the PHA has excluded; or
- Family has little income from any source; or
- Family has income they haven’t disclosed to the PHA.

**Hardship Exemption Requirements**

If a PHA adopts a minimum rent over $0, the PHA must adopt hardship exemptions that exclude a family from having to pay the minimum rent. Hardship exemptions include:

- Family has lost eligibility for or is waiting for eligibility determination for a federal, state, or local assistance program.
- Family would be evicted because they are unable to pay minimum rent.
- Family income decreases due to changed circumstances (e.g., job loss, medical problem, family member with income leaving home).
- Death in the family.
- Other PHA-determined circumstances.

If a family requests a hardship exemption from a PHA, HUD can’t evict them for 90 days after the month of the request. The PHA must suspend the minimum rent while determining if (a) there is a hardship, and (b) if so, whether it’s temporary or long-term. If the PHA determines there is no hardship, the tenant must pay the rent it owes during the suspension period, and resume paying the minimum rent.

In public housing, if the hardship is temporary (less than 90 days), HUD reinstates the minimum rent from the start of the suspension period, and sets a repayment agreement to recoup the back minimum rent owed. In Section 8 programs, if the hardship is less than 90 days, HUD reinstates the minimum rent after the suspension period, and sets up a repayment agreement to recoup back minimum rent owed to the start of the
suspension period. If the hardship is long-term (more than 90 days), HUD suspends the minimum rent for as long as the hardship continues.

**Effect of Welfare Assistance Reductions on Rent**

If the state reduces the family’s Temporary Assistance to Needy Families (TANF) or other welfare assistance (such as subsidized transportation or childcare), HUD may or may not reduce rent in HUD-funded programs.

**When HUD Doesn’t Reduce Rent**

HUD doesn’t reduce rent when TANF or other assistance decreases because:

- The family has committed fraud, or
- The family hasn’t complied with a requirement to participate in an economic self-sufficiency program.

**When HUD Does Reduce Rent**

HUD does reduce rent when TANF or other assistance decreases because of circumstances including (but not limited to):

- The family has reached the maximum time limit for receiving TANF or welfare benefits.
- The family isn’t able to find a job in spite of full compliance with all program requirements.
- The family is being sanctioned for failure to comply with program requirements OTHER THAN participation in an economic self-sufficiency program.
- The family’s benefit is reduced because of an earlier, inadvertent overpayment.

**What Is An Economic Self-Sufficiency Program?**

An economic self-sufficiency program is any program designed to encourage, assist, train, or facilitate the economic independence of HUD-assisted families or to provide work for such families. These programs include:
• Job training
• Work placement
• Education
• Workfare
• Employment counseling
• Basic skills training
• English proficiency
• Apprenticeship
• Financial or household management
• Any program necessary to ready a participant for work, including a substance abuse or mental health treatment program

**HUD Grievance Procedure Requirements for PHAs**

HUD requires all PHAs to establish and implement a formal grievance procedure to assure that a PHA tenant is afforded an opportunity for a hearing if the tenant disputes any PHA action or failure to act involving the tenant's lease with the PHA or PHA regulations that adversely affect the individual tenant's rights, duties, welfare or status. PHAs are required to include or reference the grievance procedure in all tenant dwelling leases and provide a copy of the grievance procedure to each tenant and to resident organizations.

Local PHAs may design their grievance procedures in a variety of ways as long as all federal requirements are met. The federal requirements for grievance requirements are listed in the Code of Federal Regulations (https://www.gpo.gov/fdsys/pkg/CFR-2017-title24-vol4/xml/CFR-2017-title24-vol4-part966.xml#seqnum966.50).

Individuals should contact their local PHA for a copy of the grievance procedure if they wish to file a grievance about a determination.
The CWIC’s Role in Helping Beneficiaries with Housing Programs

A CWIC doesn’t typically help people apply for HUD-funded housing programs, but she or he may recommend that families who are having difficulty affording their housing payments apply for HUD-funded assistance from PHAs.

As with other public benefits, CWICs need to verify HUD program participation. CWICs should verify the following information:

- The type of HUD program that assists the individual or family;
- The amount of the tenant’s rent payment and utility allowance (if any);
- Participation in the Earned Income Disregard (EID), including the number of EID months still available;
- Participation in the Family Self Sufficiency Program (FSS);
- Participation in the Individual Savings Account (ISA) program.

Beneficiaries may have letters from PHAs that provide some of these details. The local PHA or the rental office for a housing project can usually verify the information. If these sources aren’t forthcoming, the nearest HUD local office may provide the verification.

Find Your Local Public Housing Agency (PHA)

HUD’s Local Office Directory can be found on HUD.gov (http://portal.hud.gov/hudportal/HUD?src=/program_offices/field_policy_mgt/localoffices). CWICs should cultivate relationships with helpful staff in these offices.

CWICs should be familiar with the features of various HUD programs and should advise individuals and families they serve who participate in these programs about their options and responsibilities when they go to work. CWICs should focus especially on:

- When families should report new employment or changes in earnings to the PHA or housing management office.
• The likely impact of changes in income (particularly earnings) on the family’s payments for rent and utilities.

• Whether family members may qualify for the EID, FSS, or ISA to delay or alleviate the impact of rent increases resulting from employment.

• Whether an individual or family with a Housing Choice Voucher might request to use their voucher to purchase a home rather than rent one, if their PHA offers the Homeownership Voucher.

• Options (if any) for the individual or family to remain in their home or remain eligible for program assistance if their income should increase above the income limit for the program that assists them.

CWICs should always include information about HUD programs and work incentives in Benefits Summary and Analyses reports (BS&As) and Work Incentive Plans (WIPs), when applicable. Address the impact of projected income changes (e.g., new employment or increased earnings) on expenses and net income.

NOTE: HUD rental subsidies are NOT counted as income in the SSI program.

Remember to verify an individual’s eligibility for the Earned Income Disregard (EID), and how many EID months are still available, before providing guidance regarding this work incentive. When an individual qualifies for the EID, it’s important for the CWIC to highlight the family’s projected net income after paying for rent and utilities during each of the three phases of the EID — the first 12 months (when rent doesn’t increase), the second 12 months (when the rent increases partially), and after 24 months (when the full rent increase occurs). Individuals and families need to prepare for changing net income levels, especially because net income may decrease as rent rises.

**Tips to Help Applicants Get Approved for Housing Assistance**

• Apply everywhere (within reason) with an open waiting list.

• Apply for multiple types of programs.

• Keep application information current — report address changes.
• Respond promptly to PHA contacts to verify continuing interest, to avoid PHA purging you from waiting lists.

• Address issues that may cause PHAs to deny housing subsidies or landlords to deny rental applications, including credit problems, substance abuse, and criminal records.

Tips for Current HUD Housing Tenants

• Communicate with the PHA in writing, have the PHA date stamp correspondence, and place it in the file. Keep copies of all correspondence.

• Keep copies of repair requests, dates of repair requests, work order numbers, and other communications with the landlord.

• If the landlord fails to make necessary repairs in a timely way, a tenant with a Housing Choice Voucher should request an inspection from the PHA or contact the local court to initiate paying rent into escrow. A Public Housing tenant should have a discussion with the property manager.

• Notify the PHA in writing of any changes to household size or income within 10 days.

• Request access to the PHA’s tenant file in writing, if necessary.

• Report to the PHA immediately if the landlord asks for “side payments” in addition to the required tenant payment. This is fraud.

• Document the condition of the unit when moving in and out, and send copies to the PHA. Request a copy of the Housing Quality Standards inspection from the PHA to prove the condition of the unit upon moving out.

• Always pay the tenant’s portion of rent, even if the PHA “abates” (holds back) its portion of the rent to prompt the landlord to meet its obligations. This prevents the possibility of eviction.

Tips for Retaining Program Eligibility When Earned Income Increases

Public Housing: If a family in public housing has their income increase above 80 percent of the median area income, the PHA may evict the
family. However, the PHA may NOT evict a family solely for exceeding the income limit if the family either:

- Participates in the FSS Program, or
- Has a member who receives the EID (2 CFR 960.261).

**Housing Choice Voucher:** If income increases enough that the family pays the full rental cost of the unit, the PHA ceases payments to the owner. The family may resume a subsidy if income drops within six months of the last subsidy payment. If income doesn’t drop, the family loses eligibility for the Housing Choice Voucher. However, if the family moves to a unit with a higher rent before their voucher eligibility ends, and their income is low enough that HUD pays a portion of the rent, the family remains eligible for the Housing Choice Voucher. In this situation, the family would need to move for another compelling reason (e.g., to be closer to work), and not just to continue the Housing Choice Voucher.

**Advocating for Reasonable Accommodations**

CWICs should also help individuals with disabilities request reasonable accommodations when necessary. HUD programs must comply with Section 504 of the Rehabilitation Act, which requires them to make services and facilities accessible. Some reasonable accommodations include (but aren’t limited to):

**Application Process**

- Providing applications in accessible formats.
- Providing sign language interpreters for interviews.
- Scheduling interviews in applicants’ homes or other locations besides PHA offices.
- Permitting another person to represent an applicant.
- Contacting the applicant in the manner she or he requests.
- Granting extra time to respond to information requests.
- Reinstating an applicant’s place on the waiting list if the PHA removed him or her from the list for failure to respond to an information request by the deadline, if the delay in response resulted from a disability.
• Some PHAs provide preferences for single individuals with disabilities, or families that include members with disabilities. Preferences provide higher priority for people on waiting lists.

**Accessible Housing Units**

• Allowing an applicant to request a larger unit to accommodate a live-in aide or medical equipment.

• An applicant who needs an accessible unit may — in the absence of any accessible units — request that the PHA modify a unit to make it accessible, if this wouldn’t cause an undue burden or expense to the PHA.

• An applicant can refuse an offer of public housing, but still keep his or her place on the waiting list, if the refusal is for “good cause,” including if the offered unit isn’t sufficiently accessible.

• A PHA may provide a Homeownership Voucher as an alternative to a Housing Choice Voucher if necessary to accommodate a person with a disability (e.g., if no accessible rental units are available, but the person could buy an accessible home instead).

**Grievance Process**

• Accepting grievances at alternative sites or by mail.

• Having PHA staff transcribe an oral request from an applicant who can’t write due to a disability.

• Providing sign language interpreters, readers, attendants, or accessible locations for hearings.

**Conducting Independent Research**

The following citations are from the U.S. Code of Federal Regulations (CFR). These can be found online by using the electronic CFR (eCFR) system (http://www.ecfr.gov/cgi-bin/ECFR?page=browse)


• HOME Investment Partnerships Program – 24 CFR 92

• Housing Opportunities for Persons with AIDS – 24 CFR 574
• Continuum of Care Program – 24 CFR 578
• Supportive Housing for the Elderly and Persons with Disabilities – 24 CFR 891
• Housing Choice Voucher – 24 CFR 982
• Project-Based Voucher – 24 CFR 983
• Family Self Sufficiency Program – 24 CFR 984

**HUD Documents**


• **Instructions for calculating adjusted income** (http://portal.hud.gov/hudportal/documents/huddoc?id=DOC_35649.pdf)


• **HUD Programs – This is a comprehensive manual describing all HUD programs** (https://www.hud.gov/sites/documents/HUDPROGRAMS2016.PDF)

**Additional Resources**

**HUD Checklist for CWICs**

The following checklist provides reminders to CWICs about information they need to obtain to advise individuals and families who participate in HUD programs.
HUD Checklist for CWICs

When family income increases (e.g., when an adult member goes to work or has an increase in earnings), do they need to report the increase promptly, or can they wait for the net annual reexamination?

Do any household members qualify for the Earned Income Disregard (EID)? NOTE: Be sure to check to see if the local PHA is participating in the Moving to Work (MTW) Demonstration. If so, verify with the PHA that the EID is applicable. If so, verify whether the EID has been modified in any way? If not, does the PHA apply any other earned income disregards?

Must meet one of the following:

- Adult (18 or older) in public housing
- Adult (18 or older) with disability in one of the following:
  - Housing Choice Voucher (tenant-based Section 8) program,
  - Supportive Housing program,
  - HOME Investment Partnerships program,
  - Housing Opportunities for Persons with AIDS (HOPWA) program, OR
  - Project-Based Section 8 Voucher (but not other project-based Section 8 programs)

Must also meet one of the following:

- Previously unemployed, or earned no more than the equivalent of 500 hours at minimum wage in 12 months before starting work
- Had an increase in earnings in a self-sufficiency program or other job training program, and household income increased as a result
- Became employed, or increased earnings, during (or within 6 months after) receipt of TANF-funded employment assistance

Must not have exhausted EID in the past
If some EID months have been used, verify how many are still available, and when the 48-month limit will expire.

If a household member qualifies for the EID, need his/her baseline income (before she or he qualified for the EID) – types and amounts of non-excluded income, AND

Need his/her current income - types and amounts of non-excluded income, AND

Need to know in which time period of EID the member is currently (first 12 months of work, second 12 months of work, or EID has been exhausted)

Does the family qualify for an Individual Savings Account (ISA) as an alternative to the EID, and if so, would they prefer the ISA?

Must live in public housing and be served by a PHA that offers ISA’s

Does the family have a Housing Choice Voucher and would they prefer to convert it to a Homeownership Voucher, if their PHA allows this?

Current non-excluded income type and amount for each other household member

Any member using Plan to Achieve Self Support (PASS)?

Household qualifies for disabled or elderly family deduction? (Head of household, spouse of head of household, or sole household member is disabled or at least age 62)

# of dependents of head of household living in home

Household paying for unreimbursed attendant care and/or assistive technology costs for a household member with a disability so that any household member can work? (If yes, need amounts.)

Disabled or elderly household paying for unreimbursed medical expenses for any household member? (If yes, need amounts.)

Household paying for childcare so a household member can work? (If yes, need amount.)

Household paying for childcare so a household member can seek work or participate in education to prepare for employment? (If yes, need amount.)
Utility allowance granted by PHA (if household pays for utilities separately from rent)? (If yes, need amount.)

**NOTE:** Income and expense amounts based on average month (i.e., annual total divided by 12 months, or weekly total multiplied by 4.33 weeks).
Competency Unit 4 – Unemployment Insurance Program

Introduction to Unemployment Insurance

Unemployment Insurance (UI) is a joint state-federal program that provides cash benefits to certain eligible workers who become unemployed through no fault of their own. In times of economic distress, UI benefits provide a critical financial safety net for American workers who are suddenly without employment. In addition to helping workers and their families, the Unemployment Insurance programs play a key role in helping businesses, communities, and our nation’s overall economy. Congress originally created the UI program in 1935 in response to the Great Depression, when millions of people lost jobs. Since then, the UI program has continued to help cushion the impact of economic downturns and bring economic stability to communities, states, and the nation by providing temporary income support for laid-off workers.

At the federal level, the Office of Unemployment Insurance under the U.S. Department of Labor’s Employment and Training Administration (ETA) administers the UI program. The Office of Unemployment Insurance is responsible for providing leadership, direction, and assistance to state workforce agencies in the implementation and administration of state UI programs, federal unemployment compensation programs, and other wage-loss, worker dislocation, and adjustment assistance compensation programs. The Office of Unemployment Insurance works collaboratively with business, labor, and state governments by providing oversight, guidance, and technical assistance for the federal-state unemployment compensation system and providing budget and legislative support to state workforce agencies to administer their UI programs and assist individuals to return quickly to suitable work.

At the state level, the State Workforce Agency typically administers UI, usually through a department or office of unemployment compensation.
The Purpose of Unemployment Insurance (UI)

Unemployment insurance payments provide temporary financial assistance to eligible workers who are unemployed through no fault of their own (as determined under state law), and meet other eligibility requirements of state law.

Each state administers its own separate UI program within guidelines established by federal law. The state law under which unemployment claims are established determines eligibility for unemployment insurance and benefit amounts, and the length of time benefits are available. In the majority of states, the state bases UI benefit funding solely on a tax imposed on employers. However, in three states, employees are required to make require minimal employee contributions.

Like the Social Security system, the UI system provides an important source of social insurance. The goals of today’s UI program are (1) to prevent individuals from experiencing severe financial hardships, and (2) to provide time for individuals to find work again. Through payments UI makes directly to eligible, unemployed workers, UI ensures that at least a significant proportion of the necessities of life, most notably food, shelter, and clothing, workers can meet on a week-to-week basis while job searching.

As temporary, partial wage replacement to the unemployed, UI is of vital importance in maintaining consumer purchasing power and in stabilizing the national economy. It provides a source of income during periods of economic adjustment so that laid-off workers have money to spend and will be able to stay in their communities, thus being available to the employer when he or she has additional work.

**IMPORTANT:** A key to understanding unemployment benefits rests on two important words: **temporary** and **partial.** These benefits are a stopgap protection for individuals who are temporarily out of work and supplement other forms of financial support the individual has, such as a personal savings.
The UI Federal – State Relationship

The UI program is a federal-state partnership based upon federal law but administered by state employees under state law. Because of this structure, the program is unique among the country’s social insurance programs. Unemployment Insurance is jointly financed through federal and state employer payroll taxes (federal or state UI tax). Generally, employers must pay both state and federal unemployment taxes if: (1) they pay wages to employees totaling $1,500, or more, in any quarter of a calendar year; or, (2) they had at least one employee during any day of a week during 20 weeks in a calendar year, regardless of whether or not the weeks were consecutive. However, some state laws differ from the federal law, and employers should contact their state workforce agencies to learn the exact requirements.

Federal Unemployment Tax Act (FUTA)

The Federal Unemployment Tax Act (FUTA) authorizes the Internal Revenue Service (IRS) to collect a federal employer tax used to fund state workforce agencies. Employers pay this tax annually by filing IRS Form 940. FUTA covers the costs of administering the UI and Job Service programs in all states. In addition, FUTA pays one-half of the cost of extended unemployment benefits (during periods of high unemployment) and provides for an unemployment insurance fund from which states may borrow, if necessary, to pay benefits. FUTA taxes are calculated by multiplying 6.0 percent times the employer’s taxable wages. The taxable wage base is the first $7,000 the employer pays in wages to each employee during a calendar year.

State Unemployment Tax

State law determines individual state unemployment insurance tax rates. The taxable wage base and tax rates vary from state to state. Generally, the UI tax rate depends on reserves in the state UI trust fund and on an employer’s history of laying off workers or UI benefits charged to an employer’s account. Employers pay state unemployment tax to state workforce agencies. The agencies use these funds solely to pay benefits to eligible unemployed workers.

The major UI functions of the federal government are to:
• Ensure conformity and substantial compliance of state law, regulations, rules, and operations with federal law;
• Determine administrative fund requirements and provide money to states for proper and efficient administration;
• Set broad overall policy for administration of the program, monitor state performance, and provide technical assistance as necessary; and
• Hold and invest all money in the unemployment trust fund until drawn down by states for the payment of compensation.

Each state designs its own UI program within the framework of the federal requirements and is subject to approval by the U.S. Secretary of Labor. The state statute sets forth the benefit structure (e.g., eligibility and disqualification provisions, benefit amount) and the state tax structure (e.g., state taxable wage base and tax rates). The primary functions of the state are to:

• Determine operation methods and directly administer the program;
• Take claims from individuals, determine eligibility, and ensure timely payment of benefits to workers; and
• Determine employer liability, and assess and collect UI contributions.

Covered Employment

A primary requirement to collect UI benefits is that the individual must have worked in a type of employment that is covered under his or her state’s law. The UI program covers almost all wage and salary workers. The rules that determine classification for employment at the federal level follow common law. Federal law defines an employer-employee relationship by the amount of control exerted by the company. The facts that provide evidence of the degree of control and independence fall into three categories:

1. Behavioral: Does the company control or have the right to control what the worker does and how the worker does his or her job?
2. **Financial:** Does the payer control the business aspects of the worker’s job?

3. **Type of Relationship:** Are there written contracts or employee type benefits, such as pension plan, insurance, vacation pay, etc.? Will the relationship continue, and is the employee’s work a key aspect of the business?

The IRS evaluates these factors on **IRS Form SS-8**, which employers and workers can file with the IRS to request a determination of the status of a worker for purposes of federal employment taxes and income tax withholding (http://www.irs.gov/pub/irs-pdf/fss8.pdf). State UI agencies use their own rules to determine whether to categorize an activity as employment for state UI purposes. The UI program requires states to cover two specific groups of workers whom the IRS doesn’t always identify as employees.

**Domestic Employers Coverage**

Employers of domestic employees must pay state and federal unemployment taxes if they pay cash wages to household workers totaling $1,000, or more, in any calendar quarter of the current or preceding year. A household worker is an employee who performs domestic services in a private home. Examples of household employees are: babysitters, caretakers, cleaning people, drivers, nannies, health aides, yard workers, and private nurses.

**Employers of Agricultural Employees**

Employers must pay federal unemployment taxes if:

1. They pay wages to employees of $20,000, or more, in any calendar quarter; or,

2. In each of 20 different calendar weeks in the current or preceding calendar year, there was at least one day in which they had 10 or more employees performing service in agricultural labor. The 20 weeks don’t have to be consecutive weeks, nor must they be the same 10 employees, nor must all employees be working at the same time of the day. Generally, agricultural employers are also subject to state unemployment taxes, and
employers should contact their state workforce agencies to learn the exact requirements.

States tend to cover employers or employment subject to the federal UI tax (FUTA), even though the federal statute doesn’t require this. While states generally cover all employment that is subject to the federal tax, they also may cover some employment that is exempt from the tax, such as smaller employers of agricultural labor and domestic service. The federal statute excludes from the UI tax liability those employers who don’t meet the specific monetary or number of employee requirements.

Although the extent of state coverage is greatly influenced by the federal statute, each state is, with a single exception, free to determine the employers who are liable for contributions and the workers who accrue rights under the UI laws. The exception is the federal requirement that states provide coverage for employees of nonprofit organizations, services performed for Indian tribes, and employees of state and local governments, even though such employment is exempt from FUTA.

The UI program specifically excludes some individuals from coverage. These include, but aren’t limited to, self-employed individuals, workers who are employed by their own families, elected officials and legislators, members of the judiciary, and the State National Guard. Remember, states have a great deal of discretion to expand coverage, and state-by-state variance in coverage is significant. CWICs must contact their local workforce development agency or American Job Center for more specific information on coverage under the UI program.

**Eligibility**

Once the UI agency has established that an individual was in covered employment, the next step is to determine eligibility for benefit payments. The UI agency is looking for two specific criteria during eligibility determinations:

1. The individual must meet the state requirements for wages earned or time worked during an established period of time referred to as a “base period.” In most states, this is usually the first four out of the last five completed calendar quarters prior to the time that the individual filed the UI claim. This concept of “base period” is critical to
understanding how eligibility is determined. It isn’t only a question of whether the individual worked in a covered class and whether an employer-employee relationship existed, but also when the individual did this work.

2. Second, individuals must be unemployed through no fault of their own (as determined under state law) and meet other eligibility requirements of state law. The state will deny UI claims if the applicant doesn’t meet this test. This eligibility criterion is one area that produces the largest number of challenges in the appeal process for both employer and employee alike. Remember that each time an employee makes a claim against the employer, the employer’s tax rate will likely go up because of the “experience rating.”

UI Claims

It’s important to remember that UI isn’t a means-tested program like Temporary Assistance for Needy Families (TANF) or Medicaid, in which the primary eligibility criteria are based on strict income and resource limits. Unemployment Insurance is an insurance program, not a welfare program. To receive UI benefits, one must file a claim and have earned the right to the benefits.

Individuals file UI claims with the state Unemployment Insurance agency. In most states, individuals file the claim through the American Job Center (AJC) system. In some states, applicants may need to go to an AJC to file a claim, but many states now have systems where applicants may phone in or file their claims online. The state usually issues the first UI check within two to three weeks. Some states require a one-week waiting period. To locate the UI agency in each state, go to Career One Stop Unemployment Benefits Finder (http://www.servicelocator.org/OWSLinks.asp).

General Requirements

Once the UI Claims Representative has established basic coverage by class and individual work and has determined that the individual lost his or her job through no fault of his or her own, the UI Claims
Representative asks a series of questions focused on the individual’s ability and willingness to return to work.

Once again, remember that employers pay for this program, and the system is focused on ensuring that individual claimants are using this program’s benefits as a temporary support while they look for work. If the system finds that an individual isn’t looking for work or isn’t able or available to work, the state will deny the claim. Similarly, the state will cease benefits if a claimant doesn’t continue to meet these requirements after the state initially approved the claim. The individual making a UI claim must:

- Be actively seeking employment;
- Be available for work;
- Be able to work;
- Be willing to accept a suitable position when an employer offers one;
- Meet the state-specific eligibility requirements; and
- Have no disqualifying factors.

Most UI agencies require individuals to file weekly or biweekly claims and respond to questions concerning continued eligibility. UI recipients must report any earnings from work during the week(s) and must report any job offers or refusal of work that occurred during the week(s). Individuals usually file these claims by mail or telephone. When the UI agency directs them, individuals must report to the local Unemployment Insurance Claims Office or Employment Services/American Job Center at a scheduled date and time. Failure to report as scheduled for an interview may cause the state to deny UI benefits.

**Registering for Work**

The state may direct claimants who file for unemployment benefits to register for work with the State Employment Service, so it can assist in finding employment. The Employment Service Office/American Job Center has current labor market information and provides a wide array of re-employment services free of charge. Employment Service/American Job Center staff can refer claimants to job openings in the local area or in other parts of the state or country if an individual is willing to relocate. If job openings in a given field are limited, the staff can offer testing and
counseling to determine other jobs individuals might like to do and are able to do.

Hot Topics in the UI System

Several issues within the UI system are currently under debate. CWICs should have an awareness of these topics when providing WIPA services to beneficiaries who have applied for UI or are already receiving these benefits.

Hot Topic #1: Concurrent Receipt of UI and Social Security Disability Benefits

Under certain circumstances, individuals may be eligible for concurrent cash benefit payments due to differences in DI and UI eligibility requirements. Specifically, Social Security’s definition of a disability involves work that doesn’t rise to the level of substantial gainful activity (SGA). In contrast, the Department of Labor allows states’ determination of “able and available for work” eligibility criteria for UI benefits to include work that doesn’t rise to the level of SGA. Therefore, some individuals may have a disability under federal law but still be eligible for UI under state law because they are able and available for work that doesn’t rise to the level of SGA. Although DI and UI generally provide separate services to separate populations — and thus aren’t overlapping programs — the concurrent cash benefit payments for individuals eligible for both programs are an overlapping benefit when both replace lost earnings. While Social Security must reduce DI benefits for individuals receiving certain other government disability benefits, such as worker’s compensation, no federal law authorizes an automatic reduction or elimination of overlapping DI and UI benefits. As a result, neither Social Security nor the U.S Department of Labor (DOL) has any processes to identify these overlapping payments.

In some cases, Social Security disability beneficiaries face obstacles when applying for UI benefits. UI personnel may state that if an individual is receiving Social Security disability benefits, the individual had “proved” that he or she was unable to work and that the state would deny UI benefits based on the disability, thereby making the “assumption” that the beneficiary wasn’t eligible. A review of state statutes and codes doesn’t substantiate this position, but this is the attitude that Social
Security disability beneficiaries may face when they file a claim. When assisting beneficiaries in these cases, it’s important for CWICs to focus on the fact that the individual with the disability has been working and has established the fact that he or she “is able” to work and “available” to work per UI requirements. The person’s work history shows the required quarters in the base period to prove this.

If the state denies an individual UI benefits on the basis that he or she isn’t “able to work” because of his or her disability, the claimant should file an appeal. In many states, the claimant can engage a separate appellate board or appeals commission if the first level appeal isn’t favorable.

This is an area where the state and federal systems are changing but they aren’t in complete alignment. Social Security wants beneficiaries to work, but agencies like UI haven’t always adjusted their rules and training of field staff to support the efforts of their sister federal agency.


**Hot Topic #2: Part-time Work**

Part-time work is another hot topic within the Unemployment Insurance community. It’s possible in 27 states for an individual to establish a strong history of working part-time and have his or her employer pay UI taxes on his or her wages, and yet that person is still not eligible to collect UI benefits if he or she becomes unemployed. In fact, nationally, only 12 percent of unemployed part-time workers receive unemployment benefits. This is particularly challenging for workers with disabilities who may only be able to work part-time.

According to the National Employment Law Project, “Part-time workers most commonly run afoul of the ‘able and available’ rule or rules disqualifying those not seeking or accepting ‘suitable work.’” A majority of states explicitly require full-time work to satisfy these rules.

This issue has been debated for a number of years, and the U.S. Department of Labor encourages states to review their rules in this area and seek legislative changes to state laws that would allow unemployed
part-time workers to receive benefits when otherwise eligible. To read more about this topic, refer to the National Employment Law Project’s website at:  [www.nelp.org](http://www.nelp.org)

**UI Benefit Payments**

Keep in mind that states base UI benefits on earnings, not on need. In general, UI benefits replace about half of an individual’s after-tax earnings per week, but each state sets up its maximum and minimum benefits. Some states have also developed additional allowances for dependents.

Most states give individuals up to 26 weeks of unemployment benefits. There is nothing in federal law, however, that requires states to set their UI benefit duration maximum at 26 weeks. Thus, states have the discretion to offer fewer than 26 weeks as the maximum or may provide benefits for more than 26 weeks.

More information about the state variance in UC duration is available from the Congressional Research Service ([https://fas.org/sgp/crs/misc/R41859.pdf](https://fas.org/sgp/crs/misc/R41859.pdf))

Additional weeks of benefits may be available during periods of high unemployment. These are called “extended benefits.” Extended benefits are available to workers who have exhausted regular unemployment insurance benefits during periods of high unemployment. The basic extended benefits program provides up to 13 additional weeks of benefits when a state is experiencing high unemployment. Some states have also enacted a voluntary program to pay up to seven additional weeks (20 weeks maximum) of extended benefits during periods of extremely high unemployment. When a state begins an extended benefit period, it notifies those who have received all of their regular benefits that they may be eligible for extended benefits. CWICs should contact the state UI agency to ask whether extended benefits are available. State agencies can be found online at [Career One Stop through their Unemployment Benefits Finder](https://www.careeronestop.org/LocalHelp/UnemploymentBenefits/find-unemployment-benefits.aspx).

**IMPORTANT NOTE:** UI benefits are subject to federal income taxes, and beneficiaries must report UI benefits on
their federal income tax return. Individuals may elect to have the State Unemployment Insurance agency withhold the tax.

Other Unemployment Compensation Programs

Several other programs offer unemployment compensation in addition to the federal-state UI program. These programs typically provide coverage to certain types of employees. These programs include the following:

Unemployment Compensation for Federal Employees

The Unemployment Compensation for Federal Employees program provides benefits for eligible unemployed former civilian federal employees. States administer the program as agents of the federal government. This program operates under the same terms and conditions that apply to regular State Unemployment Insurance. The law of the state (under which beneficiaries file their claims) determines benefit amounts, number of weeks the state can pay benefits, and other eligibility conditions. Individuals file claims through their State Unemployment Insurance Agency.

For more information, refer online to U.S. Department of Labor – Unemployment Compensation for Federal Employees (https://oui.doleta.gov/unemploy/unemcomp.asp)

Unemployment Compensation for Ex-service Members

The Unemployment Compensation for Ex-service Members (UC) program provides benefits for eligible ex-military personnel. In addition, the UC program covers former members of the National Oceanographic and Atmospheric Administration (NOAA) and U.S. Public Health Service (USPHS) Commissioned Corps. The states, as agents of the federal government, administer the program. Program specifics include:

- Individuals who were on active duty with a branch of the U.S. military may be entitled to benefits based on that service.
- Individuals must have separated from the military under honorable conditions.
• There is no payroll deduction from service members’ wages for unemployment insurance protection. The various branches of the military, NOAA, or USPHS pay benefits.

The law of the state (under which individuals files their claims) determines benefit amounts, number of weeks the state can pay benefits, and other eligibility conditions. Individuals should contact the State Workforce Agency as soon as possible after discharge to apply for UI benefits. Applicants should have a copy of their service and discharge documents (DD-214 or similar form) when they submit a claim.

For more information, refer online to U.S. Department of Labor – Unemployment Compensation for Ex Service Members (https://oui.doleta.gov/unemploy/ucx.asp)

**Self-Employment Assistance**

Self-Employment Assistance (SEA) offers dislocated workers the opportunity for early re-employment. The program encourages and enables unemployed workers to create their own jobs by starting their own small businesses. Under these programs, states can pay an SEA allowance, instead of regular unemployment insurance benefits, to help unemployed workers while they are establishing businesses and becoming self-employed. Participants receive weekly allowances while they are getting their businesses off the ground.

Generally, to receive these benefits, an individual must first be eligible to receive regular Unemployment Insurance under state law. Individuals who have been permanently laid off from their previous jobs and the state identifies (through its profiling system) as likely to exhaust regular unemployment benefits are eligible to participate in the program. Individuals may be eligible even if they are engaged full-time in self-employment activities including entrepreneurial training, business counseling, and technical assistance.

SEA allowances are the same weekly amounts as the worker’s regular unemployment insurance benefits. Participants work full-time on starting their business instead of looking for wage and salary jobs.

This is a voluntary program for states and, to date, Delaware, Mississippi, New Hampshire, New York, and Oregon, have active Self-Employment Assistance programs. Individuals should contact the State Workforce Agency as soon as possible after discharge to apply for UI benefits. For
more information about SEA programs, refer online to **U.S. Department of Labor – Self-Employment Assistance**
(https://ows.doleta.gov/unemploy/self.asp)

**Disaster Unemployment Assistance (DUA)**

The Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1974, as amended, authorizes the President to provide benefit assistance to individuals unemployed as a direct result of a major disaster. The U.S. Department of Labor oversees the DUA program and coordinates with the Federal Emergency Management Agency (FEMA), to provide the funds to the state UI agencies for payment of DUA benefits and payment of state administration costs under agreements with the Secretary of Labor.

Disaster Unemployment Assistance provides financial assistance to individuals whose employment or self-employment has been lost or interrupted as a direct result of a major disaster and who are not eligible for regular unemployment insurance benefits.

When the President declares a major disaster, DUA is generally available to any unemployed worker or self-employed individual who lived, worked, or was scheduled to work in the disaster area at the time of the disaster; and due to the disaster:

- no longer has a job or a place to work; or
- cannot reach the place of work; or
- cannot work due to damage to the place of work; or
- cannot work because of an injury caused by the disaster.
- An individual who becomes the head of household and is seeking work because the former head of household died as a result of the disaster may also qualify for DUA benefits.

DUA benefits are payable to individuals (whose unemployment continues to be a result of the major disaster) only for weeks of unemployment in the Disaster Assistance Period (DAP). The DAP begins with the first day of the week following the date the major disaster began and continues for up to 26 weeks after the date the President declared the event a disaster.

State law determines the maximum weekly benefit amount payable for unemployment compensation in the state where the disaster occurred.
However, the minimum weekly benefit amount payable is half (50%) of the average benefit amount in the state.

In the event of a disaster, the affected state will publish announcements about the availability of Disaster Unemployment Assistance. To file a claim, individuals who are unemployed as a direct result of the disaster should contact their State Unemployment Insurance agency. Individuals who have moved or have been evacuated to another state should contact the affected state for claim filing instructions. Individuals can also contact the State Unemployment Insurance agency in the state where they are currently residing for claim filing assistance.

More information about DUA benefits may be found online (https://ows.doleta.gov/unemploy/disaster.asp)

Impact of UI on Other Federal Benefits

Impact of UI on Social Security Disability Benefits (SSDI, CDB, DWB)

Social Security defines Unemployment Insurance benefits as unearned income. That is the key to understanding the impact of UI benefits on Title II disability benefits, SSI, and Medicaid benefits. Individuals who receive Title II disability benefits will experience no effect on their cash benefit eligibility or payment amount as a result of receiving UI benefits since these benefits are not means-tested in any way.

Keep in mind that a person applying for UI benefits has lost employment. Beneficiaries should report loss of these earnings to Social Security. This is especially important during the Extended Period of Eligibility (EPE). Notifying Social Security of the loss of earnings may enable the agency to reinstate the individual’s cash benefit, or to pay provisional benefits while the beneficiary requests Expedited Reinstatement.

UI Impact on SSI

Federal law requires SSI beneficiaries to apply for any other benefit to which they are entitled. This goes back to the SSI principle of being the “payer of last resort.” If an SSI recipient is potentially entitled to receive unemployment benefits, he or she must apply before Social Security will process eligibility for SSI.
SSI recipients will experience an effect on the cash benefit payment because of receiving an unemployment insurance benefit. Social Security considers unemployment benefits unearned income. As a result, while the individual will receive a partial replacement of their wages through the UI benefit, that unearned income should cause a reduction or suspension of SSI payments. In fact, if not reported, UI could lead to an SSI overpayment. Social Security will reduce the SSI cash benefit by the amount of the unemployment insurance benefit minus the $20 general income exclusion (GIE). This is assuming that Social Security hasn’t already applied the general exclusion to some other type of unearned income the person may be receiving.

Unemployment benefits also affect the person’s cash benefit in a situation where deeming is taking place. If an SSI recipient is subject to deeming and the ineligible parent or spouse whose income is deemed becomes eligible for unemployment benefits, a portion of these unemployment benefits are consequently going to be deemed as being available to the SSI recipient. Again, because Social Security will consider the person to have income from this source, it may result in a reduction in the SSI cash benefit.

**UI Impact on Medicaid**

Keep in mind that the potential exists for the beneficiary to lose his or her eligibility for SSI related Medicaid coverage if he or she receives UI benefits. This won’t happen in every single case, but it may happen when the amount of the unemployment benefit in a given month is sufficient to exceed the Federal Benefit Rate (FBR) + $20 general income exclusion.

The critical issue here is one of continued eligibility. The focus needs to be on “countable unearned income.” If the countable unearned income exceeds the FBR amount, the individual won’t be eligible for continued Medicaid eligibility.

The likelihood that Medicaid eligibility will be affected is greater for individuals who are already receiving other types of unearned income such as SSDI. When Social Security adds the unemployment insurance to the SSDI, there is a greater likelihood that it will make them ineligible for SSI benefits and cause them to lose their eligibility for SSI related Medicaid. This includes Medicaid the beneficiary may have under the 1619(b) continued Medicaid provisions for people who lose SSI eligibility through work income.
Conclusion

CWICs need to be aware of Unemployment Insurance as a valuable financial protection for individuals who suddenly lose their jobs. This benefit offers protection to individuals who may have no other source of income and can help fill the gap until Social Security reinstates disability benefits, or until the agency processes a new application. Remember, accessing UI will not affect SSDI entitlement. However, SSI recipients who are receiving UI payments will have a source of unearned income. This unearned income may cause a reduction in SSI cash payments, or may result in ineligibility for SSI and SSI related Medicaid.

Conducting Independent Research

Department of Labor – Unemployment Insurance Program
(http://workforcesecurity.doleta.gov/unemploy/uifactsheet.asp)

Unemployment Compensation: A Federal State Partnership. US
Department of Labor, June 2017. This manual provides an excellent explanation of the UI system.

USDOL/Benefits by State
(http://www.servicelocator.org/OWSLinks.asp)

USDOL State-by-State Chart of Significant UI Laws

Contact information for State Workforce Investment Boards and contractors (http://www.servicelocator.org/)
Competency Unit 5 – Workers’ Compensation Benefits

Introduction to the Workers’ Compensation Program

Workers’ Compensation (WC) is a state-mandated insurance program that provides partial replacement of an individual’s lost wages as compensation for accidental, job-related injury or illness that is not self-inflicted or caused by intoxication or substance abuse. For businesses, the Workers’ Compensation Program also serves as a form of insurance since it essentially limits their liability for on-the-job injury or illness to the remedies and benefits that are available to individuals under the WC statutes in their particular state. Worker's Comp systems vary significantly from state to state, but employers pay for workers’ compensation typically in one of three ways: premiums to a state-run insurance program, payments to an insurance company, or directly to workers.

Workers’ Compensation Benefits

WC wage replacement benefits usually cover about one-third to two-thirds of the injured individual’s average weekly wage and almost all states place lower and upper limits on the amount of the weekly payments. Depending on the severity of an illness or injury, Workers’ Compensation offers four additional types of benefits beyond wage replacement payments. These include:

1. Medical treatment and related expenses;
2. Permanent disability payments if the illness or injury affects an individual’s ability to do certain jobs;
3. Vocational rehabilitation training if the injured individual can’t remain in the same job; and
4. Death benefits -- most often this includes burial expenses and a lump-sum payment.
Benefit payments are either structured payments that individuals receive over a specific period or indefinitely, or a single lump-sum payment. For example, lost wage benefits usually are structured payments that last about two years at most. With a lump-sum payment, the injured individual may have to sign an agreement giving up certain rights, such as the right to seek reimbursement for any further medical treatment, in exchange for the payment. However, injured individuals always have the option to reject a settlement proposal and instead appeal the offer or litigate a settlement in a court of law.

**Eligibility for Workers’ Compensation**

To be eligible for Workers’ Compensation benefits, an individual must work for a business the state covers under its Workers’ Compensation law. In most states, Workers’ Compensation laws apply to employers with at least one employee. Some states exempt small businesses, but states vary significantly in how they define a small business. In addition to working for a covered business, the type of work or position must also be covered by the state’s WC statues. Workers’ Compensation programs frequently exclude or don’t cover individuals working in the following types of positions: business owners, independent contractors, domestic employees in private homes, farm workers, maritime workers, railroad employees, and unpaid volunteers.

Although specific procedures and time lines vary between states, injured individuals generally must report the injury or illness to their employer within one month of its occurrence. The employer will either provide claim forms or provide information about where to get them. In most states, employers are responsible for filing the claim and all supporting documentation with the insurance company, and for notifying the state workers’ compensation agency. If the WC claim is approved, the insurance company will contact the injured individual with further instructions according to the type of benefit payment.

State Workers’ Compensation programs vary significantly, in terms of which businesses are required to participate, how much Workers’ Compensation insurance businesses must purchase, the types of employment covered as well as the percentage of wage replacement. CWICs can find information about the **Worker’s Compensation program in their state by using the online locator**
Workers’ Compensation for Federal Employees - Federal Employees Compensation Act (FECA)

For federal civilian employees who are injured on the job, their state’s Workers’ Compensation program doesn’t provide Workers’ Compensation benefits. Instead, for individuals who meet all of the necessary eligibility standards, the Federal Employees Compensation Act (FECA) provides Workers’ Compensation. The Office of Workers’ Compensation Programs (OWCP), located in the U.S. Department of Labor, administers the Federal Employees Compensation Act. Like the states’ Workers’ Compensation programs, specific regulations apply to the Federal Employee Compensation Act coverage in terms of eligibility, benefits, and payment periods.

FECA Benefits

FECA provides injured workers partial wage replacement, vocational rehabilitation, and medical benefits. This is similar to the common types of benefits state Workers’ Compensation laws provide injured workers. FECA pays wage-loss compensation at two-thirds of the employee’s pay rate if he or she has no dependents or three-fourths of the pay rate if he or she is married or has one or more dependents. Federal law establishes a minimum and maximum monthly payment and certain situations may cause a reduction of wage replacement benefits.

FECA can make compensation payments after wage loss begins and the medical evidence shows the employee can’t perform the duties of his or her regular job. FECA doesn’t require a waiting period when permanent disability exists, or when the disability causing wage loss exceeds 14 days. FECA issues short-term compensation payments each week. The period covered may include compensation for several days to several weeks. FECA issues long-term compensation payments every four weeks. An employee may receive compensation payments for as long as the medical evidence shows that total or partial disability exists and is related to the accepted injury or condition. OWCP requires most employees receiving compensation for disability to undergo medical examinations at least once a year, usually conducted by the employee’s
treated physician. OWCP may, however, require another physician to examine the employee.

For more information about FECA benefits, refer online to US Department of Labor – Division of Federal Employee’s Compensation (https://www.dol.gov/owcp/dfec/).

Other Public Disability Benefits (PDB)

A Public Disability Benefit or PDB is a benefit employers pay under a federal, state, or local law or plan to workers for temporary or permanent disabilities. State Worker’s Compensation and FECA benefits are two of the most common forms of PDBs, but they are by no means the only ones. Unlike Worker’s Compensation benefits, most PDBs are not based on a work-related injury or illness. PDBs may be in the form of periodic payments or a lump sum.

There are potentially thousands of separate PDBs an individual could receive and CWICs should never assume what the benefit is until it is verified. As you will learn in the next section, verifying receipt of Workers’ Compensation or other public or private disability benefits is important because some of these payments affect SSI and/or Social Security Title II disability benefits.

Effect of Receiving Workers’ Compensation or Public Disability Benefits (PDB) on Social Security Title II Disability Benefits

Receiving a Workers’ Compensation benefit or other public disability benefit (PDB) may affect the amount of Social Security disability benefits a disabled worker and his or her dependent family members receive. The individual and his or her family members will still be on Social Security’s records as eligible for payments, but they may not be due any cash benefits, or the payments they receive may be reduced. Social Security refers to this reduction in the title II disability payment due to receipt of a PDB as an “offset”. The PDB offset applies in most, but not all states. We will discuss that in a later section of this unit.
NOTE: Social Security does not apply a PDB offset to individuals entitled to Disabled Widow(er) Benefits (DWB) or Childhood Disability Benefits (CDB). The PDB offset only applies to disabled workers who receive SSDI.

How the PDB Offset Works

Social Security looks at three things when they decide if they must offset the WC or PDB payment:

1. The amount of the Social Security disability benefit the individual and any dependent family members receive, called the Total Family Benefit (TFB);
2. The amount of the WC or PDB benefit; and
3. The individual’s “Average Current Earnings” or ACE.

The ACE is the highest of the following:

a. The average earnings Social Security uses to figure the Title II disability benefit;
b. The person’s average monthly earnings from any work he or she performed that Social Security covered during the five highest years in a row after 1950; or
c. The person’s average monthly earnings for work during the five-year period immediately prior to becoming disabled.

Next, Social Security will determine which is higher: the total family benefit or 80% of the ACE. Social Security subtracts the WC or PDB benefit from this figure. The remaining amount represents the new adjusted Social Security monthly disability benefit payable to the disabled worker and any dependent family members.

If the computation leads to an offset, it affects the benefits Social Security pays to dependent children or a dependent spouse first. Social Security deducts the rest of the offset from the individual’s disability payment.

Beneficiaries subject to the PDB offset are still active on Social Security’s record as long as they continue to meet the requirements for entitlement, such as disability and age. If the WC or PDB payments stop while they still meet the requirements, they may again receive full payments.
Here's an offset example for a beneficiary named Tom:

This example involves both the beneficiary, Tom, and his family members receiving a Social Security benefit on his wage record. In this situation, Tom is entitled to a monthly SSDI cash benefit of $559.00. His wife and two children are also entitled to monthly benefits of $93.00 each. The total family Social Security benefit is $838.00. Tom also begins to receive a monthly Workers' Compensation benefit of $500. The ACE Social Security used to calculate Tom’s benefits is $820.10. Since the $838.00 total amount of the family's Social Security benefit is higher than the ACE, Social Security would subtract the WC payment amount from that figure.

$838.00 - $500.00 = $338.00.

If you add Tom’s WC benefit to that amount, you can see that Tom and his family still have the income they would have had if Tom only received Social Security benefits.

This is a simplified example provided to give you a basic understanding of how Social Security applies the PDB offset. CWICs will not have access to the amount of the ACE and should never try to calculate the offset. You should, however, be aware that the WC and PDB can affect SSDI payment amounts and be prepared to explain this to beneficiaries in general terms. Beneficiaries should immediately report when WC or PDB payments begin or end to ensure Social Security can make accurate payments, and avoid overpayments.

Important Points about the WC/PDB Offset

There are a couple of key points that CWICs should keep in mind with regard to the effect of the Workers' Compensation or other public disability benefits on Social Security disability insurance.

- If a beneficiary receives a lump sum Workers' Compensation benefit, Social Security calculates the monthly Workers' Compensation benefit amount by prorating the Workers' Compensation payment over the number of months the payments would otherwise have been made.

- Other public disability payments may affect the SSDI check in the same manner as described for the Workers' Compensation benefit. These payments would include those made under federal, state, or local government law that pays for injuries or
illnesses that aren't job related. Examples of these programs would include civil service disability benefits, military disability benefits, and state and local retirement benefits based upon disability. There are many disability payments that are exempt from the PDB offset. CWICs can find more information about this at POMS DI 52125.005 Benefits Not Considered a Public Disability Benefit (PDB) found online (https://secure.ssa.gov/apps10/poms.nsf/lnx/0452125005)

- A third factor to keep in mind is that, while the beneficiary may experience a reduction in his or her Social Security disability benefit, the total amount of the combined SSDI and Workers’ Compensation will never be less than the total amount of Social Security benefits the individual and his or her family received prior to reduction.

- Finally, changes in factors such as family composition and the amount of the Workers’ Compensation or public disability benefit the beneficiary received will result in Social Security recalculating the reduction. This may potentially mean an adjustment in the Social Security disability benefit. The beneficiary must report all changes to the Social Security Administration.

**Reverse Offsets**

The Workers’ Compensation offset calculation previously described doesn’t apply to all paid Workers’ Compensation or public disability benefits. In some states, the Workers’ Compensation or public disability benefit is reduced by the state instead of the Social Security disability benefit payment. These are called “reverse offset” states. States that reduce some or all Workers Compensation benefits through a reverse offset plan are:

- Alaska
- California
- Colorado
- Florida
- Louisiana
- Minnesota
The state rules are all different, and the only way to know for sure if a given plan is offset is by checking the Social Security’s Program Operations Manual Systems (POMS) at DI 52105.001 Reverse Offset Plans (https://secure.ssa.gov/poms.nsf/lnx/0452105001).

It’s important to be aware of offsets and reverse offsets, but remember, calculating these amounts is Social Security’s job. If a beneficiary reports receiving Workers’ Compensation or a public disability benefit, check to see if that the beneficiary reported the benefit to Social Security. If not, encourage the individual to make the report so that Social Security can calculate the offset, or determine if an offset is appropriate.

Effect of Workers’ Compensation or Public Disability Benefits (PDB) on SSI Benefits

Supplemental Security Income (SSI) is a program based on economic need. The more a person has in income, both earned and unearned, the less he or she receives in SSI cash benefit. For purposes of the SSI program, Social Security considers a Workers’ Compensation benefit one type of unearned income. Therefore, a person who receives a Workers’ Compensation benefit or other public or private disability benefit will experience a reduction in his or her SSI cash benefits. Specifically, Social Security will reduce the SSI cash benefit by the amount of the monthly Workers’ Compensation payment or public disability benefit less the $20 general income exclusion. This is assuming Social Security hasn’t already
applied this exclusion to some other form of unearned income the person receives.

So, if an individual had no other earned or unearned income and received a monthly Workers’ Compensation benefit of $400, Social Security would calculate his or her SSI cash benefit as follows. Subtracting the $20 general exclusion from the $400 Workers’ Compensation benefit leaves the person with a total countable income of $380. This $380 total countable income figure would then be subtracted from the individual’s base SSI rate to arrive at the amount of the monthly SSI cash benefit.

Remember that Workers’ Compensation benefits or other public or private disability benefits will also affect SSI when deeming is involved. This includes both situations of spouse-to-spouse deeming as well as parent-to-child deeming. If the spouse or parent begins receiving a Workers’ Compensation benefit, a portion of this benefit will be deemed available to the SSI recipient, and may result in a reduction in his or her SSI cash benefit.

Of potentially greater concern than the effect on the SSI cash benefit is the potential loss of Medicaid eligibility if someone receives the Workers’ Compensation or public disability benefit. Because health insurance coverage is so important, it’s absolutely critical that CWICs make SSI recipients aware of this potential effect. The receipt of a Workers’ Compensation or other public disability benefit will only result in a loss of Medicaid coverage in situations where the amount of the Workers’ Compensation or public disability benefit, in a given month, is sufficient to place the person over their break-even point.

**Conclusion**

Receipt of a Workers’ Compensation or other public disability benefit may have a significant effect on a person’s Social Security disability benefits. In some cases, the compensation or benefit could affect the beneficiary’s health care coverage as well. CWICs should commit the time necessary to become familiar with their own states’ Workers’ Compensation statues as well as the implications for beneficiaries and recipients who receive these benefits.
Conducting Independent Research

POMS DI 52101.000 Workers Compensation/Public Disability Benefits (WC/PDB) Offset – Subchapter Table of Contents: Begin here to find numerous POMS citations on how PDB affects Title II disability benefits (https://secure.ssa.gov/apps10/poms.nsf/lnx/0452101000)


Questions and Answers about the Federal Employee’ Compensation Act (FECA) (http://www.dol.gov/owcp/dfec/fec-faq.htm)

Reverse Offset (https://secure.ssa.gov/apps10/poms.nsf/lnx/0452105001)
Competency Unit 6 – Benefits for Veterans with Disabilities

Introduction

A wide range of special cash benefits, medical services, and other programs are available to veterans of the U.S. Armed Forces who experience disabilities. The programs covered in this unit are limited to those administered by the U.S. Department of Veterans Affairs (VA) under the Veterans Benefits Administration (VBA). The Veterans Benefits Administration (VBA) oversees all of the federal benefit programs available to veterans and their family members. The programs include monetary benefits such as Disability Compensation and Veterans Pension as well as vocational rehabilitation services, educational assistance, life insurance, home loans programs, and other special services.

This unit describes the most common cash payments provided to veterans with disabilities and offers detailed explanations about how employment affects these cash benefits and how these benefits interact with Social Security disability benefits. The VA administers two separate programs that provide monthly cash payments to veterans with disabilities: Disability Compensation and Veterans Pension. In addition, the U.S. Department of Defense also offers cash payments to disabled veterans through the military retirement program. Each of these programs will be described separately.

NOTE: CWICs must remember that additional benefits are available to ALL veterans (not just those with disabilities) including life insurance, home loan programs, and educational assistance. We will not cover any of these in this unit, but you may access information on these generic benefits programs for Veterans at the VA website (https://benefits.va.gov/benefits/). For information about healthcare benefits afforded veterans with disabilities, refer to unit 3 of Module 4.
Military Separation and Retirement Based on Disability

CWICs often believe that the only benefits provided to veterans based on disability originate from the U.S. Department of Veterans Affairs, but this isn’t the case. When military members have a physical or mental health condition that renders them unfit to perform their required duties, they may separate or retire from the military for medical reasons (Title 10, U.S.C., Chapter 61). In many instances, separation or retirement from the military due to medical reasons will result in the U.S. Department of Defense providing some sort of cash payment. There are basically three different ways this can happen and each has its own specific requirements. Since CWICs would seldom encounter beneficiaries receiving cash payments due to separation or retirement due to disability, we do not cover this in detail. For more information, refer online to Defense Finance and Accounting Service – Qualifying for a Disability Retirement (https://www.dfas.mil/retiredmilitary/disability/disability.html).

Understanding Benefits for Veterans with Disabilities Administered by the VA

Disability Evaluation under the VA System

Unlike the Social Security system of determining disability using an “all or nothing” criteria, the VA system uses a disability rating structure in which it assesses degree of disability using percentages. The system may determine individuals to be disabled anywhere along a continuum ranging from 0 percent to 100 percent disabled. The U.S. Department of Veterans Affairs (VA) uses the “Schedule for Rating Disabilities” for evaluating the degree of disability in claims for veterans’ disability compensation, disability and death pension, and in eligibility determinations. The provisions contained in the VA rating schedule represent (as far as can practically be determined) the average impairment in earning capacity in civil occupations resulting from disability. In other words, the VA expects a veteran who is assessed at the 30 percent rating level to have a 30 percent reduction in earnings capacity due to disability. The Schedule for Rating Disabilities is
Total Disability

In addition to the percentage rating system, the VA also designates certain veterans as having “total disability” and “permanent total disability.” Total disability exists when any impairment of mind or body is present which is sufficient to render it impossible for the average person to pursue a substantially gainful occupation. Total disability may or may not be permanent. The VA generally doesn’t assign total disability ratings for temporary exacerbations or acute infectious diseases except where specifically prescribed by the ratings schedule. Total ratings are authorized for any disability or combination of disabilities for which the Schedule for Rating Disabilities prescribes a 100 percent evaluation. In certain prescribed circumstances, a disability rating of less than 100 percent may result in a total disability rating.

Total Disability Ratings Based on Individual Unemployability

The VA may assign total disability ratings for Disability Compensation in certain cases in which the schedule rating is less than 100 percent, the usual standard for total disability. If the individual with the disability is, in the judgment of the rating agency, unable to secure or follow a “substantially gainful occupation” because of service-connected disabilities, that individual may be deemed to have total disability for the purposes of VA Compensation. The VA refers to this designation as “individual unemployability,” and it may occur under the following circumstances:

- If there is only one disability, this disability is rated at 60 percent or more; or
- If there are two or more disabilities, there must be at least one disability ratable at 40 percent or more and sufficient additional disability to bring the combined rating to 70 percent or more.

The VA provides specific instruction to VA disability rating adjudicators about how to determine when a veteran is individually unemployable. The regulations read in the following manner:

“It is provided further that the existence or degree of nonservice-connected disabilities or previous unemployability status will be disregarded where the percentages referred to in this paragraph for
the service-connected disability or disabilities are met and in the judgment of the rating agency such service-connected disabilities render the veteran unemployable. Marginal employment shall not be considered substantially gainful employment. For purposes of this section, marginal employment generally shall be deemed to exist when a veteran’s earned annual income doesn’t exceed the amount established by the U.S. Department of Commerce, Bureau of the Census, as the poverty threshold for one person. Marginal employment may also be held to exist, on a facts found basis (includes but isn’t limited to employment in a protected environment such as a family business or sheltered workshop), when earned annual income exceeds the poverty threshold. Consideration shall be given in all claims to the nature of the employment and the reason for termination.”

“**It is the established policy of the Department of Veterans Affairs that all veterans who are unable to secure and follow a substantially gainful occupation by reason of service-connected disabilities shall be rated totally disabled.**” (emphasis added) (From 40 FR 42535, Sept. 15, 1975, as amended at 54 FR 4281, Jan. 30, 1989; 55 FR 31580, Aug. 3, 1990; 58 FR 39664, July 26, 1993; 61 FR 52700, Oct. 8, 1996)

The determination of whether or not a veteran is able to follow a substantially gainful occupation is left up to the Ratings Adjudicator’s discretion within very broad guidelines. The term “unemployability” isn’t synonymous with the terms unemployed and unemployable for the purpose of determining entitlement to increased compensation. A veteran may be unemployed or unemployable for a variety of reasons yet still not be “unemployable” for the purposes of establishing a total disability rating.

For more information, refer to [va.gov – VA Individual Unemployability if you can’t work](https://www.benefits.va.gov/COMPENSATION/claims-special-individual_unemployability.asp)

**Permanent Total Disability**

The VA may classify a veteran as having permanent total disability when the impairment is reasonably certain to continue throughout the individual’s life. The federal regulations governing permanent total
disability describe the impairments that would qualify for this designation in the following manner:

“The permanent loss or loss of use of both hands, or of both feet, or of one hand and one foot, or of the sight of both eyes, or becoming permanently helpless or bedridden constitutes permanent total disability. Diseases and injuries of long standing which are actually totally incapacitating will be regarded as permanently and totally disabling when the probability of permanent improvement under treatment is remote.

Permanent total disability ratings may not be granted as a result of any incapacity from acute infectious disease, accident, or injury, unless there is present one of the recognized combinations or permanent loss of use of extremities or sight, or the person is in the strict sense permanently helpless or bedridden, or when it is reasonably certain that a subsidence of the acute or temporary symptoms will be followed by irreducible totality of disability by way of residuals. The age of the disabled person may be considered in determining permanence.”

(From 38 CFR §3.340 Total and Permanent Total Ratings and Unemployability)

The designation of total disability or permanent total disability is important because the VA only affords certain benefits to individuals with these classifications. In addition, designations of total or permanent total disability may increase the amount of monetary benefits the VA entitles a veteran to receive.

Disability Re-Examinations

After the VA has made an initial disability rating, the VA may subject veterans to periodic re-examinations. This is similar to the medical Continuing Disability Review (CDR) process utilized in the Social Security disability benefit system. The VA will request reexaminations whenever it determines there is a need to verify either the continued existence or the current severity of a disability. Generally, the VA will require reexaminations if it’s likely that a disability has improved, or if evidence indicates there has been a material change in a disability or that the current rating may be incorrect. Individuals for whom the VA has authorized or scheduled reexaminations are required to report for such reexaminations.
The schedule of reexaminations varies depending on whether an individual receives Disability Compensation or Veterans Pension. For veterans receiving Disability Compensation, assignment of a pre-stabilization rating requires reexamination within the second six-month period following separation from military service. Following initial VA examination or any scheduled future or other examination, the VA will schedule reexamination, if in order, within not less than two years or more than five years within the judgment of the rating board, unless the VA specifies another time period.

In Disability Compensation cases, the VA doesn’t deem reexaminations necessary under the following circumstances:

- When the VA establishes the disability as static;
- When examinations and hospital reports show symptoms to have persisted without material improvement for a period of five years or more;
- Where the disability from disease is permanent in character and of such nature that there is no likelihood of improvement;
- In cases of veterans over 55 years of age, except under unusual circumstances;
- When the rating is a prescribed scheduled minimum rating; or
- Where a combined disability evaluation wouldn’t be affected if the future examination should result in reduced evaluation for one or more conditions.

For veterans receiving Pension benefits in which the permanent total disability has been confirmed by reexamination or by the history of the case, or with obviously static disabilities, the VA generally won’t request further reexaminations. In other cases, the VA won’t request further examination routinely and will only request further examination if considered necessary based upon the particular facts of the individual case. In the cases of veterans over 55 years of age, the VA will request reexamination only under unusual circumstances.

**Applying for VA Disability Benefits**

Veterans can apply for both Disability Compensation and Veterans Pension benefits by filling out VA Form 21-526, Veterans Application for
Compensation or Pension. Individuals should attach the following material to their application if it’s available:

- Dependency records (marriage and children’s birth certificates)
- Medical evidence (doctor and hospital reports)

Veterans can also apply for benefits online through the eBenefits website (https://www.ebenefits.va.gov/ebenefits/homepage).

For more information about applying for VA benefits for individuals with disabilities, call toll-free 1-800-827-1000.

**VA Disability Compensation**

VA Disability Compensation is a monetary benefit the VA pays to veterans who are disabled by an injury or disease that they incurred or aggravated during active military service. The VA considers these disabilities to be service-connected. The amount of monthly Disability Compensation varies with the degree of disability and the number of veteran’s dependents. Veterans with certain severe disabilities may be eligible for additional special monthly compensation. The veteran’s Disability Compensation benefits aren’t subject to federal or state income tax. To be eligible for Disability Compensation, the service of the veteran must have terminated through separation or discharge under conditions other than dishonorable.

To find the current as well as past VA benefit rates, go to the VA website (https://www.benefits.va.gov/COMPENSATION/resources_comp01.asp).

Veterans with disability ratings of at least 30 percent are eligible for additional allowances for dependents. This includes spouses, minor children, children between the ages of 18 and 23 who are attending school, children who are permanently incapable of self-support because of a disability arising before age 18, and dependent parents. The additional amount depends on the disability rating. Disability Compensation benefits are an entitlement program and aren’t means-tested. Veterans who have other types of income or who own resources won’t lose their entitlement to Disability Compensation benefits. However, military retirement pay, disability severance pay, and separation incentive payments known as SSB (Special Separation Benefits) and VSI (Voluntary Separation Incentives) do affect the amount of VA compensation paid to disabled veterans.
Special Monthly Compensation

The VA can pay an added compensation known as “Special Monthly Compensation” or SMC in addition to the regular Disability Compensation under certain circumstances. For example, the VA may pay SMC to a veteran who, because of military service, incurred the loss or loss of use of specific organs or extremities. Loss, or loss of use, is either an amputation or, having no effective remaining function of an extremity or organ. The disabilities the VA can consider for SMC include:

- Loss, or loss of use, of a hand or foot;
- Immobility of a joint or paralysis;
- Loss of sight of an eye (having only light perception);
- Loss, or loss of use, of a reproductive organ;
- Complete loss, or loss of use, of both buttocks;
- Deafness of both ears (having absence of air and bone conduction);
- Inability to communicate by speech (complete organic aphonia); or
- Loss of a percentage of tissue from a single breast, or both breasts, from mastectomy or radiation treatment.

The VA will also pay higher rates for combinations of these identified disabilities (such as loss or loss of use of the feet, legs, hands, and arms) in specific monetary increments, based on the particular combination of the disabilities. There are also higher payments for various combinations of severe deafness with bilateral blindness. Additional SMC is available if a veteran is service connected for paraplegia, with complete loss of bowel and bladder control. In addition, for veterans who have other service-connected disabilities that, in combination with the above special monthly compensation, meet certain criteria, the VA can consider a higher amount of SMC.

Finally, if a veteran has a service-connected disability at the 100 percent rate and is “housebound, bedridden, or is so helpless to need the aid and attendance of another person,” the VA can consider payment of additional SMC. The VA refers to this additional monthly payment as “Aid and Attendance and Housebound Allowance.” The amount of this extra monthly payment will vary depending on the level of aid and attendance.
needed. The VA also considers unusual medical expenses when determining some needs-based pension and compensation payments. The VA considers medical expenses that exceed five percent of the maximum annual VA payment rate to be “unusual.” As a result, the veteran will have a higher monthly VA payment, an extra payment, or an increase in an extra payment.

**Veterans Pension**

A pension is a needs-based benefit the VA pays to a veteran because of permanent and total nonservice-connected (NSC) disability, or a surviving spouse or child because of a wartime veteran’s nonservice-connected death. The VA currently pays the following three types of pensions:

- Improved Pension, per Public Law (PL) 95-588,
- Section 306 Pension, per PL 86-211, and
- Old Law Pension.

Because the VA has phased out the Old Law and Section 306 Pension programs, a veteran filing a new claim for pension benefits must qualify under the Improved Pension program. Pension beneficiaries who were receiving a Veterans Pension on Dec. 31, 1978 and don’t wish to elect the Improved Pension will continue to receive the pension rate they were receiving on that date. This rate generally continues as long as the beneficiary’s income remains within established limits, his or her net worth doesn’t bar payment, and the beneficiary doesn’t lose any dependents. These beneficiaries must continue to meet basic eligibility factors, such as permanent and total disability for veterans, or status as a surviving spouse or child. The VA must adjust rates for other reasons, such as a veteran’s hospitalization in a VA facility.

**NOTE:** From this point forward, we will refer only to the pensions the VA provides directly to veterans based upon disability (as opposed to death pensions the VA provides to surviving spouses and children) and will focus on the Improved Pension, because this is the program currently available to veterans making claims. Because there are some differences in the way the VA counts income and assets in the pension programs that have been discontinued, it’s important to know exactly WHICH pension benefit an individual is receiving. CWICs should confirm
which type of Veterans Pension a beneficiary receives before offering case-specific advisement.

**Improved Pension**

Veterans with low incomes who are permanently and totally disabled, or are age 65 and older, may be eligible for a type of monetary support known as “Veterans Pension.” To qualify for this benefit, veterans must have 90 days or more of active military service, at least one day of which was during a period of war. Veterans who entered active duty on or after September 8, 1980, or officers who entered active duty on or after October 16, 1981, may have to meet a longer minimum period of active duty. In addition, the veteran’s discharge must have been under conditions other than dishonorable, and the disability must be for reasons other than the veteran’s own willful misconduct.

Pension payments bring up the veteran’s total income, including other retirement or Social Security income, to a level set by Congress. Unlike the Disability Compensation program, the Pension program is means-tested, and bases eligibility upon meeting certain income and asset tests. In addition, the amount of countable income of the veteran, spouse, or dependent children reduces pension payments. Just as in the SSI program, the VA disregards numerous types of income and assets. Other factors may also reduce pension payments. For example, when the VA furnishes a veteran without a spouse or a child with nursing home or domiciliary care, the VA reduces the pension to an amount not to exceed $90 per month after three calendar months of care. The VA may delay the reduction if nursing home care is being continued to provide the veteran with rehabilitation services.

The current and past pension rates are available online (http://benefits.va.gov/pension/vetpen.asp).

The VA also evaluates a veteran’s net worth when determining eligibility for the Pension program. The regulations state that “Pension shall be denied or discontinued when the corpus of the estate of the veteran, and of the veteran’s spouse, are such that under all the circumstances, including consideration of the annual income of the veteran, the veteran’s spouse, and the veteran’s children, it is reasonable that some part of the corpus of such estates be consumed for the veteran’s maintenance” (Authority: 38 U.S.C.1522(a)).
“Corpus of estate” and “net worth” mean the market value, less mortgages or other encumbrances, of all real and personal property owned by the claimant except the claimant’s dwelling (single-family unit) including a reasonable lot area, and personal effects suitable to and consistent with the claimant’s reasonable mode of life.

In determining whether the VA should consume some part of the veteran’s estate for his or her maintenance, the VA will consider the amount of the individual’s income and the following factors:

- Whether the VA can readily convert the property into cash at no substantial sacrifice;
- Ability to dispose of property as limited by community property laws;
- Life expectancy of the veteran;
- Number of dependents;
- Potential rate at which the VA would deplete the estate if the VA used it for maintenance; and
- Unusual medical expenses for the veteran and his or her dependents. With regard to the transfer of property, the VA rules state: “A gift of property made by an individual to a relative residing in the same household shall not be recognized as reducing the corpus of the grantor’s estate. A sale of property to such a relative shall not be recognized as reducing the corpus of the seller’s estate if the purchase price, or other consideration for the sale, is so low as to be tantamount to a gift. A gift of property to someone other than a relative residing in the grantor’s household won’t be recognized as reducing the corpus of the grantor’s estate unless it’s clear that the grantor has relinquished all rights of ownership, including the right of control of the property” (Authority: 38 U.S.C. 501(a)).

**Concurrent Retirement and Disability Payments (CRDP) for Disabled Veterans**

Concurrent Retirement and Disability Payments (CRDP) restore retired pay on a graduated 10-year schedule for retirees with a 50 to 90 percent VA-rated disability. Concurrent retirement payments increased 10 percent per year through 2013. Veterans rated 100 percent disabled by
the VA are entitled to full CRDP without being phased in. Veterans receiving benefits at the 100 percent rate due to individual unemployability are entitled to full CRDP starting in 2009. To qualify for concurrent retirement and disability payments, veterans must also meet all three of the following criteria:

1. Have 20 or more years on active duty, or a reservist age 60 or older with 20 or more creditable years;
2. Be in a retired status; and
3. Be receiving retired pay (must be offset by VA payments).

Retirees don’t need to apply for this benefit. The VA and the Department of Defense (DOD) coordinate the payment. More information about concurrent receipt of retirement and disability payments is available online at [Defense Finance and Accounting Service – Concurrent Retirement and Disability Pay](https://www.dfas.mil/retiredmilitary/disability/crdp.html).

**Disability Benefit Payment Options**

The VA offers three payment options to veterans eligible to receive disability benefit payments whether it is Disability Compensation or Veterans Pension. Most veterans receive their payments by direct deposit to a bank, savings and loan, or credit union account. In some areas, veterans who don’t have a bank account can open a federally insured Electronic Transfer Account, which costs about $3 a month, provides a monthly statement, and allows cash withdrawals. Other veterans may choose to receive benefits by check.

**The VA Appeals Process**

An appeal is a request for a review of a VA determination on a claim for benefits issued by a local VA office. Anyone who has filed a claim for benefits with VA and has received a determination from a local VA office is eligible to appeal to the Board of Veterans’ Appeals.

The Board of Veterans’ Appeals (also known as “BVA” or “the Board”) is a part of the Department of Veterans Affairs (VA), located in Washington, D.C. “Members of the Board” review benefit claims determinations made by local VA offices and issue decisions on appeals. These board members, attorneys experienced in veterans’ law and in reviewing benefit claims, are the only ones who can issue board decisions. Staff attorneys,
referred to as Counsel or Associate Counsel, are also trained in veterans’ law. They review the facts of each appeal and assist board members.

Individuals may file an appeal up to one year from the date the local VA office mails its initial determination on the claim. After that, the VA considers the determination final and the veteran can’t appeal it unless it involved a clear and unmistakable error by the VA. Veterans may appeal any determination issued by a VA regional office (RO) on a claim for benefits. Some determinations by VA medical facilities, such as eligibility for medical treatment, veterans may also appeal to the board. Veterans may appeal a complete or partial denial of a claim or may appeal the level of benefit granted.

The appeal process requires no special form to begin. All that the veteran needs is a written statement that the individual disagrees with the local VA office’s claim determination and wants to appeal this decision. The VA refers to this statement as the Notice of Disagreement, or NOD. Normally, a veteran files the appeal with the same local VA office that issued the original decision, because that office keeps the individual’s claims file (also called a claims folder).

Veterans who are appealing a VA determination should submit any evidence that supports their argument that the original determination was wrong. This evidence could include records from recent medical treatments or evaluations or anything else that the veteran feels supports their contentions. If the individual wants the board to consider the new evidence without sending the case back to the local VA office, he or she should include a written statement to this effect in the letter requesting the appeal. If the veteran neglects this statement, a considerable delay may occur, as the board will send back the information to the local VA office to consider.

Veterans can get help preparing and submitting an appeal from a veterans’ service organization (VSO) representative, an attorney-at-law, or an “agent.” Representatives who work for accredited veterans’ service organizations know how to prepare and present claims and will represent veterans. A listing of these organizations is available at **va.gov through the Directory of Veterans Service Organizations** (http://www.va.gov/ogc/apps/accreditation/inde.asp). Veterans may also hire private attorneys or “agents” to represent them in the appeals process. The local bar association may be able to provide a list of attorneys with experience in veterans’ law. The VA only recognizes
attorneys who are licensed to practice in the United States or in one of its territories or possessions. An agent is a person who isn’t a lawyer, but is someone whom the VA recognizes as knowledgeable about veterans’ law.

For more information about appeal rights, how to submit and appeal, and a user-friendly guide to the VA Appeals Process, refer to VA Form 4107, Your Rights to Appeal Our Decision – Contested Claims (http://www.va.gov/vaforms/va/pdf/VA4107c.pdf).

**Other Special Programs for Veterans with Disabilities**

In addition to cash benefits, healthcare coverage, and vocational rehabilitation services, the VA offers several special benefits to certain veterans with disabilities. These programs can help a veteran pay for adaptations they need for a home or vehicle, pay for attendant care, or purchase needed clothing.

**Housing Grants for Veterans with Disabilities**

The VA provides grants to service members and veterans with certain permanent and total service-connected disabilities to help purchase or construct an adapted home, or modify an existing home to accommodate a disability. Two grant programs exist: the Specially Adapted Housing (SAH) grant and the Special Housing Adaptation (SHA) grant.

**Specially Adapted Housing (SAH) Grants**

The SAH grant helps disabled veterans by providing a barrier-free living environment, such as a wheelchair accessible home, that affords veterans a level of independent living they may not otherwise enjoy. The VA may entitle veterans and service members with specific service-connected disabilities to a grant for the purpose of constructing or modifying a home to meet their adaptive needs, up to the current maximum of $90,364 in federal fiscal year 2020.

The SAH grant is available to veterans and service members who are entitled to disability compensation for permanent and total disability due to:
• Loss or loss of use of both lower extremities, such as to preclude locomotion without the aid of braces, crutches, canes, or a wheelchair, or

• Blindness in both eyes, plus loss or loss of use of one lower extremity, or

• (1) Loss or loss of use of one lower extremity together with residuals of organic disease or injury, or (2) the loss or loss of use of one upper extremity, affecting balance or propulsion as to preclude locomotion without the aid of braces, crutches, canes, or a wheelchair, or,

• Loss or loss of use of both upper extremities at or above the elbows, or

• A severe burn injury.

**Special Home Adaptation (SHA) Grants**

Eligible veterans and service members can use the SHA grant to increase their mobility within their residences by helping adapt or purchase a home to accommodate the disability. The VA may entitle veterans and service members with specific service-connected disabilities to this type of grant, up to the current maximum of $18,074 in federal fiscal year 2020. Veterans can use SHA grants in one of the following ways:

• Adapt an existing home the veteran or a family member already owns in which the veteran lives;

• Adapt a home the veteran or family member intends to purchase in which the veteran will live; or

• Help a veteran purchase an already adapted home in which the veteran will live.

The SHA grant is available to veterans and service members who are entitled to disability compensation for permanent and total disability due to:

• Blindness in both eyes with 20/200 visual acuity or less, or

• The anatomical loss or loss of use of both hands or extremities below the elbow, or

• A severe burn injury.
Home Improvements and Structural Alterations (HISA) Grant

Veterans and service members may receive assistance for any home improvement necessary for the continuation of treatment or for disability access to the home and essential lavatory and sanitary facilities. A veteran may receive a HISA grant in conjunction with either a SAH or SHA grant. The HISA program is available for both veterans with service-connected disabilities and veterans with non-service-connected disabilities. The HISA program may provide:

- Home improvement benefits up to $7,083 to veterans with service-connected disabilities.
- Home improvement benefits up to $2,000 to veterans with non-service-connected disabilities.

Veterans may visit va.gov – Rehabilitation and Prosthetic Services to learn more about HISA grants (www.prosthetics.va.gov/HISA2.asp).

Applying for Housing Grant Programs

Veterans may apply for either the SAH or SHA programs by completing VA Form 26-4555, Veterans Application in Acquiring Specially Adapted Housing or Special Home Adaptation Grant, and submitting it to the local VA Regional Loan Center. Veterans may also apply online by visiting the veteran’s portal at www.ebenefits.va.gov to register and submit an application for Specially Adapted Housing benefits. For more information, veterans may call toll-free 1-800-827-1000 or visit the VA Home Loans page on the VA website (https://www.benefits.va.gov/homeloans/adaptedhousing.asp).

Service-Disabled Veterans Insurance (S-DVI)

Service-Disabled Veterans Insurance (S-DVI) is life insurance for veterans who have received a service-connected disability rating by the Department of Veterans Affairs. The basic S-DVI program, commonly referred to as “RH Insurance,” insures eligible veterans for up to $10,000 of coverage. Veterans who have the basic S-DVI coverage and are totally disabled are eligible to have the program waive their premiums. If the program grants a waiver, totally disabled veterans may apply for additional coverage of up to $20,000 under the Supplemental S-DVI program. Veterans can’t, however, waive premiums for Supplemental S-DVI coverage. To be found eligible for S-DVI, an individual must:
• Have been released from service under other than dishonorable conditions on or after April 25, 1951;
• Have been notified by VA that they have a service-connected disability;
• Be healthy except for the service-related disability; and
• Apply within two years of being notified of your service-connected disability.

To be eligible for Supplemental S-DVI, an individual must:
• Have an S-DVI policy;
• Have the premiums on the basic coverage waived due to total disability;
• Apply within one year of being notified of the waiver; and
• Be under 65 years of age.

Veterans may be eligible for a waiver if they become totally disabled before their 65th birthday and remain disabled for at least six consecutive months. Veterans can’t waive premiums for Supplemental S-DVI. The cost of the premiums varies depending upon age, type of plan (term or permanent), and the amount of coverage.


**Assistance with Adapting an Automobile to Meet Disability Needs**

As of October 1, 2018, veterans with certain service-connected disabilities may be eligible for a one-time payment of not more than $21,058.69 toward the purchase of an automobile or other conveyance if they have certain service-connected disabilities. The VA pays the grant directly to the seller of the automobile and the veteran may only receive the automobile grant once in his or her lifetime. To be eligible for the automobile grant, an individual must:

• Be either a service member who is still on active duty or a veteran, AND
• Have one of the following disabilities that are either rated as service-connected or treated as if service-connected under 38 U.S.C 1151:
  o Loss, or permanent loss of use, of one or both feet, OR
  o Loss, or permanent loss of use, of one or both hands, OR
  o Permanent impairment of vision in both eyes to a certain degree.

Certain veterans may also be eligible for adaptive automobile equipment. Adaptive equipment includes, but isn’t limited to, power steering, power brakes, power windows, power seats, and special equipment necessary to assist the eligible person into and out of the vehicle. The VA may provide financial assistance in purchasing adaptive equipment more than once. This benefit is payable to either the seller or the veteran. Veterans must have prior VA approval before purchasing an automobile or adaptive equipment using grant funds.

To be eligible for adaptive equipment, an individual must:

• Be either a service member who is still on active duty or a veteran, AND
• Meet the disability requirements for the automobile grant (see above), OR
• Have ankylosis (immobility of the joint) of one or both knees or hips that the VA recognizes.

For more information, refer to [VA automobile allowance and adaptive equipment](https://www.benefits.va.gov/compensation/claims-special-auto-allowance.asp)

**Annual Clothing Allowance for Veterans with Service-Connected Disabilities**

Any veteran who is service-connected for a disability for which he or she uses prosthetic or orthopedic appliances may receive an annual clothing allowance. The clothing allowance also is available to any veteran whose service-connected skin condition requires prescribed medication that irreparably damages his or her outer garments. To apply, contact the prosthetic representative at the nearest VA Medical Center.
For more information, refer to [va.gov – clothing allowance](https://www.benefits.va.gov/compensation/claims-special-clothing_allowance.asp)

**Veterans Requiring Aid and Attendance or Housebound Veterans**

A veteran whom the VA determines to be in need of the regular aid and attendance of another person, or a veteran who is permanently housebound, may be entitled to additional disability compensation or pension payments. A veteran whom the VA evaluates at 30 percent or more disabled is entitled to receive an additional payment for a spouse who is in need of the aid and attendance of another person.

For more information, refer to [benefits.va.gov – Pension – Aid & Attendance and Housebound](https://www.benefits.va.gov/pension/aid_attendance_housebound.asp).

**Subsistence Allowance for Work-study Participants**

In addition to receiving the monthly Disability Compensation payment, some veterans who are participating in training or education programs may also qualify for a monthly subsistence allowance. The VA pays this each month during training and it is based on the rate of attendance (full-time or part-time), the number of dependents, and the type of training. Veterans training at the three-quarter or full-time rate may also participate in the VA’s work-study program. Work-study participants may provide VA outreach services, prepare and process VA paperwork, and work at a VA medical facility or perform other VA-approved activities. A portion of the work-study allowance equal to 40 percent of the total may be paid in advance. View the current [VR&E subsistence allowance rates](http://www.benefits.va.gov/vocrehab/subsistence_allowance_rates.asp) online.

**State Veterans Benefits**

Many states offer special benefits to veterans in addition to the benefits available from the federal government. These benefits may include educational grants and scholarships, special exemptions or discounts on fees and taxes, home loans, veteran’s homes, free hunting and fishing privileges, and more. Each state manages its own benefit programs through the state’s Veterans Affairs Office. A directory of [State Veterans](https://www.benefits.va.gov/veteransbenefits/state veterans.asp)
Affairs Offices is available online (http://www.va.gov/statedva.htm). The VA also maintains a comprehensive searchable online directory of Veteran’s Service Organizations (https://www.va.gov/vso/).

How Employment Affects VA Disability Benefits

The Veterans Pension program is means-tested, and earned income from employment would definitely affect a veteran’s eligibility for this program as well as the amount of payment due each month. In the Veterans Pension program, the VA will consider all income from sources such as wages, salaries, earnings, bonuses from employers, income from a business or profession or from investments or rents, as well as the fair value of personal services, goods, or room and board the veteran received in lieu thereof. Furthermore, the VA doesn’t determine salary by “take-home” pay, but on “gross pay” before any deductions made under a retirement act or plan and amounts withheld by virtue of income tax laws.

In the case of self-employment, necessary operating expenses, such as cost of goods sold, or expenditures for rent, taxes, and upkeep, may reduce the gross income from a business or profession. Depreciation isn’t a deductible expense. The VA may deduct the cost of repairs or replacement. The VA doesn’t consider the value of an increase in stock inventory of a business as income. The VA may not deduct a loss sustained in operating a business, profession, or farm or from investments from income the veteran derived from any other source.

Any income that the VA deems countable under VA rules reduces a Veterans Pension dollar for dollar. For example, if a veteran was entitled to pension benefits in the amount of $400 per month and went to work earnings $300 in gross wages per month, the VA would reduce the pension one dollar for each of the 300 dollars the veteran received in wages. The reduced Veterans Pension payment would be $100. Veterans receiving a Veterans Pension must report all income to the VA.

Disability Compensation benefits aren’t means-tested, so income or resources don’t affect them. Neither wages nor net income from self-employment affects Disability Compensation payments in the sense that in and of themselves they would cause a reduction or “offset” in the VA
payment amount. The Disability Compensation program doesn’t take into consideration other forms of income (not related to employment), and assets and have no effect on benefit eligibility or amount of monthly payment.

**Effect of Employment on Disability Rating**

As the reader will recall from the section describing the VA disability evaluation system, the percentage “rating” the VA assigns to an individual reflects the effect the VA expects the disability to have on that individual’s earnings capacity. The lower the rating, the less the VA expects the disability to diminish the earnings capacity of the individual; the higher the rating, the more the VA expects the disability to diminish earnings capacity. It’s possible for the VA to reduce a veteran’s rating after a medical reexamination if the VA determines that the disability has substantially improved.

Veterans sometimes fear that working might reduce their VA rating. Fortunately, in the VA system, a report of work doesn’t trigger a medical reexamination, and, unlike Social Security, the VA doesn’t typically apply a specific earnings test when re-evaluating disability (with one notable exception described below). When the VA conducts a disability reexamination, they are looking to see if there has been material improvement in the veteran’s medical condition. The VA could only reduce a veteran’s disability rating if the VA finds medical evidence that the disability has gotten better and that this improvement creates an increased ability to function in life and at work. The VA may consider a veteran’s ability to function at work as part of the medical reexamination, but only if there is medical evidence documenting that disability has materially improved. The fact that a veteran had a little improvement isn’t enough to cause the VA to reduce a rating. Unless the reexamination report shows material improvement, the VA can’t reduce a veteran’s rating.

Keep in mind that certain veterans aren’t subject to medical reexaminations (see the section in this unit describing Disability Re-examinations on page 89). The VA protects other veterans from having their disability rating reduced due to a medical re-examination.
How Employment Affects Individual Unemployability

There is one situation in which employment could cause a reduction in the veteran’s schedular rating, and that is when VA has determined a veteran to be “individually unemployable.” As a review, Individual Unemployability (IU) is a special additional benefit that addresses the truly unique disability picture of a veteran who is unemployable due to service-connected disability, but for whom the application of the rating schedule doesn’t fully reflect the veteran’s level of impairment. An award of IU allows the veteran to receive compensation at a rate equivalent to that of a 100 percent schedular award. The IU benefit continues only as long as the veteran remains unemployable. The VA monitors the employment status of IU beneficiaries and requires that they submit an annual certification of unemployability.

After the VA makes its initial IU award, veterans must submit a VAF 21-4140, Employment Questionnaire, on a yearly basis to certify continuing unemployability. The VA requires the VAF 21-4140 unless the veteran is 70 years of age or older, has been in receipt of IU for a period of 20 or more consecutive years (as provided at 38 CFR 3.951(b)), or has been granted a 100 percent schedular evaluation. The VA sends the form annually and requests that the veteran report any employment for the past 12 months or certify that no employment has occurred during this period. The VAF 21-4140 includes a statement that the veteran must return the form within 60 days or the VA may reduce the veteran’s benefits.

If the veteran returns VAF 21-4140 in a timely manner and shows no employment, then his or her IU benefits will continue uninterrupted. If the veteran returns VAF 21-4140 in a timely manner and shows that he or she has engaged in employment, the VA must determine if the employment is “marginal” or “substantially gainful employment.” If the employment is marginal, then IU benefits will continue uninterrupted. If the employment is substantially gainful, then the VA must consider discontinuing the IU benefit.

Marginal Employment

Low levels of employment, which the VA describes as “marginal employment,” wouldn’t be sufficient to reduce the disability rating. Marginal employment exists when a veteran’s earned annual income doesn’t exceed the amount the U.S. Department of Commerce, U.S. Census Bureau, established as the poverty threshold for one person.
Even when earned annual income does exceed the poverty threshold, it may still not represent substantially gainful employment if the employment occurred in a protected environment, such as a family business, or a sheltered workshop, or when the veteran is receiving supported employment services.

Substantially Gainful Employment

The VA defines substantially gainful employment as employment at which non-disabled individuals earn their livelihood with earnings comparable to the particular occupation in the community where the veteran resides” (M21-1MR Part IV, Subpart ii, Chapter 2, Section f). The VA may not reduce a veteran’s total disability rating based on IU solely because of the veteran having secured substantially gainful employment unless the veteran maintains that employment for a period of 12 consecutive months. Temporary interruptions in employment that are of short duration the VA doesn’t consider breaks in otherwise continuous employment.

Evaluating Employability

VA regulations at 38 CFR 3.343(c)(1) and (2) provide that the veteran’s actual employability must be shown by clear and convincing evidence before the VA can discontinue this benefit. The VA won’t consider vocational rehabilitation activities or other therapeutic or rehabilitative pursuits as evidence of renewed employability unless the veteran’s medical condition shows marked improvement. Additionally, if the evidence shows that the veteran actually is engaged in a substantially gainful occupation, the VA can't discontinue IU unless the veteran maintains the gainful occupation for a period of 12 consecutive months.

If the VA conducts a reexamination of disability or employability status and the lower evaluation would result in a reduction or discontinuance of disability payments the VA is currently making to a veteran, the VA prepares a rating proposing the reduction or discontinuance, which sets forth all material facts and reasons. The VA must provide the veteran with due process before the VA discontinues the IU benefit, as stated at 38 CFR 3.105(e) and 3.501(e)(2). The VA notifies the veteran in writing of its planned action and furnishes all of the reasons and details in this correspondence. The VA will give the individual 60 days for the presentation of additional evidence to show that the VA should continue compensation payments at their present level. If the individual doesn’t provide additional evidence to the VA within the 60-day period, the VA
will take a final rating action and will reduce or discontinue the award effective the last day of the month in which a 60-day period from the date of notice to the beneficiary of the final rating action expires. This process is the same regardless of whether the individual receives VA Disability Compensation or Veterans Pension.

The VA intends determinations of substantially gainful employment to be highly individualized, and they will depend greatly on the unique circumstances of the veteran. VA Ratings Specialists are directed to consider a wide variety of factors and have clear and convincing evidence before pursuing a reduction in disability rating. Due to the somewhat subjective nature of these determinations, it may be impossible to predict exactly when the VA will consider an individual to be in a substantially gainful occupation. Veterans and the CWICs serving them are encouraged to seek a formal determination from the local VA in these cases.

*(From Veterans Benefit Administration (VBA) Training Letter 07-01: Instructions to the regional VA offices on procedures for the handling and management of Individual Unemployability (IU) claims, released February 21, 2007)*

**Interactions between Social Security Disability Benefits and Veterans Disability Benefits**

It’s possible for certain veterans to receive both a form of disability benefit payment from the VA as well as from the Social Security Administration. Because certain benefits within both of these systems are means-tested (SSI and Veterans Pension), it’s possible for receipt of one form of benefit to affect eligibility for or payment amount due from the other system. The rules governing how each of the two systems view benefits from the other can be very complex. We provide a general summary below, but, when in doubt, you should seek a formal determination from the VA or Social Security accordingly.

**NOTE:** Military service members can receive expedited processing of disability claims from the Social Security Administration. The expedited process is used for military service members who become disabled while on active military service on or after October 1, 2001, regardless of
where the disability occurs. For information about Social Security benefits developed specifically to meet the needs of veterans, go to ssa.gov (https://www.ssa.gov/people/veterans/).

How VA Disability Benefits Affect Social Security Disability Benefits

Social Security disability benefits paid under Title II (SSDI, CDB, DWB): Other forms of public disability benefits (PDB) generally offset these benefits, which means that Social Security reduces the monthly payment when the veteran receives other forms of disability benefits from a public (i.e., governmental) source. While some forms of military disability benefit or a military retirement pension based on disability may be subject to this offset, Social Security doesn’t count Veterans Administration (VA) benefits (including Agent Orange payments) paid under Title 38 U.S.C. This exclusion covers payments the veteran received under both the Disability Compensation and Veterans Pension programs described in this unit. Federal law specifically excludes these VA disability benefits from offset.

NOTE: Social Security does count military disability benefits including military retirement pensions based on disability as a form of public disability benefit (PDB), which would be subject to offset. These are benefits paid by the Department of Defense (DoD), not the VA. Only disability benefits paid by the VA are exempt from the PDB offset. For more information, see POMS DI 52130.001 - Types of Federal Public Disability Benefit (PDB) Payments and DI 52130.015 - Military Disability Benefits (https://secure.ssa.gov/apps10/poms.nsf/lnx/0452130001)

Supplemental Security Income (SSI): The SSI program is means-tested, and, in most cases, a veteran’s receipt of VA disability benefits would affect eligibility for SSI or the SSI payment amount. In general, Social Security would count VA disability payments as a form of unearned income for SSI purposes. VA Disability Compensation benefits would count as unearned income with only the $20 general income exclusion available to reduce the amount of this benefit that SSI would count. However, the SSI program specifically disregards any portion of a VA Disability Compensation payment that is a VA Aid and Attendance
Allowance or Housebound Allowance as well as compensation payments resulting from unusual medical expenses. In addition, there are certain special Disability Compensation benefits the VA pays on the basis of a Medal of Honor or a special act of Congress that the SSI program does NOT count as income.

Social Security considers Veterans Pension payments to be federally funded income based on need (IBON). As such, SSI treats these payments as unearned income to which the $20 general income exclusion does NOT apply. Again, SSI disregards VA pension payments resulting from Aid and Attendance or Housebound Allowances and VA pension payments resulting from unusual medical expenses. All or part of a VA pension payment may be subject to this rule.

The VA often considers the existence of dependents when determining a veteran’s or a veteran’s surviving spouse’s eligibility for pension, compensation, and educational benefits. If dependents are involved, the amount of the benefit payable may be larger than it otherwise would be. Social Security refers to this as “augmented VA benefits.” An “augmented benefit” is an increase in benefit payment to a veteran or a veteran’s surviving spouse or higher VA income eligibility limits because of a dependent. The VA usually issues an augmented VA benefit as a single payment to the veteran or the veteran’s surviving spouse. Social Security only considers the SSI beneficiary’s portion to be VA income attributable to the beneficiary in the SSI program. The portion of a VA benefit paid by apportionment to a dependent spouse or child is considered to be income attributable to the dependent spouse or child. It isn’t a support payment from the designated beneficiary. For more information on how SSI treats augmented VA benefits, see **POMS SI 00830.314 Augmented VA Benefits** ([https://secure.ssa.gov/poms.nsf/lnx/0500830314](https://secure.ssa.gov/poms.nsf/lnx/0500830314)).

The SSI program has numerous rules governing the treatment of other VA benefits provided on the basis of disability. The SSI program specifically excludes the following items as income by in addition to the aid and attendance or housebound allowances and VA pension payments resulting from unusual medical expenses:

- **Vocational Rehabilitation:** Payments made as part of a VA program of vocational rehabilitation (VR&E) aren’t income. This includes any augmentation for dependents.
• **VA clothing allowance:** Veterans who have unique clothing needs as a result of a service-related disability or injury may receive a supplement to their disability compensation.

For more information about how SSI treats specific forms of VA benefit, refer to [POMS SI 00830.300 - Department of Veterans Affairs Payments](https://secure.ssa.gov/poms.nsf/lnx/0500830300).

Finally, the VA provides numerous educational assistance programs including the Active Duty Educational Assistance Program (“Montgomery” GI Bill), the Veterans Educational Assistance Program (VEAP), and the Post-9/11 GI Bill Program. The SSI program excludes from income any payments the VA makes to pay for tuition, books, fees, tutorial services, or any other necessary educational expenses. Any portion of a VA educational payment designated as a stipend for shelter is countable income. For more information on how Social Security treats educational assistance provided by the VA for SSI recipients, go to [POMS SI 00830.306 Department of Veterans Affairs (VA) Educational Benefits](https://secure.ssa.gov/poms.nsf/lnx/0500830306).

### How Social Security Disability Benefits Affect VA Disability Benefits

The VA Disability Compensation program isn’t means-tested, so it isn’t affected in any way by receipt of a Social Security benefit of any type. The VA actively encourages military service members with disabilities to apply for disability benefits available from the Social Security in addition to the VA benefits.

The VA Pension program is based on need, and a veteran’s receipt of Social Security disability benefits may affect eligibility for these benefits as well as the amount of the monthly payment. The VA will consider retirement, survivors, and disability insurance under title II of the Social Security Act as income for the purposes of Veterans Pension. Remember that the VA reduces pension payments using a dollar-for-dollar approach. Every dollar of Social Security Title II benefit a veteran receives will result in the VA taking a dollar away from the VA Pension payment. However, the VA Pension program doesn’t count SSI payments as income. The VA considers SSI to be a benefit the veteran receives under a “noncontributory program” (i.e., a form of welfare) that is subject to the rules applicable to charitable donations.
How Social Security Treats Income from the Compensated Work Therapy Program

Compensated Work Therapy (CWT) is a VA vocational rehabilitation program that endeavors to match and support work ready veterans in competitive jobs, and to consult with business and industry regarding their specific employment needs. The CWT program provides a range of vocational rehabilitation services to support veterans interested in competitive jobs.

There are five basic programs offered under CWT:

1. Incentive Therapy Program
2. Sheltered Workshop Program
3. Transitional Work Program
4. Supported Employment Program
5. Transitional Residence Program

For Social Security purposes, the agency excludes most payments from CWT programs from income entirely since beneficiaries receive them in conjunction with medical services. Local community employers directly pay participants in the CWT Supported Employment (SE) phase of the program. Social Security considers income from CWT SE as earned income for SSI and Title II disability benefit purposes.

Conclusion

The benefits available to veterans who experience disability are numerous and complex. The DoD and VA benefit systems are as complicated as the Social Security disability system and, in many instances, veterans receive benefits from both of these enormous systems. CWICs must investigate eligibility for the various types of benefits and encourage veterans to apply for all programs for which they are potentially eligible. In addition, CWICs must carefully verify which benefits veterans are receiving from both the DoD/VA and the Social Security systems before offering any specific advice about how employment might affect these benefits.
Conducting Independent Research

Veterans Benefits Administration Website (http://www.vba.va.gov)

Benefits A-Z (https://www.benefits.va.gov/atoz/)

Veterans Benefits Explained – Military.com Website (http://www.military.com/benefits)

Competency Unit 7 – Asset Building and Individual Development Accounts (IDAs)

Introduction

In the past, our best efforts to help American families living in poverty focused almost exclusively on providing income supports such as TANF and SSI monthly cash payments. In recent years, there has been a growing emphasis on moving beyond these methods. While monthly cash payments provide much needed assistance to meet basic living needs, they do very little to help poor families save for their future and become more self-sufficient. Some of the most current thinking in poverty reduction focuses on the accumulation of “wealth,” not just on cash flow. This approach encourages people to save money and invest in assets that increase in value over time, based on the theory that asset development has the capability to both move people out of poverty and keep them out over time. Unfortunately, individuals with disabilities historically have been left out of asset building programs for a variety of reasons, including lack of information. This is beginning to change, and the new way of thinking about asset development is gaining a foothold in the disability services community.

Examples of long-term assets include a home, higher education and training, or a retirement account. Owning a home protects an individual from the adverse effect of a landlord selling his or her rental property or raising the rent, thus forcing a move. Better training or higher education generally results in better-paying jobs and more options for job replacement if and when needed.

According to recent research, a quarter of American households are “asset poor.” This means that should they experience loss of income, the individuals and families have insufficient financial resources to support themselves at the poverty level for three months. Even more troubling, asset poverty affects children at a disproportionately higher rate.

Research conducted throughout the last decade on the effects of asset building on low-income, low-asset families indicates that positive results
extend beyond tangible assets the families accumulated. Families with assets demonstrate an orientation toward the future, a decrease in marriage dissolution, and improved housing stability. Families engaged in asset building also tend to experience improved health and wellbeing, increased civic and community involvement, and decreased rates of transfer of poverty to the next generation. Several asset building programs are available to support people with disabilities in achieving financial well-being and experiencing the benefits of asset development.

**Achieving a Better Life Experience (ABLE) Act**

A new asset-building opportunity for beneficiaries is the Achieving a Better Life Experience (ABLE) Act. This Act, signed into law in December 2014, provides an opportunity for certain individuals with disabilities to establish tax-free savings accounts to pay for disability-related expenses that will help maintain or improve health, independence, and quality of life.

**Purpose of the ABLE Act**

Many individuals with disabilities and their families depend on public benefits for income, health care, food, and housing assistance. Programs such as SSI, Medicaid, and SNAP are means-tested with resource limits, and individuals who depend on these programs are often unable to save for expenses related to their disability. The ABLE Act addresses the significant costs that individuals with disabilities have in living or working in the community, including accessible housing and transportation, personal assistance services, assistive technology, or healthcare needs not covered by Medicaid, Medicare, or private insurance. The Act allows individuals who qualify to establish a tax-advantaged savings account that will not affect the beneficiary’s eligibility for SSI, Medicaid, or other public benefits.

**Implementation of the ABLE Act in States**

An ABLE program can be established by a state, a state agency, or an instrumentality of a state. Some states formed partnerships to improve access for eligible individuals to enroll in ABLE programs. There are a variety of different arrangements states have developed to administer ABLE programs, some of which we describe below.
Some states have formed a consortium where the states have their own ABLE program but join together to provide lower administrative costs and better investment options than they could on their own.

Some states established their own ABLE program but contracted with private companies to manage their ABLE program for them.

Some states established their own ABLE program but contracted with other states to manage their ABLE program for them.

Some states do not operate their own ABLE program but partnered with another state to offer the other state’s ABLE program to their residents.

States can choose to limit their ABLE program to residents of the state or open the program up to residents of other states. Beneficiaries can open an ABLE account with any ABLE program that allows residents in the beneficiary’s state. The ABLE National Resource Center provides several tools for researching ABLE account programs, including the Three State Comparison Tool (https://www.ablenrc.org/compare-states/), Search by ABLE Program Features Tool (https://www.ablenrc.org/state-plan-search/), and the View All State ABLE Program Tool (https://www.ablenrc.org/select-a-state-program/).

Eligibility for ABLE Accounts

The ABLE Act limits eligibility to individuals with disabilities with an age of disability onset before their 26th birthday. An individual with a disability need not be under the age of 26 to be eligible for an ABLE account, but could be over the age of 26 and have documentation of a disability that indicates the onset of the disability occurred before the age of 26. Individuals who are already receiving SSI or SSDI benefits who meet the requirement of disability onset before age 26 are automatically eligible to establish an ABLE account.

An individual may only have one ABLE account at any given time. When an individual (or someone on behalf of the individual) establishes an account, the individual is the owner of the account, also known as the designated beneficiary.
ABLE Account Contributions

A contribution is the payment of funds into an ABLE account. Individuals must make contributions in the form of cash, check, money order, credit card, electronic transfer, or a similar method. Any person can contribute to an ABLE account. (“Person,” as defined by the Internal Revenue Code, includes an individual, trust, estate, partnership, association, company, or corporation.)

The total annual contributions that an ABLE account can receive from all sources is limited to the gift-tax exclusion in effect for a given calendar year. For 2020, that limit is $15,000. However, if a beneficiary is working, he or she can contribute earnings up to an amount equal to 100 percent of the previous year federal poverty level. The additional wage contribution is not allowed if the beneficiary’s employer made a contribution for him or her to an employer-sponsored retirement account.

Each ABLE program will have an account limit. The account limit is the maximum amount of money a beneficiary can have in their ABLE account. When a beneficiary’s account balance reaches the ABLE account limit, he or she will not be able deposit additional funds. Many ABLE program account limits are the same as the state 529 college savings plan account limits, ranging from $235,000 to $529,000.

ABLE Account Distributions

The Act permits designated beneficiaries to use funds in an ABLE account for qualified disability expenses (QDE), broadly defined as any expense the beneficiary has as a result of the disability. These expenses may include education, housing, transportation, employment training and support, assistive technology and related services, personal support services, health, prevention and wellness, financial management and administrative services, legal fees, expenses for ABLE account oversight and monitoring, funeral and burial, and basic living expenses.

The Interaction of ABLE and Means-Tested Federal Programs

The ABLE Act states ABLE accounts shall be disregarded when benefit agency staff determine a person’s eligibility for federal means-tested programs, or the amount of benefit assistance under those programs. Examples of federal means-tested programs include SSI, Medicaid,
Medicare Savings Programs, SNAP, and HUD subsidized housing programs.

- **ABLE Account Earnings:** The funds in an ABLE account can accrue interest, earn dividends, and otherwise appreciate in value. Federal means-tested programs will exclude any earnings an ABLE account accrues from income.

- **Third Party Contributions:** A payment made into an ABLE account is called a contribution. Third-party contributions are contributions made by persons other than the designated beneficiary. A third-party contribution is not income to the designated beneficiary.

- **Beneficiary Contributions:** Federal means-tested programs will continue to count income received by the designated beneficiary (such as wages) which he or she subsequently deposits into his or her ABLE account as income to the designated beneficiary in the month received.

- **ABLE Account Distributions:** A distribution from an ABLE account is not income but is a conversion of a resource from one form to another.

- **ABLE Account Balance:** Federal means-tested programs will exclude the ABLE account balance from resource limits, with one exception. The SSI program does not exempt the entire ABLE account balance. Instead, Social Security only excludes the first $100,000. A special rule applies when the balance of an SSI beneficiary's ABLE account exceeds $100,000. If the excess amount, whether alone or in combination with other resources, exceeds the resource limit, Social Security will suspend the beneficiary’s SSI without a time limit (as long as he or she remains otherwise eligible). The beneficiary’s SSI eligibility does not terminate after 12 continuous months of suspension.

- **Housing or non-qualified expenses:** For the SSI program, Social Security will count a distribution for a housing expense or for an expense that is not a QDE as a resource, if the designated beneficiary retains the distribution into the month following the month of receipt. If the designated beneficiary spends the distribution within the month of receipt, there is no effect on eligibility.
You can read more about the **SSI treatment of ABLE accounts at POMS SI 01130.740** (https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130740).


An ABLE account is a powerful tool individuals may use to accumulate assets. CWICs should be prepared to share general information about ABLE accounts.

### Favorable Tax Provisions, Tax Credits, and Tax Assistance

The Internal Revenue Service has several favorable tax provisions which include tax credits for workers with low to moderate incomes. These provisions include the Earned Income Tax Credit, the Child Tax Credit, IRS's Impairment-Related Work Expenses, and other provisions that increase refunds of taxes paid. Additionally, individuals can access free tax preparation services and assistance nationwide, which includes the Volunteer Income Tax Assistance (VITA), Taxpayer Assistance Centers, and Free file services available through the IRS.

The Earned Income Tax Credit (EITC) is a benefit for working people with low to moderate-income that encourages work, reduces the amount of tax an individual pays and may result in a larger refund on federal taxes. To qualify, individuals must meet certain requirements and file a tax return. The EITC is a federal tax credit, however at least half of the states in the nation have established state operated EITC that also supplements the federal credit.

Qualification for the amount of EITC in the 2019 tax year depends on income, marital status, and dependent children. Working individuals who
have incomes up to $15,570 can receive EITC. Working families with children and annual incomes below $56,000 may also qualify for EITC. The EITC is a "refundable tax credit," which means that if it exceeds a low-wage worker's income tax liability, the IRS will refund the balance. It encourages workers to increase earned income as it grows with each additional dollar of earnings until the maximum credit is received.

Similar to the EITC, workers with dependent children may benefit from the Child Tax Credit (CTC). The CTC provides taxpayers up to $1,000 for each dependent child under age 17 to offset the costs associated with raising children. This credit is available to not only low-income families, but also mid to upper-income families. Families receive a refund equal to 15 percent of their earnings above $3,000, up to $1,000 per child value.

The IRS allows individuals with disabilities to deduct Impairment-related work expenses for expenses necessary at the workplace or in connection to be able to work. Examples include attendant care services, reader services, and interpreter services. If an individual pays for these services out of pocket, he or she may claim these services as business expenses when filing federal income taxes.

Tax credits and deductions provide individuals with more income to pay for necessities, develop savings, purchase or maintain transportation necessary to commute to work or acquire additional education or training to boost their employability and earning power. Social Security does not expect CWICs to be tax experts. CWICs can make beneficiaries aware of provisions that will help to increase their income and promote employment and refer to services that will help address tax preparation and questions. Tax laws are complex and CWICs should remind beneficiaries of their obligation to file taxes when working. Across the nation, there are free tax preparation services to support individuals with disabilities.

The Volunteer Income Tax Assistance (VITA) program offers free tax help to people who generally make $56,000 or less, persons with disabilities and limited English-speaking taxpayers who need assistance in preparing their tax returns. IRS-certified volunteers explain the tax filing process to help taxpayers understand their tax returns and tax filing responsibilities and provide free basic income tax preparation with electronic filing services. VITA helps taxpayers get the most out of their tax refund and claim tax credits they may be eligible for, like the Earned Income Tax
Credit (EITC). Many VITA sites connect individuals to other resources like bank accounts, financial education or financial coaching.

There are over 11,000 VITA sites nationwide and these sites are generally located at community and neighborhood centers, libraries, schools, shopping malls, and other convenient locations. The IRS has a VITA Locator Tool online (https://www.irs.gov/individuals/find-a-location-for-free-tax-prep). Individuals may also call 800-906-9887. VITA tax sites offer services that are accessible to individuals with disabilities.

 Individual Development Accounts (IDAs)

IDAs are a great example of public policy that supports asset development. IDAs are special accounts that allow members of low-income groups (including persons with disabilities) to save for specific goals such as home ownership, small business ownership, or post-secondary education, while also receiving matching funds and financial counseling. An IDA participant identifies a specific asset that he or she would like to acquire and works with the IDA program to develop a savings plan that will make it feasible to reach the goal and ultimately purchase the asset. The individual then begins to deposit a certain amount of earned income on a regular basis, typically monthly, into an IDA account based on his or her plan.

A defining feature of IDAs is that participants are eligible to receive matching funds if they use their savings to purchase an eligible asset. The match rate is the amount that the IDA program contributes for each dollar that a participant saves. The rate varies greatly across IDA programs and can range anywhere from $1 to $8 of match for every $1 of earnings saved. For example, if a program has a $2 match rate for every $1 saved, each time a participant deposits $25 in his or her IDA account, the IDA program allocates an additional $50 in matching funds for their savings. Match dollars for IDAs come from many different places, such as government agencies, private companies, churches, or local charities. In most cases, donors can receive a tax deduction for contributions to IDAs. Depending on the program, the IDA program may place matching funds not into the individual’s IDA account during the savings period, but instead into a separate account until the person is ready to purchase his or her asset. When the account holder is ready, he or she uses both the savings and the match to purchase the asset. By
leveraging saved dollars against matched dollars, individuals are able to grow their savings more quickly and be successful in purchasing an asset with long-term return potential.

Programs that involve partnerships between local non-profit organizations and financial institutions usually offer IDAs. The IDA program recruits participants, and provides or arranges with community partner organizations to provide financial education classes for participants. They may also provide or arrange for IDA participants to receive one-on-one counseling and training. After signing up for an IDA program, each participant opens up an account with the partnering bank or credit union. The bank or credit union handles all transactions to and from the IDA, just as they do with other types of savings accounts. Each month, IDA participants receive a report telling them how much money (individual savings + match + interest) is accumulating in their IDA. An IDA program can be as short as one year or as long as five years. The program may disperse money to IDA participants as soon as they have reached their savings goal and as long as they have approval from the IDA program sponsor. Some IDA participants choose one big savings goal, such as a home, but others save for a number of related goals, such as textbooks and college tuition.

In general, IDA program eligibility is based on all or some of the following criteria:

- **Income:** Most IDA programs specify a maximum household income level for applicants. Maximum income levels are most often a percentage of the federal poverty guidelines (usually between 100 percent and 200 percent) or the area median income (usually between 65 percent and 85 percent).

- **Earnings:** Many IDA programs also require that all or part of savings come from earned income. A paycheck or the EITC refund is the most common source of earned income. Unemployment checks are also an allowable source in some IDA programs. Most IDA programs don’t consider as earnings any money a person receives as a gift.

- **Net Worth:** Some IDA programs also look at the household assets in addition to household income when they determine IDA eligibility.
While not an eligibility requirement for most IDA programs, poor credit history is typically a barrier to enrollment that applicants must address before they are able to establish an IDA. IDA programs will frequently assist individuals to address credit issues or refer them to a credit counseling center for this assistance prior to enrollment in the IDA program.

**Types of IDA Programs**

There are two types of IDAs. Some are federally funded; some have funding provided by other organizations. The Department of Health and Human Services, Administration for Children and Families (ACF) oversees the Assets for Independence (AFI) federal grant program. Congress has not appropriated funds for the AFI program since FY 2016, and previous grantees are phasing out their programs. Organizations operating AFI projects with existing grants are responsible for continuing to operate those projects for the funded project period indicated on the notice of their grant award. All federal funding for AFI IDA projects will cease after federal fiscal year 2021. To find the existing AFI grant projects, visit the [AFI project locator](https://www.acf.hhs.gov/ocs/afi-project-locator).

Around the nation, many non-federally funded IDA programs continue to serve low-income people and individuals with disabilities by offering various financial stability and asset building services. Programs that involve partnerships between local non-profit organizations and financial institutions usually offer IDAs. These partnerships may include economic and community development corporations, local government agencies, community foundations, education institutions, churches, local charities, coalitions, or social service centers, to name a few. The IDA program recruits participants and provides or arranges with community partner organizations to provide financial education classes for participants. They may also provide or arrange for IDA participants to receive one-on-one counseling and training.

To locate these IDA programs and learn the specific services offered in local communities, visit [Prosperity Now](https://prosperitynow.org/map/idas).

**Effect of IDA Participation on SSI Benefits**

Since January 1, 2001, when Social Security expanded its exemptions for funds held in TANF and AFI, also called “Demonstration Project” IDAs,
there is no negative effect on an individual’s SSI benefit for participating in those federally funded IDA programs. Funds in a TANF or Demonstration Project IDA program don’t count toward the SSI resource limit. Additionally, the IDA program matching deposits are excluded from income, and the earnings a beneficiary deposits into his or her IDA account are deducted from his or her wages in determining countable income.

IDAs funded through other means are not given the same exemptions. The IDA account may count toward the SSI resource limit, unless it is set up in such a way that it doesn’t meet the definition of resource. Social Security will count the earnings a beneficiary deposits into his or her IDA account as income using the regular SSI income counting rules. Social Security may count IDA matching funds as income to the beneficiary, depending upon how the funds are disbursed. Given these differences, you must determine the type of IDA program a SSI beneficiary is using, or plans to use, before you provide advisement.

**Effect of IDA Participation on Social Security Disability Benefits (SSDI, CDB, DWB)**

As described in Module 3, Title II disability benefit is an insurance program that an individual is entitled to based on past work in Social Security covered employment. A person may establish eligibility for benefits based on his or her own work record and insured status, or on the work record of a family member who has insured status and is disabled, retired, or deceased.

Eligibility for Title II disability benefits isn’t based on economic need and doesn’t have any restrictions on savings, investment, or asset accumulation. As a result, participating in an IDA won’t adversely affect an individual’s application or eligibility for Title II disability benefits. In addition to this, once a person has established eligibility for a Title II benefit, his or her earnings contributions to an IDA, matching funds, or interest earned won’t have any effect on the cash benefit amount. Social Security doesn’t penalize individuals receiving a Title II benefit for having cash savings, IDAs, pension funds, retirement accounts, real property, or other investments to rely upon in addition to their Social Security disability payment and Medicare coverage. Given this, IDAs are a perfect asset-building vehicle for these beneficiaries.
Conclusion

Asset development programs present Social Security disability beneficiaries with unique opportunities to accumulate wealth and save for long-term goals. CWICs are in an optimal position to assist beneficiaries to take advantage of these savings vehicles, educating them about the effect of these programs on Social Security disability benefits and other publicly funded benefits.

Conducting Independent Research

**ABLE National Resource Center**  (https://www.ablenrc.org/)

**Child Tax Credit and Credit for Other Dependents at a Glance**  (https://www.irs.gov/credits-deductions/child-tax-credit-and-credit-for-other-dependents-at-a-glance)

**Earned Income Tax Credit**  (https://www.irs.gov/credits-deductions/individuals/earned-income-tax-credit)

**Internal Revenue Service VITA Locator Tool**  (https://www.irs.gov/individuals/find-a-location-for-free-tax-prep)

**IRS Information for People with Disabilities**  (http://www.irs.gov/Individuals/More-Information-for-People-with-Disabilities)


**AFI Project Locator**  (https://www.acf.hhs.gov/ocs/afi-project-locator)

**Prosperity Now IDA Program Locator**  (https://prosperitynow.org/map/idas)

**Social Security POMS Links:**

b. **SI 00830.670 Exclusion from income and resources of Demonstration Project IDAs (AFI IDAs)**
   (https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830670)

c. **SI 00830.665 Exclusion from income of TANF-funded IDAs**
   (https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830665)

d. **SI 01130.678 Individual Development Accounts (IDAs) – TANF Funded**
   (https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130678)

e. **SI 01130.679 Individual Development Accounts (IDAs) – Demonstration Project**
   (https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130679)
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Module 6 – Providing Effective WIPA Services

Introduction

Being highly competent in terms of understanding Social Security benefits, other federal benefit programs, and associated work incentives is only part of providing high-quality WIPA services. CWICs must also master the application of this information in their day-to-day work with beneficiaries and other concerned parties. The practical application of public benefits and work incentives knowledge includes identifying and prioritizing eligible beneficiaries; providing effective information and referral services, conducting initial information-gathering interviews; developing written Benefits Summary & Analysis (BS&A) reports and Work Incentives Plans (WIP); facilitating the use of necessary and appropriate work incentives; conducting proactive long term follow-up; and applying effective time management strategies.

CWIC Core Competencies Addressed

- Demonstrates the ability to deliver WIPA services using the “Employment Progression” approach characterized by “just-in-time” provision of services that are customized to meet the unique work incentive counseling needs of beneficiaries at the contemplative, preparatory, job search, and employment stages of the employment continuum.

- Demonstrates the ability to identify WIPA eligible beneficiaries, triage services to high-priority beneficiaries, provide information and referral services, conduct initial information-gathering interviews, and verify all benefits received.

- Develops comprehensive individualized Benefits Summary and Analysis (BS&A) reports and customized Work Incentives Plans (WIPs) that reflect counseling contained in the BS&A.

- Demonstrates the ability to facilitate the use of necessary and appropriate work incentives: Impairment Related Work Expenses
(IRWE); Blind Work Expenses (BWE); Student Earned Income Exclusion (SEIE); Subsidies; Plan to Achieve Self Support (PASS); Expedited Reinstatement (EXR); etc. at each stage of the employment process, which supports the achievement of employment and financial stability goals.

- Demonstrates the ability to deliver proactive ongoing WIPA services as a collaborative member of each beneficiary’s employment support team that facilitates the achievement of paid employment or self-employment, supports employment retention over time, fosters future career advancement, and increases financial independence.

- Demonstrates the ability to counsel beneficiaries on the importance of reporting earnings to Social Security, strategies for earnings reporting, and tracking their progress through the Trail Work Period (TWP), Extended Period of Eligibility (EPE), and other work incentives.

- Practices effective time management and efficient service delivery techniques, which ensures staff direct their efforts towards high-priority WIPA candidates and focus on delivering individualized WIPA services that promote employment and increase financial stability.
Competency Unit 1 – Managing Initial Requests for WIPA Services

Introduction

When managing requests for service, CWICs must stay clearly focused on providing work incentives planning and assistance that promotes employment and enhances financial independence. Remember, the purpose of the WIPA program is to:

- Support Social Security disability beneficiaries who choose to work by providing accurate and complete information about work supports and work incentives;
- Support beneficiaries in successfully maintaining paid employment (or self-employment) over time, by helping beneficiaries anticipate benefit changes and the need to report earnings, and helping them retain essential supports; and
- Provide work incentives counseling that enables beneficiaries to increase their earnings capacity and decrease reliance upon public benefits.

Unfortunately, when you are subjected to sincere (and sometimes urgent) pleas for help related to cash benefits and health insurance, it’s all too easy for callers who have needs completely unrelated to employment to sidetrack you. Social Security doesn’t expect WIPA projects to be all things to all beneficiaries. Social Security has developed very clear boundaries for you to follow in terms of who to serve and what type of services to deliver. This unit will describe these boundaries in detail and will give specific advice about when and how CWICs should enforce those boundaries.

Social Security can’t be there to enforce the limits of WIPA services with every caller. This is something you must be disciplined enough to do independently and something that WIPA Project Managers must monitor closely. You must treat your time and expertise as a precious commodity reserved for those individuals for whom it’s intended. If you provide services to people who are ineligible, spend time resolving benefits problems for individuals with no interest in employment, or assist in areas
that are beyond your scope of work, you’ll have less time available to perform the services Social Security requires.

Organizing WIPA Personnel to Effectively Handle Initial Calls

Social Security doesn’t specify how WIPA projects should assign staff to handle incoming service requests. While a number of methods may get the job done, we recommend that WIPA projects implement a centralized point of intake to answer the majority of initial calls. A centralized intake system has three distinct advantages:

1. Centralized intake systems save valuable staff time. When all initial calls come into one location, trained and specialized staff can screen for eligibility and priority level in an efficient manner. Initial call staff can handle eligible callers with less important and urgent needs directly by providing information over the phone and delivering supplemental materials by email or mail. A centralized intake line can send high-priority eligible callers who require individualized counseling directly to a CWIC for more intensive ongoing services. Keep in mind that all staff members who dispense benefits information during initial calls must complete the full CWIC certification process. Social Security doesn’t permit WIPA projects to use non-certified personnel to perform this function.

2. When projects handle all initial requests for WIPA services centrally, results tend to be more consistent. When only one or two people perform this critical function, there is less opportunity for uneven or improper beneficiary screening and triage.

3. Centralized intake reserves scarce certified CWIC time for services closest to the WIPA program mission — promoting work and enhancing financial stability. By removing most of the CWICs from the time-consuming task of sorting through initial calls, WIPA projects save their valuable expertise and time for more intensive functions —
providing individualized work incentives planning and assistance and ongoing follow-up.

If it isn’t possible to centralize all initial call screening into one staff position, another option would be to share this function across a limited number of CWICs on a regular rotating schedule. Projects can maintain a toll-free line for all initial calls but may have the line forwarded to different staff members on a pre-determined schedule. CWICs could take turns staffing the toll-free line on a weekly basis, freeing up the remaining staff members to deliver intensive WIPA services.

Another option that will help reduce the number of ineligible or low-priority callers that access CWICs directly is to route all initial requests for WIPA services through the Ticket to Work Help Line. In fact, in the current WIPA Terms and Conditions document, Social Security requires WIPA projects to include the Ticket to Work Help Line contact information as the primary contact for beneficiaries on websites, in brochures, and within presentations to the greatest extent possible consistent with the WIPA business model. Help Line professionals have been trained on WIPA eligibility and priorities, and they can serve as an initial source of beneficiary screening and triage. They can also handle some of the basic information and referral needs that callers present. WIPA projects that choose this course of action will need to inform all referral sources of this important procedural change.

As you can see, there are numerous organizational options for handling initial requests for service that are far more efficient than having all CWICs perform this function simultaneously. For any of these strategies to be successful, WIPA projects must take the following important steps:

- WIPA personnel who handle initial requests for service must have a high level of knowledge about the local disability services system as well as benefits and work incentives. Because the screening and triage position involves considerable decision-making ability and affects overall program outcomes, WIPA personnel conducting triage must demonstrate significant competence. It’s critically important that only skilled and experienced CWICs perform this function.

- CWICs conducting triage must be thoroughly trained on the WIPA priority groups and how to interview callers to determine eligibility and priority level. Projects need to design and
implement call scripts that ask the right questions, right away. Protocols for handling initial requests for service should be in writing, and WIPA projects should implement them consistently.

- WIPA Project Managers must monitor initial contacts to ensure that staff members apply the WIPA priorities consistently. Managers should also alter call flow and protocol, if necessary, to ensure consistency and appropriateness of referrals to staff providing intensive individualized services. If you need help doing this, contact your VCU NTDC Technical Assistance Liaison to discuss the situation.

**IMPORTANT:** The current WIPA service model challenges CWICs to reduce the amount of time they spend delivering generic information and referral (I&R) services and increase in-depth, individualized services they deliver over a longer period of time. Under this service design, WIPA projects may serve fewer beneficiaries, but will provide services that are more employment focused and intensive, and of longer duration. **The only way CWICs can reduce time they spend with low-priority beneficiaries who typically present with I&R needs** is to educate their referral sources and revise their outreach materials so they receive a higher percentage of appropriate referrals.

Although the centralized intake system works efficiently, WIPA projects shouldn’t implement this system in an inflexible and dogmatic manner. Local community partners and beneficiaries already receiving individualized WIPA services should still be able to access CWICs directly as needed to answer questions. In addition, if your project uses the Ticket to Work Help Line as the single point of initial contact, don’t refer beneficiaries back to that line if callers make direct contact with you. Beneficiaries can get very frustrated by being referred to numerous agencies, and this would be considered poor customer service. WIPA projects must make every effort to keep access to services simple, with as few barriers as possible.
Managing and Prioritizing Initial Requests for Services

Centralized call screening should accomplish the following tasks in this order:

1. Determine who meets WIPA eligibility criteria: The triage process begins with determining eligibility for WIPA services. Not everyone who contacts a WIPA project will be eligible for services. Social Security requires WIPA projects to limit their services to eligible individuals.

2. Determine the priority level of eligible individuals: Once staff establishes the caller is eligible, determine where the caller is on the employment continuum. Placement on the employment continuum determines if the caller is a high priority for individualized WIPA services, or is more suited to receive generic short-term I&R services.

3. Determine which high-priority beneficiaries have an urgent need: For eligible high-priority beneficiaries who are appropriate for individualized WIPA services, determine what type, intensity, and duration of services would best meet the presenting needs. Of particular importance is identifying which high-priority beneficiaries have an URGENT need for WIPA services. Serve high priority beneficiaries with urgent WIPA services needs first.

You shouldn’t move forward with service delivery until you have completed all three tasks.

Step 1: Determining Who Meets WIPA Eligibility Criteria

Individuals must meet the following criteria to be eligible for WIPA services:
• At least age 14, but not yet full retirement age\(^1\),
• Disabled per Social Security’s definition, and
• Already receiving (or approved to receive) Social Security benefits based on disability (SSI or a Title II disability benefit such as SSDI, CDB or DWB), or
• Receiving Medicaid While Working under 1619(b) of the Social Security Act, or
• Receiving only SSI State Supplementary Payment (SSP), or
• Receiving Medicare under the Extended Period of Medicare Coverage (EPMC) as a former beneficiary of the Title II disability programs (SSDI, CDB, DWB) or as a Medicare Qualified Government Employee (MQGE) who receives Medicare based on disability.

**Important Eligibility Considerations:**

• Beneficiaries don’t have to be employed, have a current job offer, or be actively engaged in a return-to-work effort in order to be eligible for WIPA services. While it’s true that Social Security considers beneficiaries who aren’t preparing for or actively pursuing work to be a lower priority for individualized WIPA services, these individuals are still eligible for the program. CWICs must clearly understand that eligibility for WIPA services is NOT determined by placement on the employment continuum.

• At times you may receive referrals for individuals who receive Veterans Administration (VA) disability benefits, Black Lung benefits, Worker’s Compensation, or other federal benefits. These individuals may also be receiving (or be approved to receive) benefits based on disability from the Social Security Administration and are therefore eligible for services.

• A beneficiary who has received initial notice that Social Security considers him or her to be engaging in SGA is also eligible for WIPA services. This initial notice (Notice of Proposed Decision)

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\(^1\) **NOTE:** Full Retirement Age (FRA) varies depending when individuals were born. To identify the FRA for various birth dates, go to [POMS RS 00615.003 Full Retirement Age](https://secure.ssa.gov/apps10/poms.nsf/lnx/0300615003), or search for “full retirement age” or normal retirement age” on [ssa.gov](https://www.ssa.gov).
provides the beneficiary with an opportunity to submit additional evidence if he or she disagrees with the initial decision. If Social Security personnel made the SGA determination without consideration of all of the evidence or applicable work incentives, the beneficiary is likely to need WIPA services to gather the correct information. This type of caller has needs related to work incentives, and WIPA projects should provide him or her with intensive services right away.

- To be eligible for WIPA services, an individual must be already receiving (or be approved to receive) Social Security benefits based on disability. Social Security pays many benefits for entitlement based on factors other than disability, such as retirement, child’s benefits, and benefits paid to the spouse or widow(er) of someone who paid into the Social Security system through work. CWICs must be able to tell the difference between individuals who receive a Social Security benefit based on disability and those who do not.

- There are some important eligibility distinctions for people age 65 or older: Most individuals who are over full retirement age (FRA) will be receiving retirement benefits even if they once received SSDI benefits. In the Title II program, individuals who receive Childhood Disability Benefits (CDB) don’t automatically convert to the retirement system when they reach full retirement age. CDBs don’t “age out” of the disability program. Some CDBs may receive a retirement benefit if they have worked in the past and have established insured status for the Social Security retirement program, but not all will have this option. Therefore, it’s important to remember the disability benefit rules when CDBs reach full retirement age. Individuals beyond FRA who continue to receive Childhood Disability Benefits are eligible for WIPA services.

- In the SSI program, individuals meet entitlement regardless of disability after age 65, but they may be entitled under multiple eligibility categories (see POMS SI 00501.300). Current regulations instruct Social Security personnel to use the entitlement category that is most advantageous to the individual. If an individual was entitled to SSI due to disability at least one month prior to attaining age 65, he or she is eligible
to keep the Disabled Individual (DI) or Blind Individual (BI) category of entitlement after turning 65. These individuals are still eligible for WIPA services, even though they are over age 65.

• In most cases, individuals must be receiving a monthly cash payment from Social Security in order to be eligible for WIPA services. For example, some SSI recipients lose entitlement due to non-disability related reasons such as excess unearned income or resources. Social Security doesn't terminate people like this from the SSI program right away, but rather places them in a 12-month suspension period. Individuals in a 12-month suspension are NOT eligible for WIPA services. However, individuals in 1619(b) status don’t receive monthly cash payments, but they are eligible for WIPA services. This is because Social Security still considers people in 1619(b) status to be “SSI eligible”.

• Certain individuals who no longer receive a Title II disability benefit also remain eligible for WIPA services. This applies to Title II disability beneficiaries who aren’t receiving cash benefits due to Substantial Gainful Activity (SGA) level work, but who are still in the Extended Period of Eligibility (EPE) or the Extended Period of Medicare Coverage. Social Security still considers these individuals to be disabled and continue to be subject to medical Continuing Disability Reviews (CDRs).

• Individuals who have been found no longer disabled after a medical continuing disability review (CDR) are typically terminated from benefits. Many individuals appeal these determinations. Remember that if an individual files an appeal of an adverse medical determination within 10 days of the notice, benefit payments may continue while the appeal is being processed. **Individuals receiving benefit payments pending an appeal aren’t eligible for WIPA services.**

We have provided a convenient list on WIPA service eligibility in the Additional Resources section of this unit. This [WIPA Eligible or Not?](https://vcu-ntdc.org/resources/WIPA_OtherResources/WIPAEligibleorNot2019.pdf) list is available in the Resources section of the VCU NTDC website. This list is an excellent tool for you to use when making eligibility
determinations that you may also share with community agencies to help with making appropriate referrals.

**Methods for Determining Eligibility**

Although determining whether a caller is eligible for services sounds like a simple task, it can sometimes be more difficult and time consuming than it first appears. You must remember that establishing eligibility for WIPA services is the first and most important task to accomplish during the first few minutes of an initial call.

**NOTE:** Determining WIPA eligibility is straight forward for people referred by the Ticket to Work (TtW) Help Line. If the TtW Help Line referred the person, you can find the type(s) of Social Security benefit listed in the encrypted referral email. In these cases, you should confirm the type of benefits received with each person. If there are discrepancies between what the beneficiary says he or she receives and what shows in the referral section, ask additional questions to clarify.

It’s imperative that you take charge of the conversation at the very beginning by asking direct, yet courteous questions that will determine the caller’s potential eligibility for services. Some possible questions to ask would include:

- Can you tell me what type of benefits you get from Social Security?
- Do you know if you get Social Security disability benefits (SSDI) or SSI?
- Do you get more than one benefit payment from Social Security each month?
- How much is your Social Security payment?
- Do you know if your benefits are based on your past work, or do you get benefits from the earnings record of a parent or a spouse?
- Do you know if you have Medicare or Medicaid health insurance? **Note:** If they don’t know, have them describe their insurance card. Is it white with a red white and blue stripe? Is it (whatever color of card your state uses for Medicaid)?
These questions are just a beginning. Depending on how the individual responds, you may need to ask additional probing questions to determine exactly what type of benefits the individual is receiving and whether or not the benefit is based on disability. In the overwhelming majority of cases, you’ll be able to ascertain if a caller is eligible by using phone interview techniques.

**NOTE:** WIPA projects should use some type of written format to structure questioning during initial interviews to make certain CWICs ask all essential questions in the proper order. We have provided a sample format you can use to structure your initial interviews called “**WIPA Initial Interview Guide**” at the end of Unit 3 and on the VCU NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=197)

If you can’t determine eligibility by asking the questions presented above, another alternative for verifying basic Social Security benefit information is the “my Social Security” online portal system. Beneficiaries can go to Social Security’s website and create a personalized account that they can use to print a benefit verification letter. The beneficiary will also be able to see his or her record of annual earnings, benefit amount, and payment information. Beneficiaries can also change their address, phone number, and direct deposit through this portal. Beneficiaries can sign in or create an account using the following link: [www.ssa.gov/myaccount](http://www.ssa.gov/myaccount)

Finally, if you are unable to confirm benefit type using the strategies outlined above, you can request a Benefit Verification Letter from Social Security. This can be done in several ways. First, the beneficiary may call Social Security’s toll-free line (1-800-772-1213) and request that a Benefit Verification letter be mailed or faxed directly to the CWIC. Another, more time-consuming approach, is to send the caller a standard Social Security release of information form through the mail or by email with a self-addressed, stamped envelope the person can use to return the signed release to you. The signed release can then be sent to the local office with a request for a Benefit Verification Letter. The beneficiary may also opt to obtain a Benefits Planning Query or BPQY from Social Security. The BPQY and strategies for obtaining it are discussed in detail in the following unit.
What to do about Ineligible Callers

CWICs are often uncertain about how to proceed once they’ve determined that a caller isn’t eligible for WIPA services. While it’s never appropriate to simply dismiss callers by informing them that they are ineligible and abruptly ending the call, you must also be careful not to err in the opposite direction. Spending significant amounts of time working with ineligible callers isn’t appropriate, given the amount of work there is to do for those beneficiaries who are eligible for services and are presenting needs close to the WIPA mission.

As soon as you determine ineligibility, you should ask the caller what the presenting need is and recommend alternate referral sources that could potentially assist the individual. Below is an example of how to handle a caller who is ineligible for WIPA services in a professional and courteous manner:

Example of how to handle an ineligible caller:

Suzy CWIC is on the phone with Ernest, who is currently in the process of applying for Social Security disability benefits. Ernest says that his attorney assures him that he will be awarded benefits, and he has heard about the Ticket to Work program, so he is planning to begin work at a local restaurant next week. He wants Suzy to tell him how much he can make without risking eligibility for benefits. Ernest is very insistent that Suzy tell him the specific amount he can earn.

The best response for Suzy is to give Ernest a quick overview of the services the WIPA program offers and explain the eligibility criteria. After this explanation, Suzy could then refer Ernest back to his attorney as well as to the local Social Security office for further information. Prior to closing the call, Suzy should invite Ernest to call back once he is actually awarded disability benefits so that a CWIC can talk to him about the impact of work and his options. CWICs should always thank the individual for calling.

It’s important to be polite and professional when assisting ineligible callers without allowing these calls to demand an unreasonable amount of
time. There is a delicate balance between being courteous and safeguarding the boundaries of WIPA eligibility.

**Step 2: Determining the Priority Level of Eligible Individuals**

Once you determine that an individual is eligible for WIPA services, the next step is determining whether or not the beneficiary is a high priority for individualized WIPA services, or is more appropriate for short-term information and referral (I&R) services. Sorting of eligible beneficiaries into the two service groups is a very important part of a CWIC’s job. It requires a clear understanding of the differences between these two types of services.

**Comparison of I&R and Individualized WIPA Services**

Generally, CWICs address I&R needs by providing basic summary information about benefits, work incentives, programs or services. This type of service typically doesn’t require extensive information gathering or verification of benefits. Most often, CWICs handle I&R requests by one or two phone or email contacts with the beneficiary. In some instances, CWICs may supplement the information provided during phone or email communication with printed resources. I&R services are short term in nature and do not involve repeated contacts with the beneficiary. More detailed information about providing effective I&R services is available in Unit 2 of this Module.

In contrast, individualized work incentives planning and assistance requires CWICs to gather specific information about the individual beneficiary and perform customized analysis, informational support, and counseling. For most beneficiaries receiving individualized WIPA services, CWICs provide a written summary of the customized analysis known as a Benefits Summary and Analysis (BS&A) report. CWICs generally follow the written BS&A with direct assistance and support to resolve problems or apply work incentives. CWICs typically provide this assistance over a period of weeks, months, or even years. Often, a CWIC and beneficiary use a document called Work Incentives Plan or WIP to guide the services over time. More detailed information about providing effective individualized WIPA services is available in Unit 3, 4 and 5 of this Module.
The priority groups covered in the unit provide the basis on which CWICs sort beneficiaries into the two primary service groups: those receiving only I&R services and those receiving individualized WIPA services.

**Understanding the WIPA Priorities**

Social Security developed the WIPA priority groups to help CWICs manage requests for individualized, intensive, ongoing work incentives counseling services. Social Security expects WIPA projects to prioritize individualized WIPA services to eligible beneficiaries who fall into two groups:

**Priority Group 1:** Individuals who are currently working or engaging in self-employment and have both a need for and interest in receiving individualized work incentives planning and assistance services. Priority group 1 also includes transition age youth. Social Security defines transition age youth as being at least 14 years old through the age of 25. You should prioritize transition-aged youth even if they are in the earlier stages of considering work or preparing for work. Social Security considers youth a separate high priority category.

**Priority Group 2:** Beneficiaries who are actively pursuing employment or self-employment and who are interested in receiving individualized work incentives planning and assistance services. This group includes:

- Beneficiaries with a clear employment goal who are conducting an active and regular job search. Active and regular job search is defined as searching for job openings on at least a weekly basis (using online job postings or other sources), submitting applications or resumes, and participating in job interviews.

- Beneficiaries with a clear employment goal who have taken active steps to prepare for achieving that goal. Beneficiaries who have taken active steps to prepare for employment or self-employment would include individuals who:
  a. Have an approved PASS, a pending PASS, or are good candidates for PASS development;
  b. Are participating in an education or training program related to the employment goal;
  c. Have a Ticket assigned (or “in use”) with the State Vocational Rehabilitation (VR) agency or an Employment...
Network (EN) with a signed Individualized Plan for Employment (IPE)/Individual Work Plan (IWP) and are actively engaged in the services stipulated in the plan;

d. Are in the process of developing a business plan, securing financing for business start-up, or otherwise preparing to pursue the self-employment goal;

e. Are participating in a work-study program, On-the-Job Training (OJT) opportunity, apprenticeship, paid or unpaid internship, or other job preparation program.

**IMPORTANT:** In order to be a member of Priority Group 2, a beneficiary must have a clear employment or self-employment goal. If the beneficiary needs assistance with career exploration, he or she wouldn’t meet the criteria for this group.

Keep in mind that members of these two high-priority groups must have an interest in receiving individualized, employment-focused benefits counseling. You wouldn’t consider a beneficiary who is employed or actively pursuing employment but who only wants assistance with non-employment-related benefits issues a high priority. Be careful when trying to determine this. Never assume that a caller who begins by asking questions about benefits issues unrelated to employment is inappropriate for work incentives planning and assistance services. Beneficiaries may have many benefits issues they need help with, and questions related to employment may only be a part of the puzzle. Be sure to explain the mission of the WIPA program and describe the valuable information and support you can provide. Ask the beneficiary if he or she is interested in receiving individualized benefits analysis to find out how his or her unique employment or earnings goal might affect his or her benefits. If the beneficiary isn’t interested, be sure to politely ask the caller to explain his or her reasons. You may need to sell the idea of WIPA services to the beneficiary in some cases. Don’t give up too easily, especially with a beneficiary who is already working. Use your best persuasive skills to encourage the beneficiary to participate.

**IMPORTANT:** Social Security doesn’t prohibit WIPA projects from serving beneficiaries who are a lower priority. The agency established the priorities because it recognizes that WIPA projects have limited staff and fiscal resources.
The high-priority groups include individuals who are closest to employment and most at risk of experiencing benefit problems if wages and work incentives aren’t properly reported or developed. Social Security permits WIPA projects to provide individualized services to beneficiaries who are a lower priority as they deem appropriate and as time permits.

**What to do about Eligible Beneficiaries Who are a Low Priority for WIPA Services**

Obviously, not everyone who contacts you will meet the criteria for Priority Groups 1 or 2. You may receive a great many requests for services from individuals who have only begun to think about the possibility of going to work for the first time, or returning to work. Most of these individuals would be in the “contemplative stage” of the employment continuum. In most cases, beneficiaries at this stage have no clear vocational goal and have taken few, if any, steps to prepare for employment. Beneficiaries at the contemplative stage may feel ambivalent about the possibility of work and fear the impact of paid employment on benefits. Common identifying characteristics of people in the contemplative stage of employment include the following:

- Beneficiaries may have attempted to work since they became entitled to benefits and may have had a bad experience with benefits.
- Individuals typically don’t have clear employment goals, may be unsure how much they are able to do, given the effects of the disabling condition(s), or may be unable to perform the type of work they did in the past and will express confusion about what other options are available.
- Beneficiaries haven’t taken steps to prepare for employment, there has been no attempt to access services from the VR system or any other employment services providers or are unaware of the disability services system or what services may be available to help with returning to work.
- Beneficiaries haven’t taken steps to gain additional training or education.
Another group of beneficiaries whom Social Security considers a lower priority are those who indicate that they have no interest in working at the current time. These individuals typically state this fact pretty clearly and generally have one or more well-thought-out reasons for this decision. In some cases, the individual’s health status may make it difficult for him or her to withstand the rigors of employment, while in other cases the beneficiary may have opted not to work in order to care for young children or an elderly parent. Take the time to probe beneficiaries in a sensitive manner about their reasons. There are many well thought out reasons beneficiaries have for deciding not to work at any given time, and you have to respect these choices. You don’t want to judge beneficiaries harshly for choosing not to work when they experience or perceive major barriers to employment.

Sometimes, beneficiaries say they aren’t interested in working because they are fearful about how paid work will affect benefits. In addition, some individuals say they aren’t interested in employment because they simply aren’t sure what they are able to do, or would require significant workplace supports in order to be successful. These are people who need information and that’s something you can provide. When you encounter beneficiaries like this, don’t be afraid to talk about the value of paid employment in the lives of individuals with disabilities. In a sense, you are an employment cheerleader. You should actively share the benefits of employment with the people you serve. You should view every interaction with a beneficiary as an opportunity to promote the advantages of working.

The best way to encourage beneficiaries who aren’t interested in employment is to focus on how employment affects Social Security disability benefits. When talking to beneficiaries at this stage, focus on the following points:

- Help beneficiaries think about whether or not they are physically and emotionally ready to work. Make sure they know that it’s possible to attempt work for a period of time and not lose benefits.
- Anyone who wants to work CAN work, given appropriate services and support.
- Discuss barriers to employment and offer information about services and supports that could help overcome these barriers.
• Refer beneficiaries who need vocational counseling or other employment support to agencies providing those services.

• Help beneficiaries understand that they could be better off financially if they work.

• Explain that Medicare, Medicaid, and other programs have protections that may permit them to keep health insurance even if they earn high wages. Don’t forget to mention that there are more options for accessing healthcare now through the Affordable Care Act (ACA).

• Leave the door open to future contact from the beneficiary by making sure callers know how to reach you if they change their mind or want additional information.

CWICs shouldn’t simply dismiss beneficiaries who are a lower priority for WIPA services. Remember that you still have an obligation to provide basic information and referral services to all eligible individuals, regardless of priority level. By providing a bit of encouragement, targeted information, and counseling now, some beneficiaries may later decide that work is a viable option. Be sure to encourage the beneficiary to contact you again for individualized WIPA services when he or she makes the decision to pursue employment and has a clearer earnings goal. Detailed information about providing effective I&R services is provided in Unit 2 of this module.

**Step 3: Determining Which High-Priority Beneficiaries Have an Urgent Need for WIPA Services**

In his famous book, *Seven Habits of Highly Effective People*, author Steven Covey describes a time management matrix governed by analyzing activities by two essential criteria — urgency and importance. Covey describes “urgency” as something that requires immediate attention. Urgent matters are usually very visible; they press on us — they insist on action. In contrast, he describes “importance” as being related to results. When something is important, it contributes to your mission, your values, and your high-priority goals. Covey’s premise is
that too many people focus too much time on activities that may be urgent but aren’t actually important.

We can apply this same premise when we examine how to decide which beneficiaries to work with first, what services beneficiaries need over what period, and what methods to deliver services. Like most people, CWICs tend to spend too much time responding to the urgency of the initial caller instead of focusing counseling efforts on beneficiaries who present important issues that contribute to employment and financial independence. Keep in mind that we are defining “importance” as it applies to WIPA priorities. The issue is important to the caller, or he or she wouldn’t have contacted you.

When prioritizing WIPA services, the “importance” of a presenting need relates directly to where the caller is on the employment continuum. In this context, a person who isn’t interested in working or who is just beginning to think about working at some undetermined point in the future would have presenting needs that are less "important" for WIPA services than an individual who is actively seeking employment or already employed.

We should also look at how "urgency" (as Covey defines it) comes into play in WIPA services. Issues that are pressing, immediate, or time sensitive are urgent. An example of this is a working beneficiary who must submit accurate information for a pending work CDR and needs your help understanding the requirements. Beneficiaries with high-urgency needs would include beneficiaries whom Social Security has determined to be engaging in SGA because Social Security didn't know about work incentive use, and the beneficiary has a very limited time to appeal this determination. It would also include employed individuals who have been offered a promotion and need immediate information about how the increased earned income will affect cash payments and health insurance.

**Finally, put both urgency and importance together.** The best way to think about this is to visualize a square divided into four quadrants:

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<tr>
<th>Quadrant 1</th>
<th>Quadrant 3</th>
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<tbody>
<tr>
<td>Low Importance – Low Urgency</td>
<td>High Importance – Low Urgency</td>
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<th>Quadrant 2</th>
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<td>Low Importance – High Urgency</td>
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People who manage their time effectively try to minimize their activity in Quadrants 1 and 2 while maximizing activity in Quadrants 3 and 4. The object is to focus more on the importance of an activity rather than the urgency of an activity – at least to the greatest extent possible and practical. Quadrant 1 would be characterized by eligible callers presenting needs of low importance, meaning not closely related to the purpose and mission of WIPA services and of low urgency (things that aren't time sensitive or pressing). These callers would generally receive services of the lowest intensity and duration. In most cases, you would provide a beneficiary with low-importance and low-urgency needs basic information and referral services.

In contrast, Quadrant 4 contains activities that are both important and urgent. You should respond quickly to meet those needs. Beneficiaries with needs in this quadrant may also require the most intensive follow-up and support. Quadrant 4 would include beneficiaries who meet the criteria for Priority Groups 1 or 2 AND who have urgent needs that must be met quickly. Quadrants 2 and 3 would fall somewhere in between these two extremes.

To help put this framework into practice, the following list contains examples of presenting needs beneficiaries may have and illustrates how you would sort these needs by urgency and importance. Deciding which quadrant a beneficiary’s needs fall into isn’t an exact science — there are few black and white answers. You must use your best judgment in applying the broad principles presented here when you determine levels of importance and urgency.

**Quadrant 1: Low Importance and Low Urgency**

- Caller is the mother of an SSI recipient who states her son isn’t capable of working due to the severity of his disability. He has a reduced monthly SSI payment and would like information on how to receive the full Federal Benefit Rate (FBR).
- Caller is on SSDI and is contemplating marriage. Caller isn’t currently considering working but wants to know how marriage would affect benefits.
- Caller is 62 years old and wants to know if early retirement would be more beneficial than disability. Caller has been a homemaker since she became disabled, and has no interest in working.
• Caller just became eligible for SSDI and states she is still too ill to work. She has questions about when Medicare coverage will begin and how to meet her healthcare needs in the meantime.

**Quadrant 2: Low Importance and High Urgency**

• Caller isn’t interested in employment but has just received notice from Social Security that she is being terminated due to medical recovery. She relies on this check to pay all of her expenses and is very upset.

• Caller is unable to work due to severe health problems and receives attendant care services through the Home and Community Based Services (HCBS) Medicaid waiver. He has received an inheritance and is at risk of losing Medicaid coverage due to excess resources.

• Caller has worked part-time in the past, but his disability has worsened and he had to resign. He may need to move to a nursing facility for an extended period of time and wants to know if this will affect his SSI.

• Caller is the representative payee of an SSI recipient who has just received a letter from Social Security indicating that she has been overpaid by a substantial amount due to unearned income, which wasn’t reported. The beneficiary is in a non-vocational day program and isn’t seeking paid employment.

**Quadrant 3: High Importance and Low Urgency**

• Concurrent caller recently began actively seeking employment but needs help with transportation. The CWIC determines he is a possible PASS candidate.

• Caller has a goal of self-employment but is unsure how to realize this goal and is worried that owning his own business will cause the loss of SSI and Medicaid.

• Caller just began a two-year vocational-technical program paid for by the State VR agency. She needs help paying certain costs and wants to know how employment in her field would affect her benefits.
• An SSDI caller just began a part-time job earning approximately $500 per month. She hasn’t reported this income to Social Security yet. She would like to increase her hours but is unsure how this would affect her benefits.

Quadrant 4: High Importance and High Urgency

• Caller has a job offer and needs immediate assistance to understand how the job will affect cash benefits and public health insurance.

• Caller is considering a promotion at work but needs information about how the promotion would affect benefits.

• Caller has received a letter from Social Security saying that he is no longer disabled due to Substantial Gainful Activity (SGA)-level work activity. Caller is considering quitting his job and seeks immediate information on how countable earnings are determined.

• Caller works and earns enough money to cause the cessation of his SSI cash payments. He just received a letter from the state Medicaid agency that his Medicaid will stop as well.

• Caller works part-time and receives services through a Medicaid waiver program. The state Medicaid agency has determined that the caller will need to pay “patient liability” to the waiver provider, which would consume almost all of his wages.

Using Importance and Urgency to Plan Delivery of WIPA Services

There is a practical reason for making these determinations. They help you decide how to move forward in delivering WIPA services. Importance and urgency ratings should help you answer the following questions:

• **Type and Intensity of Services**: Does this person need individualized benefits analysis with work incentives planning and assistance, or will generic information and referral services meet the presenting needs?

• **Duration of Service**: Will this beneficiary require multiple contacts or extensive follow-up over time to meet the presenting needs?
The answers to these questions should provide the direction in terms of mapping out future service delivery and will drive the amount of information gathering you’ll need to undertake.

Under the current WIPA service model, Social Security has made your job much easier with regard to determining the relative importance of a beneficiary’s needs. Remember, beneficiaries who meet the criteria for Priority Groups 1 and 2 would be considered to have “important” needs. These are the people you should invest the most time in serving. Within each of these priority groups, there will be certain beneficiaries who also present with “urgent” needs — those that are the most time sensitive and would require immediate attention. Beneficiaries in Priority Group 1 (employed beneficiaries) with the most urgent needs include:

- Beneficiaries who are working at a level that might result in an overpayment of benefits. This would include Title II beneficiaries who have earned income at or above the current SGA guideline and SSI recipients with earnings that would cause a reduction in SSI cash payments;
- Title II disability beneficiaries who are working at a level that will result in the use of work incentives. This would include individuals who have earnings above the current TWP amount or at SGA level;
- Working beneficiaries who have encountered a problem that might result in resignation, cutting back on hours, or otherwise reducing earned income; and
- Working beneficiaries considering a promotion, a second part-time job, a job or career change, or becoming self-employed.

Beneficiaries in Priority Group 1 with needs that are least urgent (those that aren’t time sensitive and wouldn’t need immediate attention) include:

- Beneficiaries who are (1) working (or self-employed) at such a low level that no work incentives will be used and (2) who don’t have the ability or interest in working more. For a Title II disability beneficiary, this would qualify as earned income of less than the TWP amount (including less than 80 hours per month of work for Title II beneficiaries who are self-employed). For an SSI recipient, this would be earnings of less than $65 per month.
Within Priority Group 2 (individuals who are actively pursuing employment), beneficiaries with the **most urgent** needs include:

- Beneficiaries with one or more job offers pending who require WIPA services in order to make an employment decision;
- Beneficiaries who are actively using a work incentive to support work preparation efforts and require assistance in managing or resolving issues;
- Beneficiaries with an employment (or self-employment) goal that requires the purchase of items or services and who may be an appropriate candidate for PASS or other work incentives development; and
- Beneficiaries who are engaged in education or training programs they will complete within a year.

Within Priority Group 2, cases that would be considered **least urgent** (those that aren’t time sensitive and wouldn’t need immediate attention) include:

- Beneficiaries who are engaged in education or training programs that will take a year or more to complete; and
- Beneficiaries who have recently initiated services with an EN, State VR agency, or other vocational services provider and who have more than one year of preparation before a job search will begin.

**Remember:** You should serve high-priority beneficiaries with urgent needs FIRST!

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**Determining the Type, Intensity, and Duration of WIPA Services Necessary to Meet Presenting Needs of High-Priority Beneficiaries**

It’s a relatively simple task to figure out whether or not a beneficiary is a high priority for WIPA services — simply apply the criteria for Priority Groups 1 and 2. However, it’s much more challenging to figure out HOW to meet the needs presented by high-priority beneficiaries, particularly
when callers are experiencing rather dire circumstances and are urgently seeking assistance.

In order to begin planning what type and intensity of WIPA services to provide, you need to start by figuring out exactly where each caller is in relation to progression along the employment continuum. To simplify this process and facilitate the sorting of beneficiaries for service planning purposes, we have collapsed the employment continuum into the following categories:

1. Employment Stage
2. Job Search Stage
3. Preparatory Stage
4. Contemplative Stage

Once you have identified where each beneficiary currently stands on the road to employment, you should think about what information, counseling, and support services you need to provide to encourage the beneficiary to take that next step. You should ask the following questions:

- What is the next step along the road to employment for this person, and what can I do to help him or her commit to taking that step?
- What information do I need to provide to this beneficiary in order to facilitate progression along the employment continuum?
- Are there any barriers to employment the person faces related to public benefits? What can I do to remove or minimize these barriers?
- What community partners do I need to coordinate with to enhance the effectiveness of my efforts to promote employment with this person?

The answers to these questions will help direct your work. It’s even advisable to write down answers to each of these questions when you’re determining the proper course of action and planning what services you should provide. By staying focused on these questions, you’ll spend less time on activities that are of low importance and have no direct
relationship to promoting employment and enhancing financial independence.

You need to recognize that not all beneficiaries march along the road to employment in identical lock-step fashion. In fact, there is infinite variation. In a perfect world, every Social Security disability beneficiary would make initial contact with a skilled CWIC at the beginning of the contemplative stage and would receive just-in-time WIPA services through the preparatory stage, then go on to a successful job search, and end up securing a job that negates the need for continued dependency on public benefits. While this ideal outcome certainly does occur in real life, it isn’t the typical scenario. Beneficiaries may skip steps along the continuum and jump right from contemplation to a job that leads to benefit termination. You need to be able to support any beneficiary at any stage and provide work incentives information and supports that will encourage and enable the individual to take that next step.

Let’s take a look at each of the first three stages along the employment continuum and describe the kinds of services and supports that beneficiaries at each stage might need in order to move forward.

**Employment Stage:** Individuals at this stage would meet the criteria for Priority Group 1 as described earlier in this unit. Identifying characteristics of beneficiaries - would include the following:

- Beneficiaries who are working for pay in some form or have already initiated self-employment.
- Beneficiaries employed for some time (possibly even years) or may have only recently begun working.
- Beneficiaries who have encountered a problem that is causing them to consider quitting or cutting back on their work.
- Employed beneficiaries considering a promotion, a second part-time job, or scheduled for a pay increase, which could cause a change in benefit status.
- Employed beneficiaries that have not reported wages or wages haven’t been fully developed by Social Security. Beneficiaries may initiate contact with a CWIC at this stage due to a notice of overpayment.
• Employed beneficiaries that suppress their wages or self-employment income may contact a CWIC when earnings approach various limits (SGA for Title II, break-even point for SSI).

• Employed beneficiaries that have concerns related to the termination of benefits, especially the potential loss of health insurance coverage.

• Employed individuals with non-employment related issues that, in combination with wages, can cause their benefits to change (marriage, in-kind support and maintenance (ISM), unearned income, etc.).

Common Informational and Support Needs of Beneficiaries in the Employment Stage

• I am considering a change in my employment status — what will this do to my benefits? CWICs should perform detailed benefits analysis here with discussion of any applicable work incentives. Develop or revise the BS&A to reflect the expected change.

• My earned income will soon be high enough to cause the loss of benefit payments — should I scale back my work? CWICs should conduct a cost/benefit analysis to illustrate the overall financial outcome of pursuing work that causes loss of cash payments. Review all applicable work incentives to make certain actual countable income is clear.

• Social Security has just notified me that my cash payments will stop — what happens if I lose my job and need to go back on benefits? You need to reassure beneficiaries that Social Security can restore benefits if they are lost due to employment. You should provide specific information about available options for getting benefits reinstated in the SSI or Title II disability programs.

• My employer is offering health insurance — should I sign up? You should conduct a cost/benefit analysis of the various health insurance options and assist the beneficiary in selecting the plan(s) that best meets his or her needs at the most affordable price.
• Social Security sent me a letter saying I owe them money — help! CWICs should determine the cause of the overpayment and check to see if Social Security can reduce or eliminate the overpayment by applying specific work incentives.

**Job Search Stage:** Beneficiaries in this stage along the employment continuum would meet the criteria for Priority Group 2 in most cases. Individuals who are at the job search stage are actively looking for paid employment or are about to begin small business ownership. Typically, these individuals are in the process of submitting resumes or applying for positions and may be interviewing with employers. These individuals have an anticipated level of earnings and a clear vocational or career goal, and have completed whatever preparation they need to pursue this goal (if any). In some cases, individuals at this phase will be receiving some form of employment service and will have a job developer actively contacting employers. In other cases, the beneficiary will be applying for positions independently. Some individuals at this stage may already have job offers pending. Beneficiaries in Job Search Stage have the following identifying characteristics:

- An anticipated level of earnings and a clear employment goal, and has completed all (or most) of the preparatory steps necessary to attain that goal.

- Possibly involved with other agencies such as State VR, EN, American Job Center, or others.

- The beneficiary has begun job search activity of some sort or is about to begin. They may be actively seeking and applying for positions, or a representative (job coach, job developer, etc.) is contacting employers on the beneficiary’s behalf.

- Beneficiaries with a self-employment goal, will have completed the business plan, will have purchased all (or most) of the items needed to operate the business, and is on the verge of initiating sales of products or services.

- Some beneficiaries may have been conducting a job search for some time and may have one or more job offers pending. In some cases, the need for WIPA services will be urgent, as the beneficiary has accepted a job.
Common Informational and Support Needs of Beneficiaries in the Job Search Stage of Employment

• Can you explain how my anticipated level of earnings and employment goal will affect my benefits again? This is the point at which you should provide very detailed case-specific information about how the targeted job and level of earnings will affect ALL public benefits. You should explain all applicable work incentives and provide examples.

• What do I need to tell Social Security when I get a job or open my business? You need to review with the beneficiary all Social Security reporting requirements and provide specific information about effective ways to report earned income.

• What if I get a job that offers health insurance benefits — should I sign up? Beneficiaries may require help assessing health care needs and determining which plan (or combination of plans) best meets their needs. This includes comparing cost and coverage.

• My job search isn’t going very well — where can I get help finding a job? Beneficiaries may need information about what employment services or supports are available for job search and may need help with a referral to a specific agency.

• What happens if I try to work, but end up having to quit? You need to reassure beneficiaries that Social Security can restore benefits if they lose them due to employment. You should provide summary information about available options for getting benefits reinstated in the SSI or Title II disability programs.

Preparatory Stage: Beneficiaries at the employment preparatory stage may meet the criteria for Priority Group 2. These individuals have essentially decided that they do want to pursue paid employment of some type at some level, although they may have lingering questions or doubt related to this decision. These individuals have taken some steps to prepare for employment such as initiating services with the State VR agency, American Job Center, Employment Network, or other community rehabilitation provider. Individuals who are preparing for employment generally have a clear occupational goal and have investigated what it would take to achieve that goal. Beneficiaries in the preparatory stage tend to have the following characteristics:
• Beneficiaries have decided that they do want to pursue paid employment (or self-employment) of some type at some level.

• Individuals have taken some steps to prepare for employment such as initiating services with the State VR agency, American Job Center, Employment Network, or other community rehabilitation provider.

• Beneficiaries have identified a relatively clear occupational goal or level of earnings desired, although some refinement may still be necessary.

• Beneficiaries have conducted some investigation into what it will take to achieve the employment or self-employment goal.

• Beneficiary is well on the way to completing the preparatory steps (education, training, business plan development, etc.) and may be on the verge of starting a job search.

• Some beneficiaries may already be working while preparing for a future occupational goal.

**Common Informational and Support Needs of Beneficiaries in the Preparatory Stage of Employment**

• Where can I get help paying for the preparation I need to achieve my occupational goal? Your counseling needs focus on getting the assistance the beneficiary needs to complete the preparatory phase. This may mean making referrals to VR or ENs, providing information about the Ticket to Work, and providing information about Individual Development Accounts (IDAs), or the benefits of using a Plan to Achieve Self-Support (PASS).

• Can you explain how my occupational goal and desired level of earnings will affect my benefits again? This is a good time to review the work incentives and provide more specific information about how the beneficiary’s chosen career goal and earnings goal will affect all public benefits.
Conclusion

This unit provides important information about eligibility for WIPA services and clearly describes which beneficiaries Social Security considers to be a high priority. CWICs must diligently apply these standards as they process initial requests for service and conduct triage to determine which beneficiaries require immediate attention. Remember — you have an obligation to maximize the amount of time you spend working with high-priority beneficiaries.

Whenever you consider possible next steps for a high-priority beneficiary after an initial call, you should always keep the mission of the WIPA program foremost in your mind. You should be thinking about what information and counseling you need to provide to encourage the beneficiary to take that next step down the road to paid employment and greater financial independence — whatever that might be for that individual.

Additional Resources

On the following pages, we have provided a reference guide for determining WIPA eligibility. We have also provided a reference guide for determining the WIPA priority group, which includes examples for the level of urgency within each priority group.
WIPA Eligible or Not?

Eligible for WIPA Services

- Individuals receiving SSI benefits due to disability who are in cash payment status. This includes persons who only receive state supplement payments.

- Individuals receiving Title II benefits based on disability (SSDI, CDB, DWB) who are in cash payment status.

- Individuals who have lost cash SSI payments due to work, but are considered SSI eligible due to eligibility for 1619(b) extended Medicaid.

- Individuals who have lost Title II disability cash payments due to work, but are still in the Extended Period of Eligibility.

- Title II disability beneficiaries who have received initial notice that Social Security considers them to be engaging in SGA.

- Individuals who have lost Title II disability benefits due to SGA-level employment, but are still receiving Medicare through the Extended Period of Medicare Coverage (EPMC).

- Individuals who have received notice of approval for Title II disability benefits, but are still in the 5-month waiting period before payments may begin.

- SSI recipients and Title II disability beneficiaries who have completed the disability determination process and are receiving benefits under Expedited Reinstatement.

- Individuals who continue to receive CDB payments due to disability after full retirement age.

- Individuals with disabilities who receive Medicare as Medicare Qualified Government Employees (MQGE) based on disability.

Ineligible for WIPA Services

- Individuals who have become ineligible for SSI and 1619(b) extended Medicaid.

- Individuals who have lost SSI or Title II disability benefits due to medical recovery.
• Individuals age 65 or older who receive SSI due to advanced age, rather than disability.

• Individuals who receive a Social Security Title II benefit not based on disability.

• Individuals who receive Medicare only under the End Stage Renal Disease (ESRD) provision, but who haven’t established entitlement for Title II disability benefits.

• SSI recipients and Title II disability beneficiaries receiving continued disability benefits in spite of medical recovery under section 301 provisions.

• Individuals only receiving other federal, state or local benefits (other than SSI State supplementary payments) who aren’t also entitled to Social Security benefits based on disability.

• Individuals who have applied for Social Security disability benefits, but for whom no determination has been made.

• SSI recipients and Title II disability beneficiaries receiving provisional benefits under Expedited Reinstatement (EXR) who haven’t completed the disability determination process (unless eligible under EPMC).

• Individuals who are receiving cash payments (SSI or Title II) while appealing an adverse medical determination.
CWIC Reference Guide to Beneficiary Priority Groups and Urgency Levels

Instructions

In applying the following guidelines, keep in mind that CWICs must provide information and referral (I&R) services to ANY eligible beneficiary who makes contact with the WIPA project. Social Security developed the priority groups to help CWICs manage requests for individualized, intensive WIPA services. Social Security does not intend for WIPA projects to use the priority groups to deny I&R services to eligible beneficiaries who are a low priority for individualized services. **Any eligible beneficiary who makes contact with a WIPA project should receive basic information and referral services** based on presenting needs.

**Priority Group 1:** Individuals who are currently working or engaging in self-employment and have both a need for and interest in receiving individualized work incentives planning and assistance services. Priority group 1 also includes transition age youth who are interested in work. Social Security defines transition age youth as being at least 14 years old through the age of 25. You should prioritize transition age youth even if they are in the earlier stages of considering work or preparing for work.

Within each priority group, there will be certain beneficiaries who also present with “urgent” needs — those that are the most time sensitive and would require immediate attention. Beneficiaries in Priority Group 1 (employed beneficiaries) with the most urgent needs include:

- Beneficiaries who are working at a level that might result in an overpayment of benefits. This would include Title II beneficiaries who have earned income at or above the current SGA guideline and SSI recipients with earnings that would cause a reduction in SSI cash payments;

- Title II disability beneficiaries who are working at a level that will result in the use of work incentives. This would include individuals who have earnings above the current TWP amount, but not at SGA level;

- Working beneficiaries who have encountered a problem that might result in resignation, cutting back on hours, or otherwise reducing earned income; and
• Working beneficiaries considering a promotion, a second part-time job, a job or career change, or becoming self-employed.

Beneficiaries in Priority Group 1 with the **least urgent** needs (those that aren’t time sensitive and wouldn’t need immediate attention) include:

• Beneficiaries who are (1) working (or self-employed) at such a low level that no work incentives will be used, and (2) who don’t have the ability or interest in working more. For a Title II disability beneficiary, this would qualify as earned income of less than the TWP amount (including less than 80 hours per month of work for Title II beneficiaries who are self-employed). For an SSI recipient, it would be earned income of less than $65 per month.

**Priority Group 2:** Beneficiaries who are actively pursuing employment or self-employment and who are interested in receiving work-related benefits counseling. This group includes:

• Beneficiaries with a clear employment goal who are conducting an active and regular job search. Active and regular job search is defined as searching for job openings on at least a weekly basis (using online job postings or other sources), submitting applications or resumes, and participating in job interviews.

• Beneficiaries with a clear employment goal who have taken active steps to prepare for achieving that goal. Beneficiaries who have taken active steps to prepare for employment or self-employment would include individuals who:
  
  a. Have an approved PASS, a pending PASS, or are good candidates for PASS development;

  b. Are participating in an education or training program related to the employment goal;

  c. Have a Ticket assigned (or “in use”) with the State VR Agency or an EN with a signed IPE/IWP and are actively engaged in the services stipulated in the plan;

  d. Are in the process of developing a business plan, securing financing for business start-up, or otherwise preparing to pursue the self-employment goal;
e. Are participating in a work-study program, on-the-job-training (OJT) opportunity, apprenticeship, paid or unpaid internship, or other job preparation program.

Within Priority Group 2 (individuals who are actively pursuing employment), beneficiaries with the most urgent needs include:

- Beneficiaries with one or more job offers pending who require WIPA services in order to make an employment decision;
- Beneficiaries who are actively using a work incentive to support work preparation efforts and require assistance in managing or resolving issues;
- Beneficiaries with an employment (or self-employment) goal that requires the purchase of items or services and who may be an appropriate candidate for PASS or other work incentives development; and
- Beneficiaries who are engaged in education or training programs they will complete within a year.

Within Priority Group 2, individuals with the least urgent needs (those that aren’t time sensitive and wouldn’t need immediate attention) include:

- Beneficiaries who are engaged in education or training programs that will take a year or more to complete; and
- Beneficiaries who have recently initiated services with an EN, State VR agency, or other vocational services provider and who have more than one year of preparation before a job search will begin.
Information and Referral (I&R) Services Defined

Information and referral (I&R) services are a common form of assistance human services professionals provide within a number of fields, including disability services. I&R is the active process of: (1) providing accurate and complete information to beneficiaries that will enable them to pursue their employment and economic self-sufficiency goals; and (2) linking beneficiaries who need services or supports with a program or organization that will provide them the assistance they require. In the most basic sense, I&R assistance is the practice of bringing people and services together.

In the WIPA program, beneficiaries most often request information on how paid employment will affect cash benefits, public health insurance, and other income support programs. CWICs provide information to meet that need so that beneficiaries can make fully informed choices about work. The obstacles to employment that beneficiaries often face include a lack of services and supports necessary to make employment possible. CWICs solve this problem by connecting beneficiaries to local resources that provide employment services and other important supports.

The Purpose of I&R Services

Providing I&R services in the WIPA program has the following critical purposes:

1. To educate beneficiaries about Social Security disability benefits, health insurance programs (Medicaid and Medicare), and how these benefits may be affected by paid employment;
2. To connect Social Security disability beneficiaries with the employment services and other supports they need to be successful in the pursuit of their employment goals;

3. To link beneficiaries with local community resources and support services that address additional beneficiary needs, such as specialized transportation, personal assistant services, assistive technology, or financial education.

**CWICs provide I&R services to every beneficiary** (or designated representative) with whom they have contact. Beneficiaries who reach out to a WIPA project have a reason for making contact – there is always an underlying need for information or assistance that addresses their individual situation. The CWIC’s job is to work with each beneficiary to determine his or her presenting need and then provide the specific information and/or necessary service referrals. CWICs deliver I&R services during every interaction with beneficiaries since so much of what they do involves explaining how various complex systems work and providing support to successfully navigate those systems. This applies to the Social Security disability benefits, public and private health care, and the employment services system, as well as a large number of other income support and community service programs (housing, transportation, advocacy, financial services, etc.).

**Remember** – CWICs provide I&R services to every beneficiary they talk to during every interaction!

While every beneficiary who contacts a WIPA project receives I&R services, there is no one standard for delivering that service. It all depends on where an individual stands on the employment continuum, his or her employment goals, and each individual’s unique circumstances. For example, beneficiaries who are just beginning to think about the possibility of work may pose simple questions that the CWIC can answer with summary information during a brief phone conversation. Other beneficiaries who receive individualized WIPA services may require a great deal of I&R support on a variety of topics provided over multiple contacts in addition to customized benefits analysis and advisement.

**IMPORTANT** – In the WIPA program, some beneficiaries will receive ONLY I&R services. Beneficiaries requiring individualized WIPA services will receive I&R as part of their customized work incentives analysis and advisement.
As we discussed in Unit 1 of this module, beneficiaries who are not a high priority for individualized WIPA services typically receive only I&R services, which consist of basic summary information about benefits, work incentives, health care, and employment services programs, as well as referrals to appropriate services agencies. This type of service doesn’t require extensive information gathering or verification of benefits. Most often, CWICs handle I&R requests from beneficiaries in one or two phone or email contacts. In some instances, CWICs may supplement the information provided during phone or email communication with printed resources. In most instances, I&R services are short term in nature and do not involve repeated contacts with the beneficiary.

In contrast, individualized work incentives planning and assistance requires CWICs to gather specific information about the individual beneficiary and perform customized analysis, informational support, and counseling. For most beneficiaries receiving individualized WIPA services, CWICs provide a written summary of the customized analysis known as a Benefits Summary and Analysis (BS&A) report. CWICs generally follow the written BS&A with direct assistance and support to resolve benefit problems or apply work incentives. CWICs typically provide this assistance over a period of weeks, months, or even years. During the course of this contact, beneficiaries will often require additional I&R service as questions occur or their needs change. It’s important to understand that CWICs provide I&R services on a continuous basis to beneficiaries with high priority WIPA needs with whom they stay in contact. As long as a CWIC provides WIPA services to an individual, there will be some level of I&R support involved.

**How to Provide I&R Services**

So, how do CWICs go about providing I&R services? The first step is to determine the presenting need. What information does the beneficiary require to move forward on the employment continuum? What problem is the beneficiary experiencing that the CWIC could help resolve by making a referral? The process of determining a beneficiary’s presenting need isn’t always as easy as it might seem. The CWIC often needs to spend considerable time communicating with the beneficiary to identify the precise information needs, which may differ from their initial question. Miscommunication can sometimes happen because Social Security benefits language is complex and can be confusing. At other
times, the beneficiary doesn’t feel safe or comfortable revealing the real reason for the call. CWICs should not assume that the initial request for information is all that the beneficiary really wants to know. During I&R, they should gently probe with follow-up questions to make sure the beneficiary doesn’t want additional information. Active listening is a crucial skill for CWICs to develop. The following strategies can help you determine the beneficiary’s presenting needs:

- Pay close attention to what the beneficiary is saying and listen for cues to other potential needs.
- Avoid thinking about what you’re going to say while the beneficiary is talking. Instead, actively listen to what the beneficiary is saying.
- Ask clarifying questions and rephrase what you think the need is in order to confirm.
- Maintain control of the call; gently re-direct the beneficiary as needed to stay on track.
- It may be helpful to take notes during the conversation so as not to lose track of questions the beneficiary poses or problems he or she describes. This list is what you will use when you provide I&R services.

Once the presenting needs are clear, the next step is to decide how best to meet them. Can the CWIC simply provide a verbal or written explanation of the issue, or does the need require a referral to another agency? In many cases, both will be necessary. Sometimes there may be more than one presenting need or problem. Here are some practical tips for CWICs:

- The key is to stay organized and handle one presenting need at a time. Based on your notes about the various needs and questions posed, answer the simplest ones first, then cover the more complex questions.
- When addressing each need, provide a summary explanation of the issues involved and be specific about steps the beneficiary can take to resolve the issue.
- Use plain language and avoid technical terms and jargon.
• Stop periodically and ask the beneficiary for feedback to determine how well he or she comprehends the information you provide. Be prepared to explain some concepts multiple times in different ways and give examples to illustrate your points when appropriate.

• If you mention a specific agency, program, or service, ask the beneficiary if he or she has ever heard of it before or is familiar with it. Be prepared to provide an overview of what the agency or program does and who it serves. You should assume that the beneficiary may not have prior experience with specific disability service providers.

• Follow up your verbal explanations with written material that the beneficiary can refer back to later. This is especially important when you make referrals to agencies. Providing written contact information and instructions on how to apply for a program or service will help the beneficiary act on the referral.

• In most cases, CWICs should not contact programs or agencies on behalf of a beneficiary receiving I&R services. Your job is to provide adequate information and guidance to enable the beneficiary (or his/her representative) to directly contact the referral entity.

• Manage expectations by not making guarantees about the services beneficiaries will receive when they contact local agencies. Some agencies have waiting lists for certain programs while others may have a lengthy application process.

• CWICs need to have a solid understanding of local services, program eligibility requirements, and application procedures. Do NOT refer beneficiaries to programs or services for which they are clearly ineligible.

**Limits on I&R Services**

Under the current WIPA service design, Social Security expects CWICs to use most of their time delivering individualized WIPA services instead of generic I&R services. In particular, Social Security expects WIPA project personnel to be efficient and limit the amount of time they spend providing I&R services to beneficiaries who do not currently have a need for individualized benefits counseling. CWICs must balance the amount of
time they spend delivering I&R services and the more intensive, time-
consuming individualized WIPA services. Here are some practical tips for
maintaining an optimal balance:

- You do NOT need to complete the full initial interview process,
request a BPQY, or conduct any type of benefits verification for
beneficiaries who only receive I&R services. Instead, provide
summary information about the effect of work on the type of
Social Security benefits the beneficiary says he or she receives,
and answer any specific questions the person asks about work
and benefits.

- Ask the person to contact you again for more individualized
counseling when they have a clear employment or earnings goal.
Encourage the beneficiary to contact you as soon as he/she
begins to prepare for employment or conduct a job search so
that there is sufficient time to provide adequate counseling. A
lot of beneficiaries who start out only requiring limited I&R
services receive individualized WIPA services at a later date as
they move closer to employment.

- Try to manage I&R only calls as efficiently as possible. You may
need to redirect the beneficiary multiple times to make sure the
conversation stays on track. Try to limit for the amount of time
you spend providing I&R services with each beneficiary.

- Do NOT offer to re-contact, follow-up or provide any additional
services at this point. The only follow-up you should provide is
sending written materials to beneficiaries by mail or email, while
encouraging the beneficiary to contact you if his or her situation
changes.

Now, let’s take a detailed look at the three primary areas in which CWICs
provide information and make referrals. Those areas are Social Security
benefits, employment services, and other important support services.

Providing I&R about Social Security Benefits

As we described above, not all beneficiaries who are eligible for WIPA
services receive individualized work incentive counseling services. There
are not enough hours in the day for CWICs to provide intensive,
customized WIPA services to everyone seeking help. Because demand for
WIPA services exceeds the current program capacity, Social Security directs WIPA projects to reserve individualized counseling for high priority beneficiaries who are currently employed, about to enter employment, or pursuing a specific employment goal. So, what do busy CWICs do to meet the informational needs of beneficiaries who are not currently receiving individualized counseling and a written BS&A report? For these beneficiaries, I&R services are really critical – especially summary information about how work affects Social Security disability benefits. CWICs typically provide this service by offering a brief verbal discussion and following that with written information sent to the beneficiary by mail or email. There are many options for providing this information in writing, including the following:

- Fact sheets that give an overall description of how work affects benefits by program (Title II and SSI) or by individual work incentive (e.g., Student Earned Income Exclusion, Impairment Related Work Expense, etc.). Approved resource materials are available on the VCU NTDC website (https://vcuntdc.org/resources/index.cfm). Social Security publications, such as “The Red Book,” a pamphlet titled “Working While Disabled” and a publication on Plans for Achieving Self-Support (PASS). Social Security publications are available at www.ssa.gov (https://www.ssa.gov/pubs/).

- For SSI recipients, Social Security has a number of short “SSI Spotlights” that are really easy to understand and cover most areas that beneficiaries have questions about. You can find those online at www.ssa.gov (https://www.ssa.gov/ssi/links-to-spotlights.htm). There is also an excellent discussion of the SSI program in an online publication entitled “Understanding Supplemental Security Income” (https://www.ssa.gov/ssi/text-understanding-ssi.htm).

- Customized packets of information that include general information and referral documents with a cover letter.

Remember that if you develop original materials, your Office of Employment Support (OES) Project Officer must review and approve them prior to use. In most instances, it is not necessary to develop original informational materials since there are so many resources already available on Social Security’s website. You can create your own fact sheets or handouts by cutting and pasting information directly from Social
Security materials. If you do this, you still need to have these fact sheets approved by your Project Officer, but you can indicate that the information is taken directly from agency materials. This will help facilitate the approval process. You can also reach out to your VCU TA Liaison to see if he or she has additional approved materials to share.

**Special Considerations for Delivering I&R about Social Security Benefits and Work**

There are two situations in which CWICs need to use extra caution when delivering I&R services.

**Situation 1:**

A beneficiary receiving I&R ONLY asks questions that require individual analysis and benefits verification

When CWICs limit services to ONLY I&R, they do not perform extensive information gathering or verification of benefits. This means CWICs do not have all of the facts needed to get into case-specific details when discussing work and benefits. When providing I&R services about Social Security benefits to beneficiaries, CWICs must be very careful to stick with general summary information. CWICs can only speak in general terms when they explain how Title II disability benefits and/or SSI are affected by paid employment. If beneficiaries receiving I&R services ask specific questions about their unique benefits circumstances, the CWIC must not try to provide answers without having complete information. CWICs have two courses of action in this situation. They can decline to provide answers to the questions and explain why the CWIC is unable to answer the questions with additional, detailed information. The alternative is to offer individualized services to the beneficiary. If the beneficiary accepts, you would move on to full information gathering, benefits verification, and development of a BS&A report.

**Situation 2:**

A beneficiary who is employed or close to employment who requests only general information about how work will affect benefits during the initial contact

There are some important things to consider when a beneficiary who is employed or very close to employment requests lengthy explanations about work and benefits during the initial interview. Experience has shown that when CWICs provide too much summary work incentives
information during the initial contact, beneficiaries are less willing to participate in individualized benefits analysis and counseling. CWICs need to be very cautious about this. For beneficiaries who really need customized benefits analysis and advisement, it’s best to initially refrain from providing extensive generic information until you have the opportunity to discuss the value of individualized services and benefit analysis.

The detailed, case-specific counseling CWICs provide after extensive information gathering and benefits verification will be far superior to generic I&R and will enable the beneficiary to make truly informed decisions about work. Some beneficiaries may feel an urgent need to receive immediate information. CWICs should answer questions briefly to alleviate any immediate concerns about working, but should educate the beneficiary about why individualized services are advantageous and worthwhile.

**Referrals to Social Security**

The primary focus of the WIPA program is to provide information to assist beneficiaries to return to work. There are many questions or problems a Social Security disability beneficiary may have about benefits that aren’t related to work that may make it necessary for you to refer the beneficiary to Social Security. For individuals who will only receive I&R services, the best way to handle these issues is to provide a brief explanation and then direct the person to contact Social Security. The following common questions indicate when you should refer the beneficiary to Social Security:

- Can you help me get my name or address changed?
- Can I get my payee taken off my account so I can get my own check?
- I’m on disability and just had a baby. Can I get a check for my child too?
- My husband just died. How can I get benefits off his record?
- How can I get more SSI? I just moved into my own apartment, and I need more money.
- How can I get less money taken out of my check for this overpayment?
• My check didn’t show up in my account this month! What do I do?
• I got a letter from Social Security saying they are going to conduct a review of my medical condition – what do I do?
• I am engaged to be married (or just got divorced). Will this affect my benefits?

When referring beneficiaries to Social Security, it’s best practice to offer the phone number and address to the local office as well as the 800 number so they have options for contact. In some cases, referring a beneficiary to information on Social Security’s website will resolve the issue.

Providing Employment Focused I&R Services

It’s important to remember that CWICs serve as an active and integral part of the vocational services team for persons with disabilities. While work incentives planning and assistance continues to be the core work performed by CWICs, there is more to actively promoting employment outcomes than only assisting beneficiaries with work incentives. To truly be effective in supporting beneficiaries in their efforts to attain paid work, CWICs must expand their counseling skills to assist beneficiaries to establish earnings goals and identify the services necessary to achieve their objectives. These areas include the following:

1. Helping beneficiaries determine what specific services and supports they may need to identify, select or clarify their career goals;

2. Helping beneficiaries determine what specific services, supports, or accommodations they may need to achieve the desired career goal;

3. Explaining Social Security’s Ticket to Work (TTW) program and the full array of vocational services and supports available to individuals with disabilities in the local service area;

4. Connecting beneficiaries with the specific services and supports they need to obtain and maintain paid employment from state Vocational Rehabilitation (VR) agencies, Employment Networks (ENs) under the TTW
program, American Job Centers (AJCs), or the Veteran’s Administration.

Each of these four areas requires CWICs to provide employment focused I&R services, regardless of their priority level or position on the employment continuum. Since our primary mission is to support employment among Social Security disability beneficiaries, this type of I&R service is essential for everyone we serve. Let’s take a look at the CWIC’s role in each of these areas individually.

**Remember** – Every WIPA eligible beneficiary a CWIC talks to should receive employment focused I&R services designed to help that person acquire the accurate information and services they need to move forward along the employment continuum!

**Helping Beneficiaries Determine the Specific Services and Support they may need to Identify, Select or Clarify their Career Goals**

Assisting beneficiaries to identify and pursue career goals is a challenging task. To be clear, Social Security does not expect CWICs to provide formal career counseling or vocational assessment. Trained and experienced rehabilitation professionals either within the state VR system, ENs, or other employment service provider agencies best perform this function. CWICs do need to know what type of career exploration and vocational assessment services are available within the community. They also must be prepared to refer beneficiaries to the various agencies based upon need. CWICs must take the time to conduct research and interview personnel from local agencies to gather this information. Here are some of the most common resources for career exploration services available in most areas:

- The State VR agency;
- ENs;
- Community Rehabilitation Agencies offering short- and/or long-term employment services;
- AJC/Workforce Centers operated by the Department of Labor;
- Veteran’s services (Veterans Rehabilitation and Employment Programs);
• Private-for-profit entities such as staffing agencies, private rehabilitation companies, etc.;

• **Online self-service resources**  
  (http://www.careerinfonet.org/explore/)

To address this need, CWICs should begin by asking beneficiaries about their desired employment outcome and earnings goal before they begin providing I&R or analyzing benefits. Beneficiaries may not even be aware that there are services available to help them select an appropriate career goal and develop a plan for achieving this goal. A beneficiary who indicates that he or she has no clear employment objective is obviously in need of career counseling, and CWICs should refer him or her for this service before any individualized work incentives counseling begins. While CWICs can provide general information about the effect of earned income on Social Security benefits at this point, beneficiaries need to have a fairly specific earnings goal before CWICs can provide customized WIPA services.

**Helping Beneficiaries Determine the Specific Services, Supports, or Accommodations that may be Necessary to Achieve the Desired Career Goal**

CWICs often meet with beneficiaries who have a clear employment objective, but who also face challenges when pursuing their goals. In these cases, CWICs can offer a valuable service by helping the beneficiary think through the requirements of various jobs (or self-employment), to identify their specific service needs, and recognize the supports or accommodations they will need to successfully pursue their chosen career.

While some CWICs may feel uncertain about their ability to assist beneficiaries identify appropriate employment services, technical support and advice in this area is usually readily available. In most local communities, **Centers for Independent Living (CILs)** and **State Assistive Technology Technical Assistance Projects** can offer training seminars to acquaint CWICs with the use of various assistive technologies and available accommodations, as well as rehabilitation services and supports. In addition, getting to know the full range of services available through the **State VR agency** will help beneficiaries to understand what is available to support their employment or return-to-work objectives. CWICs don’t need to be experts in rehabilitation...
technology or job site accommodation, but they do need to have an awareness of what is possible, as well as what is available in the local area.

Another excellent source of information in this area is the **Job Accommodation Network (JAN)**. JAN is a leading source of comprehensive information and guidance on workplace accommodations and disability employment issues. JAN provides detailed, individualized technical assistance on workplace accommodations, the Americans with Disabilities Act (ADA) and related legislation, and self-employment and entrepreneurship options for people with disabilities. It serves a wide audience, including people with disabilities and their families, large and small private employers, government agencies, and service providers. CWICs can learn more about JAN by going to their web site here: [askjan.org](https://askjan.org/index.cfm)

**Explaining Social Security’s Ticket to Work Program and the Full Array of Vocational Services and Supports Available to Individuals with Disabilities in Local Communities**

Many individuals with disabilities have difficulty navigating the complex array of employment services available in their local community. CWICs must be prepared to explain how the TtW program functions and how beneficiaries may use a Ticket to access the services and supports needed to achieve paid employment. There are many resources available on the [TtW website](https://choosework.ssa.gov/) that are developed specifically for beneficiaries to help them understand how the Ticket program works.

Not only is it important to explain how beneficiaries can use the Ticket program to access services, but CWICs also must be able to provide information to beneficiaries about the various agencies that deliver vocational services and supports. This includes ENs operating within the TtW program, as well as other federal, state, and local agencies that may also provide assistance to beneficiaries. When providing beneficiaries with information, CWICs should do more than merely hand out a list of agency names with contact information. They should review the provider options with the beneficiary and discuss which options make the most sense for the individual given his or her unique preferences and circumstances. Each agency has its own eligibility criteria, enrollment
procedures, and program guidelines. It’s essential that CWICs assume responsibility for helping beneficiaries locate the services and supports that best meet the beneficiary’s needs.

You can find a listing of approved ENs and contact information for the state VR agencies here: choosework.ssa.gov (https://choosework.ssa.gov/findhelp/)

**Connecting Beneficiaries with the Specific Employment Services and Supports They Need to Obtain and Maintain Paid Employment**

CWICs will often assist beneficiaries with formal referrals to vocational service provider agencies. To make effective referrals, the CWIC needs to know which agency offers services that best meet a beneficiary’s needs. Unit 3 of Module 1 provides a detailed explanation of the employment services system for people with disabilities and describes the main service providers in that system. The most common sources of employment services are listed below, along with the types of services provided by each agency.

**Employment Networks:** Many beneficiaries can benefit from the employment services and supports provided by ENs. These agencies provide a wide variety of employment services, such as vocational counseling, job skill training, job placement assistance, supported or customized employment, and many others. Some ENs specialize with certain groups of individuals, such as those who require extensive assistive technology or specific types of job accommodations. Others focus on transition-age youth, English language learners, or other specialized populations. Keep in mind that some ENs don’t provide a direct service, but rather process ticket payments to reimburse beneficiaries directly for the cost of services or items they purchase in order to work. The following questions would be good indicators that the person would be well served by an EN.

- I really want to work enough to get off of Social Security benefits, but I need help with my job search. What options do I have?
- I got services from the State VR agency in the past, but I wasn’t satisfied with the outcome. Where else can I get the services I need to achieve my work goal?
• I need training to help me get a job that pays more money. Who can help me find the right training?

• Once I get a job and the State VR agency closes my case, where can I go to get vocational counseling to help problem solve issues I run into on the job?

**State Vocational Rehabilitation Agencies:** CWICs often provide referrals to state VR agencies, which serve a broad population and provide services to all eligible beneficiaries. State VR agencies also tend to be a major source of financial assistance for higher education, vocational training programs, or capitalizing a small business. For example, state VR agencies may be an appropriate referral for beneficiaries who pose the following questions.

• I want to work, but the training for the job I want costs a lot of money. Where can I get help with the training costs?

• I want to start my own business, but I need help with buying some expensive equipment. Where can I get help?

• Where can I go to get some help with getting a wheelchair lift for my van so I can use it to drive to work?

• I already have a degree, but I need some special equipment to help me do my job since I became disabled. Where can I go?

**American Job Centers (AJC):** AJCs provide free help to all job seekers for a variety of career and employment-related needs. The centers help beneficiaries search for available jobs, receive training, and obtain specialized supports to address their employment-related needs. Some AJCs are also ENs within the TTW program. Examples of beneficiary questions that indicate the AJC would be an appropriate referral include:

• I just lost my job; my employer laid me off. Where do I go for help to find another job?

• I don’t need any of the Ticket services you talked about. I just need a place to use the computer and send out some resumes. Is there a place like that in my town?

• Is there somewhere I can go to get some help with working on my resume?
• I heard that there are some places around that may let me be an apprentice. Is there someone I can talk to about getting that set up?

• Where can I get information on childcare assistance?

• I have been interviewing for jobs, but not getting any offers. Is there some place I can go to get help developing a better resume or learning interview skills?

**Veterans Administration Resources:** The Veteran’s Benefits Administration (VBA) operates a number of programs that provide a vast array of information and services for veterans. The Education and Training program assists veterans seeking to obtain additional post-secondary education or specialized training that will enable them to pursue their chosen career. The Vocational Rehabilitation and Employment (VR&E) program provides many different types of services to veterans seeking to obtain employment or start their own business. The VBA is an appropriate referral source for veterans who ask:

• Is there any kind of help I can get to train for a different job?
• What kind of help can I get to set myself up in a business?
• Who can help me figure out what I can do for work, now that I have this disability?
• I think I could do the kind of work I used to before my injury, but who can I get to help me figure that out?
• Is there any help for me to go back to school?
• Will working affect my percentage of disability or my veteran’s benefit amount?
• I’m worried about keeping a place to live. Are there any special programs for veterans?

The following websites provide access to a wealth of great information about the VBA programs:

• [benefits.va.gov/benefits/](http://benefits.va.gov/benefits/)
• [www.benefits.gov/](http://www.benefits.gov/)
The **[www.benefits.va.gov](http://www.benefits.va.gov)** website provides access to Frequently Asked Questions, an online “Ask a Question,” and listing of toll-free numbers under the Contact Us tab.

**Self-Employment Resources:** We provide extensive discussion of resources for beneficiaries who are interested in self-employment in Unit 8 of Module 3. Often, individuals who are actively operating a business or pursuing a self-employment goal will meet the criteria for individualized services. However, beneficiaries who are just starting to think about self-employment as an option and are requesting more information are appropriate candidates for I&R services. Several agencies providing resources and information for beneficiaries considering self-employment are identified below:


- **The Small Business Administration (SBA)** helps Americans start, build and grow businesses. Small business start-up guide and other resources are available on the website at ([https://www.sba.gov/business-guide](https://www.sba.gov/business-guide)).


- **JAN** provides a wealth of information about self-employment for people with disabilities (https://askjan.org/info-by-role.cfm#for-individuals)

**Assisting Beneficiaries with Disabilities to Resolve Problems or Overcome Barriers Related to Obtaining a Job and Maintaining Employment**

After receiving referrals for employment services from CWICs, some beneficiaries encounter problems connecting with the proper contact person, or the agency may determine that the individual is not eligible for services. When the plan for accessing the services necessary to attain employment goes awry, the CWIC must be available to get the plan back
on track. Depending on the reason for the problem, there may be a number of actions the CWIC can take. In some cases, the beneficiary may need to appeal unfavorable eligibility determinations that limit a beneficiary’s ability to access services. The CWIC must be well-versed in the various processes agencies have for handling complaints or appeals and must be able to explain these to beneficiaries as well as offer support to complete these procedures.

One type of referral CWICs may make in this area will be to the state **Client Assistance Program (CAP)**. The CAP ensures the protection of individuals receiving or seeking services under the Rehabilitation Act; for example, from the state VR agency. The CAP may be a division of the same agency that provides other Protection & Advocacy programs, but not always. In some cases, separate agencies house CAP. A referral to CAP is appropriate when a beneficiary asks the following type of questions:

- My VR counselor told me that I must pay for my own hand controls for my car, but I can’t afford to. Is that right?
- The VR office in my town told me that I am not eligible for their services. Where can I go to appeal this decision?
- I want to change to a different VR counselor and the local office says I can’t. What are the rules on this?
- I need VR to open my case back up and help me with some issues I’m having, but they said no. What do I do now?

Another source of advocacy services for beneficiaries struggling with barriers to employment is **Protection and Advocacy for Beneficiaries of Social Security (PABSS)**. As described in Unit 3 of Module 1, PABSS is a program provided by state Protection & Advocacy agencies for Social Security beneficiaries who need assistance with issues involving their employment service providers, employers, WIPAs, or Social Security. Situations that PABSS may assist with include inadequate services provided by ENs, rights violations, adverse Social Security work-related decisions or overpayments, or TTW issues. PABSS services may be helpful in the following types of situations:

- I signed a plan with my EN and now they won’t provide the services they agreed to. What do I do?
• I have been trying for three years now to get my local VR to open up a case and give me the help I need to get a job. They keep telling me they have no services available for me. Can I get a lawyer to help me with this?

• My EN agreed to pay me part of my outcome payments, and now every time I call them, they tell me they never agreed to that. What do I do?

• I worked a few years ago, and now I have this huge overpayment from Social Security. They think I worked more than I did, and their records don’t match mine. How can I get help?

• I requested an accommodation from my employer. Now my employer is threatening my job because of my disability. Now that they know I have a disability, can they keep asking about my medical condition?

Finally, there are a whole host of things that can create barriers to employment or cause problems at an existing job that are completely unrelated to the employment services system. During the initial contact, CWICs should ask beneficiaries about their perceived barriers to employment and be prepared to make referrals for assistance. CWICs need to have a clear understanding of local resources that can assist with the following common areas:

• Lack of reliable transportation;
• Lack of child or elder care;
• Communication barriers;
• Family or personal crises; and
• Past felony convictions or other issues related to the criminal justice system;

Providing I&R to Meet Other Needs

During the delivery of I&R services, beneficiaries may describe unmet service needs that make it difficult for them to obtain and maintain employment. While none of these areas are the primary focus for WIPA
projects, they are still areas in which some assistance may need to be provided. The most common areas include:

1. Financial Assistance
2. Physical and Mental Health Resources
3. Advocacy or Legal Assistance
4. Crisis Intervention

**Referrals for Financial Assistance**

As you learned in Module 1, poverty and disability often go hand-in-hand. Beneficiaries who reach out to WIPA projects often express a need for financial assistance to meet the most basic human needs such as food and shelter. There are many income support programs available in local communities. We discuss the most common ones in Module 5. These include:

- Supplemental Nutrition Assistance Program (SNAP)
- Temporary Assistance for Needy Families (TANF)
- Federal Housing Assistance Programs
- Veteran’s Benefits
- Unemployment Insurance
- Workers Compensation

CWICs should be prepared to make referrals to these programs as appropriate, but there are additional programs to be aware of that are not covered elsewhere in this manual. These include:

- **Programs for individuals who are homeless**
  (https://www.hudexchange.info/homelessness-assistance/)

- **Energy assistance programs such as Low Income Home Energy Assistance Program (LIHEAP)**
  (https://www.acf.hhs.gov/ocs/programs/liheap)

- Emergency financial assistance offered by local churches, county or city governments, or other non-profit groups.

*A good way to start exploring options* in your area is to conduct a search at [Benefits.gov](https://www.benefits.gov). The U.S.
The government established Benefits.gov in 2002 as its official benefits website. It’s an easy-to-use, comprehensive source of benefit information to help individuals understand which benefit programs they may be eligible for, and how to apply. Benefits.gov provides easy, online access to information from across 17 federal agencies.

The website provides options to browse for assistance by category, state, agency, or other resources. It also has a nifty tool called “Benefits Finder” that allows individuals to input specific information about themselves in categories such as household, education, health, income and assistance, and work experience. Users can view results at any point in the process after they answer core questions. This is a great way for beneficiaries to explore other potential benefits they may be eligible for from any of the agencies connected to Benefits.gov.

Another great place to research assistance options is United Way 211/Social Services. 2-1-1 is a network of nearly 1,800 community-based United Way agencies supported by United Way Worldwide. 2-1-1 is available throughout the U.S. by phone, text, and web. A toll-free call to 2-1-1 connects individuals to a community resource specialist in their area who can help find services and resources. Beneficiaries can connect to their local 2-1-1 agency by dialing 2-1-1 from any phone or by going online to www.211.org and entering the zip code or city and state in the search box on the home page. This resource provides information about:

- Supplemental food and nutrition programs
- Shelter and housing options and utilities assistance
- Emergency information and disaster relief
- Employment and education opportunities
- Services for veterans
- Health care, vaccination and health epidemic information
- Addiction prevention and rehabilitation programs
- Re-entry help for ex-offenders
- Support groups for individuals with mental illnesses or special needs
- A safe, confidential path out of physical and/or emotional domestic abuse
Referrals to 2-1-1 are appropriate in situations where the beneficiary asks:

- I can’t work right now and can’t afford my rent. I’m losing my apartment. Who can help me?
- I just moved to a new town, and I got sick. Can you help me find a clinic so I can see a doctor that takes Medicaid?
- Where can I go to get help with a ride to get to my doctor?
- Do you know someone who can help me with some housework and running errands?
- My check isn’t enough to last the month after I pay my bills. Where can I get some help with groceries?
- I just had a baby and I’m having trouble handling her. Where can I get some help?
- I was recently released from prison and my benefit check isn’t enough for me to afford a place to live. I’m also having trouble finding work because of my record. Where can I go for extra help?

Another related area of need for many beneficiaries is developing greater financial stability and independence through asset development programs, financial literacy and education, credit counseling, tax preparation, and numerous online financial resources. Referrals in this area include the following:

- Individual Development Account (IDA) Programs: To Locate IDA programs funded through the Assets for Independence (AFI) Act, visit website, (https://www.acf.hhs.gov/ocs/programs/afi) that lists the IDA programs by state. Prosperity Now, formerly the Center for Financial Education, also provides links and resources to IDA programs and can be located at prosperitynow.org/
- Financial Stability Resources:
  - Visit the Consumer Financial Protection Bureau (CFPB) website (https://www.consumerfinance.gov/) for brochures, frequently asked questions, and toolkits about managing money.
  - Visit the Department of Health and Human Services Administration for Children and Families Find Help tool for
individuals (http://www.acf.hhs.gov/help-for-individuals) for resources on financial security, health, and housing.

- The National Disability Institute's Real Economic Impact (REI) Network is an alliance of organizations and individuals dedicated to a common mission the economic advancement of people with disabilities. For more fact sheets, tool kits and information, visit the National Disability Institute's Real Economic Impact (REI) Network website (https://www.nationaldisabilityinstitute.org/newsletters/rei-network-news/).

- Money Smart, a financial education program provided by the Federal Deposit Insurance Corporation (FDIC) provides training modules for adults and youth (https://www.fdic.gov/consumers/education/index.html).

- Credit Counseling: To locate Consumer Credit Counseling Service (CCCS) visit credit.org/cccs/. For credit counseling and debtor education visit justice.gov (http://www.justice.gov/ust/eo/bapcpa/ccde/index.htm)

- Tax Assistance:
  - For information about eligibility for Earned Income Tax Credit, visit the IRS at irs.gov (https://www.irs.gov/credits-deductions/individuals/earned-income-tax-credit)
  - The IRS has publications and tools for individuals with disabilities. To access these, visit http://www.irs.gov/Individuals/More-Information-for-People-with-Disabilities and (http://www.irs.gov/pub/irs-pdf/p3966.pdf)
  - The Center on Budget and Policy Priorities (CBPP) provides tax credit outreach information (http://eitcoutreach.org/).

- Online Financial Education Resources:
- **Better Money Habits** provides online tools for achieving financial goals and making sound choices (https://www.bettermoneyhabits.com/index.html)

- **Smart About Money (SAM)** is a program of the National Endowment for Financial Education (NEFE). It’s a nonprofit national foundation that provides resources and online tools for financial decision-making for individuals and families through every stage of life (https://www.smartaboutmoney.org/).

- **The Federal Trade Commission online financial education resources** provides a variety of publications and tools for credit management, jobs, housing and money management (http://www.consumer.ftc.gov/features/feature-0022-financial-educators).

**Referrals for Physical and Mental Health Resources**

Beneficiaries receiving I&R services often pose questions about health insurance – typically Medicaid and Medicare. If the questions are related to how paid employment will affect eligibility, be sure to provide brief generic information about the Extended Period of Medicare Coverage (EPMC) or 1619(b). If the question is related to non-employment issues such as coverage, payment for services, eligibility or enrollment, it’s often best to refer the individual to the administering agency. CWICs can find detailed information about Medicare and Medicaid and how work affects these programs in Module 4 of this manual.

To find answers to most beneficiary questions related to **Medicare**, beneficiaries may call **1-800-MEDICARE** or visit the **Medicare.gov** website. Medicare.gov is the official U.S. Government site for Medicare. CWICs should refer any Medicare inquiries not related to work incentives directly to Medicare. Medicare.gov has links to the following types of assistance:

- Enrollment;
- Medicare costs;
- Medicare covered services;
- Drug coverage (Part D);
- Supplements and other insurance;
- Claims and appeals;
- Health management; and
- Forms and resources

Another excellent source of information about Medicare is the local **State Health Insurance Program (SHIP)**. SHIPs offer local, personalized counseling and assistance to people with Medicare and their families. SHIPs can help with questions about coverage, premiums, deductibles, coinsurance, complaints and appeals. They also provide information on joining or leaving a Medicare Advantage Plan (like an HMO or PPO), any other Medicare health plan, or a Medicare Prescription Drug Plan (Part D). To locate your local SHIP, go to [shiptacenter.org](https://www.shiptacenter.org/).

Questions about Medicaid can be more difficult to find answers to since state Medicaid programs vary significantly. For general questions, you can refer beneficiaries to the **Medicaid website, Medicaid.gov** (https://www.medicaid.gov/index.html). For state specific information, [start with state program overviews found medicaid.gov](https://www.medicaid.gov/state-overviews/index.html). From this website, you can find a state locator that will direct the beneficiary to his or her state agency.

Some beneficiaries contact CWICs to inquire about getting health insurance. The best place to start with those queries is at the official website for the **Affordable Care Act (ACA), healthcare.gov** (https://www.healthcare.gov/). In addition, the [Kaiser Family Foundation operates an excellent website](https://www.kff.org/understanding-health-insurance/) for helping people understand general health insurance concepts.

If the presenting need is related to mental health or substance abuse services, CWICs may direct beneficiaries to a services locator operated by the **Substance Abuse and Mental Health Services Administration (SAMSHA)** within the U.S. Department of Health and Human Services (https://www.samhsa.gov/find-help). Keep in mind that we provide a description of the mental health and substance abuse services system in Unit 3 of Module 1.
Referrals for Advocacy or Legal Assistance

There are a variety of agencies available to help beneficiaries with legal issues or advocacy unrelated to employment. Beyond CAP and PABSS, **State Protection and Advocacy (P&A)** agencies provide a variety of advocacy services, addressing issues such as the following:

- Problems accessing publicly funded services;
- Issues in publicly funded residential programs;
- Issues related to representative payees; and
- Termination of needed services

In some areas, the local **Center for Independent Living (CIL)** may provide advocacy services on certain types of disability-related issues. CWICs need to contact the local CIL directly to determine if the agency provides advocacy support, and if so, in what specific areas. **A CIL locator is available** (http://www.ilru.org/projects/cil-net/cil-center-and-association-directory).

For individuals who require help with civil legal issues, the best source of assistance is Legal Aid. Legal Aid programs are funded in part by the **Legal Services Corporation (LSC)**. LSC is an independent nonprofit established by Congress in 1974 to provide financial support for civil legal aid to low-income Americans. The Corporation currently provides funding to 133 independent nonprofit legal aid organizations in every state, the District of Columbia, and U.S. Territories. To find the nearest **LSC-funded legal aid organization, go to www.lsc.gov** (https://www.lsc.gov/what-legal-aid/find-legal-aid)

Referrals for Crisis Intervention

When CWICs believe that an individual they are working with may be in a crisis situation, an excellent resource is the **National Suicide Prevention Lifeline**. This is a national network of local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress. They operate 24 hours a day, 7 days a week.

Some beneficiaries may express needs that you might consider a crisis; however, they may not be threatening immediate harm to themselves or others and directing them to the **Lifeline** may be appropriate. Additional resources for youth, disaster survivors, Native Americans, veterans, loss survivors, LGBTQ+, attempt survivors, and deaf or hard of hearing


individuals are available on the **Lifeline’s website** (www.suicidepreventionlifeline.org).

**Conclusion**

I&R is an extremely important part of the CWIC’s role. I&R services include providing detailed general information to beneficiaries in response to their questions or concerns, as well as linking beneficiaries to the services and supports necessary to enable them to achieve their employment goals.

In the I&R service, the CWIC only provides general information to beneficiaries. For beneficiaries receiving I&R, the CWIC does not obtain the BPQY, complete information gathering activities, or complete an individualized benefit analysis. Beneficiaries that need this level of assistance would be served through the intensive, individualized services component of the program. However, I&R services do require CWICs to communicate with the beneficiary to identify their need for assistance, potentially conduct detailed research to obtain the necessary information, share the information with the beneficiary and make sure that the person fully understands and can use the information to pursue their career goals.

The I&R service requires CWICs to be very knowledgeable regarding all employment services available to beneficiaries attempting to enter or maintain employment, especially ENs and state VR agencies. CWICs must be able to describe program eligibility criteria, application procedures and the types of services provided by each agency. In addition to ENs and state VR agencies, CWICs should be aware of vocational training services provided by American Job Centers and educational institutions, as well as specialized services for specific populations, such as veterans training and education programs, services provided by mental health or developmental disabilities state agencies, or other community rehabilitation programs.

Finally, CWICs also need to be familiar with other employment support services that are necessary to enable beneficiaries to be successful in their employment activities. These support services include specialized transportation, assistive technology and job accommodations, personal assistant services, housing supports, advocacy and financial services such
as financial education, credit counseling, tax preparation assistance, or specialized savings accounts.
Competency Unit 3 – Preparing for Individualized WIPA Services: Information Gathering and Benefits Verification

Introduction

Unit 1 presented a method for assessing how closely a beneficiary’s needs align with the goals of the WIPA program. This method relies on determining the relative importance and urgency of the needs the beneficiary presents. Determining whether a caller has needs that are of high or low importance and high or low urgency isn’t merely an abstract academic exercise. This process helps you decide how to move forward in delivering WIPA services. Assessments of importance and urgency help answer the following questions:

- **Type of Services:** Does the beneficiary need individualized benefits analysis with work incentives planning and assistance, or will generic information and referral services meet the presenting needs?
- **Intensity of Services:** Will the beneficiary require multiple contacts in a short period to meet the presenting needs?
- **Duration of Service:** Will the beneficiary require regular or extensive follow-up contacts over time to meet the presenting needs?
- **Initiation of Service:** Does the beneficiary have service needs that are urgent and would call for an immediate response, or would it be acceptable to start services later?

The answers to these questions provide direction for mapping future service delivery and drive the amount of information gathering that you need to do. In the most basic terms, eligible callers present needs in two service categories:

- Basic Information and Referral services (I&R), or
• Individualized Work Incentives Planning and Assistance.

Generally, you address information and referral (I&R) needs by providing basic summary information about benefits, work incentives, programs or services. This type of service typically doesn’t require extensive information gathering or verification of benefits. In contrast, individualized work incentives planning and assistance requires you to gather specific information about the individual beneficiary and perform customized analysis, informational support, and counseling. For most beneficiaries receiving individualized WIPA services, you provide a written summary of the customized analysis (Benefits Summary and Analysis report). You generally follow the written Benefits Summary and Analysis (BS&A) with direct assistance and support to resolve problems or apply work incentives. Usually you provide this assistance over a period of weeks or months, guided by the Work Incentives Planning (WIP) process described in Unit 3 of this module. This unit addresses how to gather the information you need to provide individualized WIPA services.

**Overview of Individualized Work Incentive Planning and Assistance Services**

Individualized work incentive planning and assistance consists of the following services:

• In-depth benefits analysis covering all federal, state, and local benefits;

• Customized counseling about the impact of work on all federal, state, and local benefits;

• Assistance with identifying, developing, using, and managing work incentives;

• Assistance with resolving problems related to benefits;

• Assistance with identifying and resolving barriers to obtaining or maintaining employment;

• Coordination with members of the beneficiary’s employment support team;

• Training and support on effective reporting procedures and benefits management techniques;
• Proactive follow-up to prevent or resolve problems related to benefits or employment.

In order to provide these services, CWICs must begin by gathering comprehensive information about any benefits an individual receives that could be affected by paid employment. This information gathering process is the foundation upon which all subsequent work incentives counseling services stand. You can’t provide high quality individualized WIPA services without first investing time and effort in gathering and verifying all relevant information.

**IMPORTANT NOTE:** Only beneficiaries who are a high priority for WIPA services (Priority Groups 1 and 2) and who will be receiving individualized benefits analysis, work incentives planning, and assistance require comprehensive information gathering. Beneficiaries who are a lower priority and who won’t be receiving individualized WIPA services don’t warrant the time and effort this process entails. CWICs shouldn’t waste precious time gathering and verifying benefits information for individuals who will only be receiving generic I&R services.

### Information Gathering for Beneficiaries Receiving Individualized WIPA Services

There is no standard, required WIPA information-gathering form or process, but you must collect certain categories of information in order to provide comprehensive individualized benefits counseling. Thorough information gathering is not optional – it is required for any beneficiary prior to the provision of individualized work incentives counseling.

A list of the information that should be included in an information-gathering tool is provided below. Additionally, an initial interview guide is provided at the end of this unit. We designed this guide to provide CWICs with a standard set of interview questions in a prescribed sequence with scripting options. This interview guide covers all relevant areas of information you will need to properly analyze benefits in relation to an individual’s employment or earnings goal. We highly recommend that you use this tool or something very similar when you conduct initial interviews with beneficiaries to ensure you gather all necessary
information. Whatever tool you use, it should include the following information categories and we recommend collecting the information in the order it appears here.

**NOTE:** The first 3 categories of information (contact information, Social Security benefits, and placement on the employment continuum), are collected for ALL beneficiaries you make contact with – not just those to whom you will provide customized benefits analysis and work incentives counseling. This information is gathered early on in the initial interview process and is used to determine eligibility for WIPA services and determine whether eligible individuals will receive I&R only or are appropriate for individualized WIPA services. WIPA projects are required to provide some of the data they gather to Social Security. We list these categories here as they are part of the initial interview guide provided at the end of this unit.

1. **Contact Information**

Make sure you have ALL of the contact information you need to communicate effectively with the beneficiary, including correct landline and cell phone numbers, email addresses, and street addresses. Be sure to ask beneficiaries which methods of contact they prefer and make a note about that in your information-gathering tool. When beneficiaries provide an email address, be sure you ask if they check email regularly. If calling is the preferred method of contact, be sure to ask about the best times to call. When beneficiaries provide a cell phone number, be sure to ask if they prefer calls or text messages. You can save a great deal of time and energy communicating by email or text message instead of relying on calls.

2. **Social Security Benefits**

The next category to collect is information on the beneficiary’s current Social Security benefit status. This includes the type of Social Security benefits and the amounts the beneficiary receives. You should ask these questions early on in the interview process as you need this information to determine if the individual is eligible for WIPA services. Questions to ask include:
• Can you tell me what type of benefits you get from Social Security?
• Do you know if you get Social Security disability benefits or SSI?
• Do you get more than one benefit payment from Social Security each month?
• How much is your Social Security payment?
• Do you know if your benefits are based on your past work, or do you get benefits from the earnings record of a parent or a spouse?
• Do you know if you have Medicare or Medicaid health insurance? Note: If they don’t know, have them describe their insurance card. Is it white with a red white and blue stripe? Is it (whatever color of card your state uses for Medicaid)?

Keep in mind that some beneficiaries may not be clear about what benefits they get or how much the monthly payment is. Reassure beneficiaries that you will verify everything with Social Security before providing counseling.

If the person was referred to you by the Ticket to Work Help Line, you can find the type(s) of Social Security benefit in the encrypted referral email message. In these cases, you should confirm with the person what benefits show in the referral. If there are discrepancies between what the beneficiary says he or she receives and what shows in the referral section, ask additional questions to clarify.

3. Current Employment Status and Future Employment or Earnings Goals

By the time you get to comprehensive information gathering, you should already know where the beneficiary stands on the employment continuum since employment status determines whether or not the individual is a high priority candidate for individualized WIPA services. At this point, your objective is to fill in as many details as you can – especially if the beneficiary is already working or on the verge of starting a job. Some of the questions you might want to ask an employed beneficiary include the following:

• What type of work (or self-employment) are you doing or will you be doing?
• Is your employment (or job offer) full-time or part time?
• How many hours do you work (or will you be working) per week?
• What is (or will be) your hourly wage or salary?
• When did you (or will you) start your job (or self-employment)?
• Have you notified Social Security that you are working? If so, how did you make contact with Social Security?

For employed individuals, don’t assume that the job they currently HAVE is the one they eventually WANT. Remember that one of your primary objectives is to support beneficiaries to achieve improved financial stability. An important strategy for accomplishing that end is moving up the career ladder or retooling to attain a higher paying career. In order to help beneficiaries achieve future employment or earnings goals, you need to know what these goals are. Some questions you could ask include:

• Are you satisfied with the job you have now?
• Do you hope to increase your hours and/or earnings in the future?
• Are you considering a promotion or a job change?
• Do you have a raise pending?
• Do you have any long-term career goals?
• Have you thought about what you need to do in order to meet your future employment or earnings goal? For example...

For beneficiaries who are in the job search or job preparation stages of the employment continuum, you might want to ask the following questions:

• Are you actively looking for a job (are you going on interviews or submitting applications/resumes?)
• Are you actively working to become self-employed or planning to start a small business?
• Are you currently in school or participating in any kind of education or training program? If so, when do you expect to complete this program?
• Are you getting help from an agency to prepare for work or find a job?

• Do you have an open case with the state VR agency or an appointment to meet with the state VR agency?

• Have you done anything in particular to prepare for getting a job?

IMPORTANT: If you don’t have clear information about the beneficiary’s employment and earnings goal, there is no way to provide the beneficiary with an individualized analysis of how employment will affect his or her benefits. The analysis is performed using the earnings goal as the point of reference; it’s what you use to provide information about how benefits will be affected. Without an earnings goal, you can’t provide specific individualized information that’s useful to the individual as he or she moves along the employment continuum. This step in the information gathering process is critical and you can’t skip it. More information about what constitutes an earnings goal is provided in Unit 3 of this Module.

4. Gather information about current employment (if applicable) and past work since entitlement to Social Security benefits

If the beneficiary indicated that he or she is currently working or self-employed, there is a lot of important information for you to gather about that work. You need this information to determine monthly earnings so you have something concrete to analyze benefits against. You also need to ask probing questions to see if any work incentives such as Impairment Related Work Expenses (IRWEs) or Subsidy/Special Conditions might apply. Specifically, you need to know the following things:

1. Employing company and job title;

2. Start date;

3. Hourly wage and average number of hours per week, monthly salary, or average monthly Net Earnings from Self Employment (NESE);
4. Pay periods or pay days; and

5. Potential for use of work incentives. For SSI recipients you should check for Student Earned Income Exclusion (SEIE), Impairment Related Work Expenses (IRWEs) and Blind Work Expenses (BWE), as applicable. For Title II disability beneficiaries, check for possible IRWEs and Subsidy/Special Conditions (unincurred business expenses and/or unpaid help for self-employed Title II beneficiaries).

Past employment status is an important category of information to gather because it may have some bearing on current benefits. SSI recipients may not have reported past earnings, which would indicate the possibility of an overpayment. For a Title II disability beneficiary, past employment may mean that he or she has already used TWP or EPE months. Gathering information about past work from beneficiaries during the initial interview may result in an incomplete history. Beneficiaries may not remember when they worked, the names and addresses of companies they worked for, or even how much they earned. Here are some questions to start with:

- Have you worked or been self-employed since you started getting disability benefits?
- Can you give me a general idea of when you worked and what you did?
- Do you remember what your hourly wage was and how many hours you worked in each job?
- Do you remember if you let Social Security know you were working? If so, did you get any correspondence from Social Security asking for information about your work?

Research into past employment can be time consuming as it generally requires requesting information from the Social Security field office. Many times, even Social Security’s information is incorrect or incomplete, because beneficiaries may not have reported their wages reliably. Fortunately, CWICs have access to a valuable report on past and current work history that is readily available from the Social Security field office. This report is called the Benefits Planning Query (BPQY). Information on the BPQY report draws from several Social Security electronic records such as the Master Beneficiary Record (MBR), the Summary Earnings
Query (SEQY), and the Disability Control File (DCF). Detailed information on the BPQY is included later in this unit.

When you ask questions about past work during the initial interview, be sure to explain that you will be requesting a BPQY and that past work will show up on that report. During the interview, assure the beneficiary that it’s OK if he/she is unclear about the details of the past work, as you can work on that later on if needed. At this point, you just want a basic list of the different jobs the person may have had, a rough idea about when the beneficiary worked in those jobs and about how much the person may have earned. Be aware that this conversation may cause some anxiety – be sensitive to that possibility.

5. Information about Employment Services and Supports the Beneficiary Currently has and Unmet Needs

If you recall the discussion from Module 1 of this manual, helping beneficiaries connect with the employment services and supports needed to achieve their career goals is an important part of a CWIC’s job. It’s critically important that you determine which services a beneficiary is already receiving and gather specific information about other agencies or professionals the beneficiary is involved with. Questions you might want to ask include the following:

- Do you have an open case with state VR or blind services agency? If so, what services are you getting? Are you satisfied with the services you are currently getting?

- Are you receiving employment supports from an EN? If so, what services are you getting? Are you satisfied with the services you are currently getting?

- Are you receiving services from other community agency? If so, what services are you getting? Are you satisfied with the services you are currently getting?

- Has anyone talked with you about the Ticket to Work Program? Do you know if your ticket is assigned or “in use”? (The beneficiary may need to verify Ticket status by calling the TTW Help Line – you will have to provide that contact information).

As you work through the interview, don’t assume that the beneficiary understands the vocational service system for adults with disabilities, or how the various programs, services or agencies work. You may need to
explain how the state VR agency works or answer questions about other employment services providers – even if the beneficiary is already participating in those services. Be prepared to review the Ticket to Work program, what it means to have a ticket in assignment or in use with the state VR agency, and what timely progress reviews entail. You should take your time with this part of the interview and make sure you have fully explained how the employment services system for people with disabilities works so beneficiaries know what to expect.

In addition, don’t assume that a beneficiary’s needs are being met just because he/she already has an open case with the state VR agency or is being served by an Employment Network (EN). Be sure to ask specific questions about existing employment barriers or unmet vocational service needs. **This applies to all beneficiaries for whom you plan to provide individualized WIPA services.** Some of the questions you might want to ask include:

- Do you feel like you need any specific services or supports to achieve your employment goal?
- Do you have barriers to employment that you feel are keeping you from achieving your career goals? Check for the following:
  - Lack of reliable transportation
  - Lack of child/elder care
  - Unresolved health issues
  - Communication barriers
  - Lack of access to assistive technology or inability to use technology
  - Need for job accommodations
  - Accessibility issues
  - Family or personal crises

6. Information about Family Members who also Receive Social Security Benefits

Many of the beneficiaries you will serve are members of families, with dependent children and/or a spouse living in the same household. Some dependent family members also receive benefits that are means-tested
and household income may affect eligibility for these benefits or the benefit amount. When disability beneficiaries go to work, their earned income may affect the benefits of dependent family members. Since families tend to pool their resources to pay the household expenses, you must consider how an employment goal will affect the entire family unit. Be sure to explain to beneficiaries why you need information about family members. Be aware that some beneficiaries won’t know for sure what benefits family members get or how much the benefit payments are. Some of the questions you should consider include:

For Title II disability beneficiaries:

• Do you have dependents in your household such as a spouse or minor children who receive a Social Security benefit check because you receive disability benefits?

• Do any of your dependents (children, spouse, or domestic partner) receive SSI? If so, who receives this and how much is the monthly benefit?

For SSI recipients:

• Do you live in your own household, or in someone else’s household?

• If you live with someone else, do you pay your share of the household expenses, OR if not your share, do you contribute something to the household for food and/or rent/mortgage?

• If you live in your own household, does anyone help you pay your food and shelter costs? If so, can you describe the help you get?

• Are you married? If so, does your spouse live with you? Does your spouse have any income, such as earnings or cash benefits or other income? If so, can you tell me the amount of that income?

• Do any of your dependents (children, spouse, or domestic partner) receive SSI? If so, who receives this and how much is the monthly benefit?
7. Information about Health Insurance and Healthcare Needs

This is another important category of information to verify since some forms of health insurance (primarily Medicaid) may be affected by income and resources. In some cases, beneficiaries may be more concerned about the loss of critical health insurance than they are about potential loss of cash benefits. One of the most difficult aspects of gathering information about health insurance is how many different programs there are and how little beneficiaries understand about what programs they (or their dependent family members) are enrolled in. In particular, there are lots of ways to qualify for Medicaid and it’s possible to be enrolled in more than one Medicaid program at the same time. Different Medicaid programs are affected by working in different ways, so it’s really important that you know exactly which type of Medicaid beneficiaries and their dependent family members get. Begin by asking questions about forms of government funded health insurance or healthcare since these programs are most likely to be affected by paid employment. This includes Medicare, Medicaid, and the VA healthcare system.

For individuals who have Medicare you could ask:

- Are you enrolled in Medicare? If so, which parts of Medicare are you enrolled in? For example, Part A which pays for hospitalization, Part B which pays for doctor visits and outpatient services, and Part D which pays for prescription drug coverage. Some people are enrolled in something called Medicare Advantage or Part C. Which of these apply to you?

- If you are enrolled in Part B, is your monthly premium deducted from your benefit check?

- Do you know if you get assistance in paying for the Part B premium from the state? If so, does the state also help with the other Medicare out-of-pocket costs?

- If you are enrolled in a Part D prescription drug plan, do you get help paying the premium and other out-of-pocket costs for this coverage? Social Security calls this Part D assistance “extra help” or “the low-income subsidy”.

For individuals who have Medicaid you could ask:

- In most states, when you get SSI, you also qualify for Medicaid coverage. Do you know if the Medicaid coverage you have is related to your SSI benefit?

- One type of Medicaid coverage is provided to people who have really high medical expenses. That program is called “Medically Needy Medicaid” or sometimes “Spend-Down”. Do you have any out of pocket expenses each month before your Medicaid coverage begins (which is typically called a spend-down or share of cost)? If so, are you able to meet these expenses each month?

- If the state has a Medicaid Buy-In program and if the person is working: Now that you are working, are you participating in the state’s Medicaid Buy-In program, which is called (Buy –In name)?

- There is a special type of Medicaid that’s provided to certain people who used to get SSI but who lost eligibility for SSI because they started getting SSDI or Childhood Disability benefits. Did you lose SSI when you started getting another type of disability benefit from Social Security?

- There are some Medicaid programs that cover services related to your disability in addition to medical services. These programs are often referred to as Medicaid waiver programs. Are you enrolled in one of these programs? (You may want to provide the names of specific waivers in your state to help the person identify if he or she is enrolled in a waiver program.)

- Do you have any other family members or dependents living in your household who receive Medicaid?

- For individuals who indicate they use the VA healthcare system you could ask:

- Which services from the VA healthcare system do you use? Do the services you receive from the VA meet all of your healthcare needs?

NOTE: There are different levels of VA health care (i.e. some get full coverage and others just use prescription
drug coverage). Be sure to ask what services the person gets from the VA.

Don’t assume that beneficiaries only receive publicly funded healthcare. Be sure to check on private health insurance coverage. Some of the questions you could ask include:

- Do you have private health insurance coverage, such as coverage through a family member current employer or previous employment? If so, are you satisfied with the services you get and the cost of your coverage?

8. Information about Other Federal, State or Local Benefits

Many Social Security disability beneficiaries receive additional benefits such as HUD housing subsidies, SNAP (formerly known as food stamps), veterans’ benefits, or other federal, state, or local benefits. Many of these benefits are means-tested, and paid employment or self-employment may affect them. Some benefits are provided to assist an entire household, not just a specific individual. If earned income affects these benefits, it may affect the entire family’s ability to pay critical living expenses. Social Security requires you to address all of these benefits when you provide individualized WIPA services to ensure that beneficiaries can make fully informed decisions about work. In order to provide thorough and complete benefits analysis, you have to know about benefits the individual and his or her dependent family members receive that an increase in household income could affect. The most common programs you should check for include:

- Supplemental Nutrition Assistance (also known as Food Stamps)
- Housing assistance or rental assistance
- Temporary Assistance for Needy Families (TANF)
- Low Income Energy Assistance Program (LIHEAP)
- Workers Compensation
- Disability insurance benefits provided by a previous employer
- Unemployment Insurance benefits
- Veteran’s benefits
• Railroad Retirement
• Black Lung benefits
• Any other assistance, such as Community Action Program Assistance, etc.

9. Information about Other Sources of Income and/or Resources

This step is more important for SSI recipients than Title II beneficiaries since the SSI program involves strict income and resource limits. Use your judgment to determine whether or not to ask questions about other income and resource when you are interviewing a beneficiary. If this information isn’t necessary for benefits analysis, don’t gather it. Some of the things you should look for include child support, maintenance or alimony, Pell Grants or other forms of educational assistance, or other forms of income. Be sure to explain the SSI resource limit as appropriate and provide examples of common resource that Social Security disregards. Check to see if SSI recipients have resources that are worth more than the current SSI limit or have questions about the SSI resource policies.

10. Information about Representative Payee and Legal Guardianship

You also need to know if the beneficiary has a representative payee, an authorized representative, or a legal guardian, and you need to have the contact information for these people as well. These individuals are authorized by Social Security to act on behalf of beneficiaries, so it’s necessary to work closely with them.

When Information Gathering Should Go Beyond the Usual Requirements

Certain groups of beneficiaries have specific issues that require additional information gathering. In these cases, gather the basic information recommended above and then gather supplemental information as needed. Two populations in particular tend to require supplemental information gathering: veterans and transition-age youth.

• Veterans: The Department of Veterans Affairs (VA) provides a whole host of special benefits to veterans of the U.S. Armed
Forces in addition to the basic cash benefit programs. Because there are so many different programs, spend extra time and effort when interviewing veterans to make certain you have gathered all of the relevant information. **A Veteran’s Information Gathering Template** is available on the VCU National Training & Data Center website to guide this interview process (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=78)

- **Transition Age Youth:** Social Security considers beneficiaries who are between the ages of 14 and 25 to be transition-age youth. This is a high priority for individualized WIPA services and this population has some unique characteristics that may require supplemental information gathering and analysis. In particular, beneficiaries who are nearing their 18th birthday may require a special interview in addition to the basic information-gathering process to identify potential problems or opportunities that will require attention. A special template CWICs may use to track all of the **changes that might occur at the age of 18 can be accessed on the VCU NTDC website** (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=71)

Other beneficiaries with very complicated benefits situations may also require extra research. For example, eligible couples with children who receive benefits can present very convoluted situations that may require collection of information beyond the minimum. In addition, beneficiaries who receive uncommon forms of benefits such as Railroad Retirement or Black Lung benefits may require additional questioning and information gathering. The objective is to be as thorough as possible when interviewing beneficiaries to make certain you know all relevant facts before beginning your analysis and counseling.

**Strategies for Performing Information Gathering**

Unlike earlier iterations of the WIPA program where face-to-face contact with beneficiaries was encouraged, the current service model directs CWICs to provide services via distance methods wherever possible. In the face of limited resources, larger service areas, and improved distance technologies, distance and virtual services facilitate immediate beneficiary services, rather than dealing with travel or transportation challenges. Social Security supports the use of teleconferencing, videoconferencing, Skype, FaceTime, and related technologies to “virtually” meet in secure
environments with beneficiaries. Although Social Security doesn’t prohibit face-to-face meetings with beneficiaries, you should only use them as a last resort when distance communication techniques aren’t possible or appropriate.

You can conduct the initial information-gathering process very successfully by phone, and Social Security strongly encourages WIPA projects to stop the practice of in-person initial intake meetings. Here are some tips for using the phone effectively to gather information:

• When you make initial contact with a beneficiary, ask for a phone appointment to conduct an interview. You never know what you might be interrupting when you make that first call, and you can’t expect the beneficiary to be available right then for an information-gathering session. Explain what the information-gathering process is and why it’s necessary. Be sure you and the beneficiary have set aside enough time to conduct the interview — an hour isn’t unusual.

• Keep in mind that you may need several sessions to gather all of the necessary information from the beneficiary. It probably isn’t reasonable to hold the beneficiary on the phone for longer than an hour. Set up the next session before you complete the call if you need to gather more information.

• Don’t interrogate the beneficiary — have a conversation. It’s possible to gather the necessary information by simply having a friendly chat. Try not to simply read any information-gathering templates or interview guides you use, but rather spend time getting to know the individual. The goal is to establish trust and rapport while gathering the information you need to perform in-depth individualized benefits analysis.

• Don’t simply mail or email the information-gathering tool to the beneficiary and ask them to fill it out and return it to you. You’ll learn much more about the beneficiary and end up with fewer informational gaps if you conduct the interview personally by phone.

• Don’t skip sections of the information-gathering tool. If a section doesn’t apply to the beneficiary, make a note to that effect. The more information you can provide on the tool, the
easier it will be for someone else to pick up the case if a transition is needed.

- Some of the questions you pose may seem intrusive to the beneficiary. Be sure to explain WHY you need information when a beneficiary seems reluctant to answer. Take your time and answer questions about the process as you move through it. If a beneficiary doesn’t want to answer certain questions, don’t pressure the person. Make a note to that effect and move on.

**Explaining Next Steps to Beneficiaries**

Before you end the interview, make sure the beneficiary understands that you can’t provide in-depth individualized benefits counseling without performing the necessary benefits verification. Here are some tips for helping the beneficiary understand what to expect next:

- Let the beneficiary know that you will be mailing him or her several release forms that need to be signed and returned to you. Be sure to explain what information you are seeking and that you will go over the information you receive with the beneficiary. Stress the importance of getting the required forms back to you promptly.

- Explain that the benefits verification process can be a bit slow sometimes and encourage the beneficiary to call you as questions arise.

- Review what the beneficiary should expect from you once you verify the benefits. You will review the BPQY and other verification documents with the beneficiary and you may need to get some additional questions answered at that time.

- Reiterate that the most valuable part of WIPA services is the individualized benefits analysis and work incentives counseling you will provide. Explain that you will go over how the employment or earnings goal is likely to affect all benefits received in detail. You will explain everything verbally, and then summarize it in a special report called a Benefits Summary and Analysis or BS&A (if appropriate).

- Thank the beneficiary for taking the time to complete the interview process. End the conversation with information about when the beneficiary can expect to hear from you again. Always
encourage the beneficiary to contact you with questions or concerns as they may arise.

**Working with Community Agencies when Gathering Information**

Many times, concerned third parties initiate calls about an individual’s benefits. Be careful to discuss specific cases with caseworkers or other community partners ONLY with the proper, signed consents from the beneficiary. It isn’t unusual for a case manager, supported employment professional, employment specialist, or VR counselor to contact the WIPA program with questions about work and benefits on behalf of a beneficiary. Information is often incomplete and will require that you contact with the beneficiary separately to gather full information to provide advisement. Providers will sometimes assume that because they initiated the service request on behalf of the beneficiary, that they can be privy to all the information that you subsequently provide the beneficiary.

**REMEMBER:** You may only share information if the beneficiary has signed the appropriate consent forms.

It’s essential to discuss the inclusion of other members of the employment support team with the beneficiary and obtain his or her consent to share information such as the BS&A and the WIP. Similarly, you should get signed releases from the beneficiary allowing you to request information from members of the employment support team such as the VR counselor or staff of an EN. You’ll want to request copies of the Individual Plan for Employment (IPE) to make sure you are abreast of the current employment goal and the activities planned to help the beneficiary achieve that goal.

**Working with Guardians and Representative Payees when Gathering Information**

There will be times when it’s necessary to work with others in addition to the beneficiary during the initial information-gathering process. For example, when the beneficiary is under the age of 18, the legal parent or guardian has the right to make decisions on the child’s behalf in most cases. Once Social Security considers the beneficiary an adult, it’s
possible to work with the beneficiary directly without having to have parental involvement. Social Security defines adulthood in the following manner:

**An adult is:**

- A person age 18 or older, or
- A person under age 18 who is emancipated under state law, or
- For representative payment purposes, a person age 17 ½ who is initially filing for benefits or who will be converted to Childhood Disability Benefits (CDB) or Social Security Disability Insurance (SSDI) at age 18.

In some cases, the state has appointed a legal guardian for a person over the age of 18. This means that the person has no ability to make decisions for himself or herself and isn’t able to legally sign documents or enter into agreements. Social Security refers to this situation as “legal incompetence” and defines it in the following manner:

**Legal Incompetence:** Legal incompetence is a decision by a court of law that a claimant or beneficiary is unable to manage his or her affairs. Legal incompetence is determined under state law and applies to more than Social Security benefits.

When a beneficiary has a legal guardian, you may only work directly with the legal guardian, as the beneficiary has no right to sign documents. In some cases, the legal guardian is a family member, but in other cases, the state may appoint a state guardian. It’s common for parents of individuals with significant disabilities to think they are their adult child’s legal guardian when, in fact, they aren’t. Just because a beneficiary has limited intellectual capacity or is mentally ill doesn’t mean that the state has appointed a legal guardian. This process may only take place in a court of law, and designation as a guardian is a legal designation. You should never assume that a parent or anyone else is a beneficiary’s legal guardian unless the beneficiary presents legal documentation proving this designation.

When a beneficiary is his or her own legal guardian, but is unable to handle his or her own finances, Social Security may deem the individual to be “incapable.” The agency defines this term in the following manner:
**Capability:** Incompetence and incapability are two different things. Incapability is a decision by Social Security that an individual is unable to manage or direct the management of benefits in his or her best interests. Social Security typically uses medical evidence as a basis for a decision about whether the person is capable of being his or her own payee. The most important factor, however, is a functional test of how well the person handles money. When Social Security decides that a beneficiary is incapable of handling his or her benefits, they will assign the beneficiary a “representative payee.” This assignment only gives the representative payee responsibilities to the beneficiary around Social Security benefits. An incapability decision is valid only for Social Security matters. It doesn’t extend to other programs or issues.

- Payees can be individuals or organizations, and may be unpaid or paid. Finding a suitable payee can vary from asking the beneficiary to finding information in medical records. Social Security doesn’t overlook any potential source to find a suitable payee. Some of the most common or readily available sources are:

  - The incapable adult beneficiary. Often, a legally competent adult beneficiary may be able to tell Social Security who helps him or her with daily living or provide the name of the person he or she trusts to help manage his or her money;
  
  - The beneficiary’s family or a close friend;
  
  - Anyone who acts on behalf of the beneficiary for other payments he or she may be receiving;
  
  - A social worker;
  
  - The person or institution who has custody of the beneficiary;
  
  - The beneficiary’s medical records, which may mention the name of the person who brought the beneficiary in for medical treatment;
  
  - The claims file, which may include possible leads discovered during an ALJ allowance;
• Governmental agencies that may be providing social services;

• Social agencies such as the Salvation Army, Catholic Charities, the Alliance for the Mentally Ill, Travelers Aid, etc.;

• Advocacy groups located in the community; and

• Public and private nonprofit organizations that are funded under the Recipients Public Health Service Act receive block grants for the care of mentally ill homeless people. If these organizations routinely provide case management services, they are also responsible for providing representative payee services for beneficiaries who receive SSI.

Keep in mind that a representative payee is simply someone who is charged with making sure the beneficiary uses the benefit payments for the beneficiary’s needs. A payee’s authority is limited to matters relating to the receipt and management of benefits unless the payee is:

• The claimant’s legal guardian,

• A parent (or person standing in place of a parent for a claimant under age 18), or

• Someone who has been granted the power of attorney.

**Signing Forms**

A beneficiary can and should sign Social Security forms, even if he or she has a representative payee, provided that the beneficiary is an adult and legally competent. If the person needs a representative payee, however, Social Security won’t issue the benefits until a representative payee is available and has determined the payee capable of receiving benefits and using them for the beneficiary’s needs. That means, even though the beneficiary may sign forms, Social Security must resolve payee status in order to issue benefits.

As long as Social Security hasn’t declared an adult legally incompetent, he or she should sign his or her own forms. A payee who isn’t a guardian can’t sign a consent form authorizing the release of a beneficiary’s Social Security information. Also, even if the parent is the legal guardian, the beneficiary can sign his or her own forms if the payee refuses to cooperate and the local office thinks the beneficiary understands what he or she is doing. This decision is up to Social Security, and is usually
based on medical evidence submitted by the person applying to be his own payee.

Statements authorizing the release of financial or medical records may only be validly signed by:

- The beneficiary,
- His or her authorized representative,
- A parent (in case of a minor child), or a
- Legal guardian.

**Verification of Benefits**

The cornerstone of work incentive planning services is to provide complete and accurate information about the effect of earnings on the various benefits an individual (and dependent family members) receives. Given the many benefits a person may be receiving, individualized advisement should only occur after you verify all of a beneficiary’s benefits from an authoritative source.

The alternative, trying to offer benefits advice based on unverified information, is extremely dangerous business. The risk of error is high, and the consequences can be severe for the beneficiary. It’s very common for beneficiaries to have inaccurate, incomplete, or out-of-date information about the benefits they receive. You cannot simply take self-reported information at face value without checking it. Admittedly, benefits verification can take time and does slow down the counseling process. There will be times when beneficiaries will push you for an immediate answer to a question, but you must resist being rushed. It’s far better to move slowly and dispense correct information than to respond quickly with incorrect advice. It may be necessary to explain this clearly to beneficiaries to help them understand why services take time.

**NOTE:** Verifying the information you gathered during the initial interview process is not optional – it is a required step in WIPA services provision. You must verify any and all benefits received by the person you are serving prior to delivering work incentives counseling.
When to Verify Benefits

When working with a newly enrolled beneficiary, CWICs should verify benefits prior to giving any individualized counseling. That means, before writing a BS&A or telling the beneficiary how the employment goal may affect benefits, you should have verified all benefits. In some circumstances, it may be necessary to re-verify benefits as well. If a beneficiary returns for additional individualized services several months later, you’ll need to review his or her benefits to determine if changes may have occurred and if updated verification is necessary. The general rule is that **if it has been six months or more since you last verified benefits, plan to re-verify all of them.** If it’s been less than six months since you last verified benefits, discuss whether the beneficiary has gone through a redetermination process and what may have changed with each benefit. If there has only been a change in one of the benefits, it’s only necessary to re-verify that one. If there is any doubt as to whether a change has occurred, re-verify.

What to Verify

When it comes to verification, you must verify all public benefits the beneficiary receives, which includes: SSDI/CDB/DWB, SSI, state supplement, Ticket assignment, Medicare Parts A/B/C/D, Medicaid, Medicaid Home and Community Based Services (HCBS) waiver, Medicare Savings Program, Low Income Subsidy, SNAP, low income housing, worker’s compensation, unemployment Subsidy, Veteran’s Pension/Compensation, Black Lung benefits, and Railroad Retirement benefits. If an individual is receiving a private benefit, such as a private long-term disability or private health insurance and he or she has concerns about how work will affect that benefit, you must work with the beneficiary to contact the benefit administrator and verify the benefit and impact of working.

It isn’t enough to verify the receipt of benefits. Be prepared to verify all pertinent information such as entitlement date, amount of benefit, time-limited income exclusions, and use of special programs within a benefit program. For example, some Title II disability beneficiaries may have used some or all of their Trial Work Period. Because each benefit program is unique in so many ways, what you may need to verify will differ from one program to another. A Benefit Verification Quick Reference Guide is included at the end of this unit, which provides a detailed list of what Social Security recommends to verify each benefit.
In most situations, the benefits you’re verifying are those of the beneficiary you’re serving. In some situations, though, it may be necessary to verify his or her spouse’s benefits or children’s benefits. If a beneficiary’s spouse or dependent children are receiving public benefits and the beneficiary has concerns about how working will affect those, you must verify those benefits as well.

How to Verify Benefits

The first step in verifying benefits is to explain to the beneficiary the need for verification and obtain signed releases of information. You’ll need a release of information to verify each benefit the person receives. To obtain verification from Social Security, you are required to use their specific release of information form: Consent for Release of Information, form number SSA-3288. You may find other agencies that administer benefits also require the use of their specific release of information form, while others may allow the WIPA agency’s general release of information. As the WIPA projects establish a protocol for how to verify each benefit, you’ll want to clarify any specific release of information requirements and keep a list handy about what type of release is appropriate for each agency.

The second step in verifying benefits is to contact the agency that administers the benefit. How you make contact and communicate with the agencies will differ from one to another. The following section provides some details on how to communicate with the most common federal benefit programs to obtain verification of common federal benefits. Because there are numerous state and local benefits that you must verify, you’ll need to identify the process for verifying these state or local benefits for your service area. Establishing the means for verifying benefits may require a concerted effort of networking and relationship building on your part. In most benefit administering agencies, personnel have substantial workloads and may be slow to respond or unresponsive to requests for benefit verification. In these situations, you’ll need to build and use a network to find alternate avenues or approaches for obtaining verification.

The third step in verifying benefits is to clarify any abnormalities or inconsistencies you find. You should scrutinize all verifications to determine if there are any inconsistencies with what the beneficiary shared about his or her situation. In some situations, the verification information may raise as many questions as it provides answers. It’s a
critical part of your job to identify these abnormalities as well as the appropriate course of action to correct them, if any correction is needed. Make sure you have a clear understanding of who to talk to within each agency to answer questions and provide clarification. These situations will generally require you to have a conversation with an agency staff member to resolve the issues.

**Verifying Benefits from Federal Entities**

The following is a list of common federal benefit programs and the specific steps CWICs can take to verify them.

**Benefit Planning Query (BPQY)**

The Social Security Administration’s BPQY (SSA-2459) contains comprehensive information about an individual’s disability benefits and work status. This includes the status of the beneficiary’s Social Security administered disability cash benefits, Medicare, Medicaid (in some situations) scheduled medical reviews, representative payee, last work review action, and work history. In essence, the BPQY provides a snapshot of the beneficiary’s benefits and work history as stored in Social Security’s electronic records.

CWICs can use several methods to request a BPQY. A beneficiary may request his or her own BPQY directly at the local Social Security office or by calling the national toll free number at 1-800-772-1213 (TTY 1-800-325-0778). Another option is to have the CWIC request a BPQY from Social Security by submitting proper authorization. Social Security and IRS rules require that you submit two SSA-3288 Release of Information forms when requesting a BPQY. POMS reference GN 03305.001 Disclosure With Consent - General explains why one form is needed to give consent to disclose Social Security information and records (non-tax return information) and a second form is required by IRS regulations to authorize the disclosure of tax return information. The IRS supplies the earnings data on the BPQY, and their regulations, specifically 26 C.F.R. §301.6103(c) – 1T, require that a consent statement authorizing the disclosure of tax return information must “address only the disclosure of tax return information.”

While Form SSA-3288 was designed as a consent form that beneficiaries use to authorize Social Security to disclose non-tax return information, GN 03305.001 states that “if the form specifically requests the disclosure of tax return information it may be accepted.” It also states that a single
consent form that authorizes Social Security to disclose detailed earnings information AND information from the Social Security record is unacceptable, and instructs the local office to provide ONLY non-tax information if both are requested on the same form.

SSA-3288 is the recommended form for requesting a BPQY, because it meets all of the criteria for disclosure of Social Security information and records required by Social Security regulations. Specifically, a consent form must:

• Contain the name, Social Security number, and date of birth of the individual whose information is to be disclosed;

• Be written, signed, and dated by the individual or someone who can consent for him or her. GN 03305.005 provides additional instructions on who may give consent;

• Specifically authorize Social Security to release records. In other words, the form may not be addressed “to whom it may concern” or to “all third parties”;

• Specify the information to be disclosed. Form 3288 provides check boxes so that you can be specific about what you want disclosed. A consent form may not request disclosure of “all records” or “all information from my record”;

• State the purpose for which the information is being requested. Social Security may charge a fee to disclose information for “non-program” purposes, so indicate that the information is needed for program purposes, or because the individual is planning to go to work and is seeking work incentives counseling. GN 03311.005B.3.b provides a definition of “program purposes,” which includes “information needed by the beneficiary seeking to return to work or participating in the current Ticket to Work program”;

• Specify to whom the record may be disclosed; and

• State a time during which the record may be disclosed. If no time frame is given, Social Security will assume the consent is for a one-time only disclosure.

You can go to socialsecurity.gov to find the current form (http://www.socialsecurity.gov/online/ssa-3288.pdf). This is now a
“fillable form,” so it’s possible to type the information into the boxes, print the form, and have the beneficiary sign it. Or, you may simply print the form and make copies to send to beneficiaries.

An important resource for CWICs is the Benefits Planning Query Handbook (BPQY) Handbook. The BPQY Handbook is a Social Security publication that includes information on the purpose of the BPQY, how to request a BPQY, and explains the details of each section of the BPQY. The BPQY Handbook also includes two Form SSA-3288 exhibits with the appropriate information for requesting a BPQY inserted. These pre-populated SSA-3288s are also provided on the VCU NTDC website (https://vcu-ntdc.org/resources/resourceDetail.cfm?id=6). CWICs should use these pre-populated forms when obtaining a BPQY for a beneficiary.


Send the completed forms to the beneficiary’s local Social Security office with a specific request for the BPQY. Some Social Security offices require WIPA projects to submit all releases to a central point of contact (such as the WIL or Office Manager). Other offices allow you to send the releases directly to Claims Representatives or Service Representatives. Be sure to research how each local office in your service area prefers to have BPQY requests submitted, and always follow the proper procedure for each office. Social Security must receive the form within 60 days of the date the beneficiary signed it in order to process the request.

The Area Work Incentive Coordinator (AWIC) is also a valuable resource if you encounter difficulty receiving BPQYs or other information from the local Social Security office. The AWIC is charged with training and technical support to the local offices on work incentive issues, and he or she may know how best to go about getting what you need to serve the beneficiary.

In situations when a WIPA project needs additional support when working with the field office staff, you should advise your Project Manager, and the Project Manager can contact the OES Project Officer for assistance. The best way to avoid these problems, however, is by doing positive, proactive outreach with the WIL in each local office.

Additional tips for obtaining BPQYs in a timely manner:
1. Develop a good working relationship with the local WIL. Ask how long you should expect to wait for BPQYs.

2. Follow proper protocol. If the office accepts faxes, fax the releases. If they require original signatures, mail or hand-deliver releases.

3. If you don’t receive the BPQY in the expected timeframe, call to follow up and submit a second request. It’s always a good idea to have a copy of the releases in case originals were mailed or hand-delivered.

4. Ask beneficiaries to get the BPQY themselves by calling Social Security’s toll-free number or by visiting the local Social Security field office.

**Reviewing the BPQY:** Social Security generates the BPQY by pulling from several different data sources at Social Security, including the Master Beneficiary Record (MBR), the Disability Control File (DCF), the Supplemental Security Income Display (SSID), the Summary Earnings Query (SEQY), and the Inquiry Response (QRSL). If any information in these data systems is outdated or incorrect, the information on the BPQY will be inaccurate. For example, if the beneficiary didn’t report earnings or if Social Security hasn’t yet processed work reports, the work incentive information on the BPQY will probably be outdated. You can help identify discrepancies or errors in any item on the BPQY by bringing this to the beneficiary’s attention and helping him or her resolve this through the local Social Security office to avoid future misunderstandings or overpayments. A subsequent BPQY should confirm that Social Security made the correction(s). It’s important to keep in mind that the BPQY, as with all verifications, is a starting point. You must scrutinize it for inconsistencies or missing information.

The Social Security BPQY Handbook explains the details of each section of the BPQY. In general, when you examine the BPQY, you should take these steps to try to answer questions or resolve concerns:

1. Contact the beneficiary or his or her representative and specifically ask questions about the information on the BPQY. You need to know if it matches what the beneficiary is experiencing or what he or she remembers about work history. In some cases, this simple step will provide the
information you need to resolve the mystery at hand. If not, move on to the next step.

2. Many of the resolutions to BPQY problems will come from contact with the WIL in the local office, or possibly the AWIC. These Social Security employees have access to the computer files and may be able to look up the question and answer in a matter of minutes. Make sure you have a signed release of information before you make a request of this nature.

An additional resource for verifying basic Social Security benefit information is the “my Social Security” online portal system. Beneficiaries can go to Social Security’s website and create a personalized account, which they can use to print a benefit verification letter. The beneficiary will also be able to see his or her record of annual earnings, benefit amount, and payment information. Beneficiaries can also change their address, phone number, and direct deposit through this portal.

Beneficiaries can sign in or create an account using the following link: [www.ssa.gov/myaccount](http://www.ssa.gov/myaccount).

Unfortunately, it isn’t currently possible to request a BPQY using the “my Social Security” account or to access the information contained in the BPQY through these accounts.

**Medicare Part D, Low Income Subsidy, and Medicare Savings Program:** Because the BPQY can’t verify Medicare Part D, Low Income Subsidy, or the Medicare Savings Programs reliably, you can instead use Medicare’s 1-800 call center to provide that information. To use this process, you must have the beneficiary with you on the call. The following steps outline how to obtain this verification:

Approximate time to verify: 5-10 minutes

1. Call 1-800-633-4227.

2. At the main menu say, “Help me with something else”.

3. Provide the requested PII about the beneficiary.

4. An operator will come on the call; let him or her know you are a social worker calling to verify a client’s Part D enrollment information. The operator will ask you for the following information about the beneficiary: Medicare
number, name, date of birth, whether he or she is enrolled in Part B, and your name.

5. Ask the operator to verify if the beneficiary is enrolled in Part D, at which time the operator will let you know what prescription drug plan the beneficiary is enrolled in and when he or she enrolled.

6. Ask the operator to verify if the beneficiary is enrolled in the "Low Income Subsidy Program" or "Extra Help." If the operator says yes, make sure to clarify if it’s partial subsidy or a full subsidy.

7. Ask the operator to verify if the beneficiary is enrolled in the "Medicare Savings Program" or "Qualified Medicare Beneficiary." If the operator says yes, be certain to clarify which Medicare Savings Program the beneficiary is enrolled in, such as Qualified Medicare Beneficiary (QMB), Special Low Income Beneficiary (SLMB), or Qualified Individual (QI).

Please note the following important points:

• Calling Medicare’s 1-800 call center will not work if the beneficiary isn’t on the call with you. Call center workers are strictly prohibited from speaking with you without the beneficiary being present.

• Please be aware that if there are any abnormalities that arise when verifying the Medicare Savings Program, you won’t be able to talk through those issues with this call center operator. He or she is simply reading off the individual’s eligibility status as it’s coded in the data system. The state Medicaid agencies are responsible for determining eligibility for Medicare Savings Programs, so you’ll need to contact that agency to clarify any abnormalities.

Another option is to use the “myMedicare” online portal system. MyMedicare.gov is part of the Medicare.gov website. MyMedicare.gov is an optional, free, and secure site designed to help beneficiaries check the status of their eligibility, enrollment, and other Medicare benefits — including enrollment in the Low Income Subsidy and Medicare Savings Programs. It also lets beneficiaries access claims information almost
immediately after Medicare processes their claims and provides beneficiaries with preventive health information 24 hours a day, seven days a week. To create a “myMedicare” account, beneficiaries simply go to mymedicare.gov and follow the instructions.

**Ticket Assignment:** In advising beneficiaries about their Ticket to Work and the medical continuing disability review protection, there is some key information you need to verify. You need to confirm when the beneficiary’s Ticket was assigned (month and year), to whom his or her Ticket is currently assigned, when his or her last Timely Progress Review occurred, and if his or her Ticket is considered in “active” status. You can verify this information by contacting the Ticket to Work Help Line at 1-866-968-7842 when you have the beneficiary with you in person or on conference call. Ticket Call Center personnel are strictly prohibited from speaking with you unless the beneficiary is present.

**Veteran’s Benefits:** You may verify veteran’s benefits by reviewing a copy of an award letter. If a veteran doesn’t have a copy of his or her award letter but he or she has, or is willing to, set up a password to access his or her VA benefit information through the online portal, “eBenefits,” you can verify benefits that way as well (https://www.ebenefits.va.gov/ebenefits/homepage).

**Railroad Retirement Benefits:** You may verify Railroad Retirement Benefits by reviewing a copy of an award letter or by requesting a copy of verification at the Railroad Retirement Board’s website (https://secure.rrb.gov/mep/ben_services.asp).

**Black Lung Benefits:** You may verify Black Lung Benefits by reviewing an award letter or by requesting verification through the DOL Division of Coal Mine Worker’s Compensation (https://www.dol.gov/owcp/dcmwc/).

**Documenting Verifications**

CWICs are required to maintain documentation of verification in the beneficiary’s record for any beneficiary receiving individualized services. This documentation could include copies of BPQYs, statements of benefits or other correspondence that verifies the public benefits he or she received, current benefits status, payment amounts, and the work incentives the beneficiary used. When verifying benefits through a conversation with an agency representative (such as when calling the Medicare call center), CWICs should record the conversation in a case
note. The case note should include the date of the conversation, the name of the person with whom you spoke, and details about what information you verified. Additionally, copies of relevant releases of information should be on file to verify that the beneficiary granted permission to obtain information from agencies.

As previously mentioned, it’s imperative that you verify ALL benefit information BEFORE offering individualized benefits counseling. Providing benefit information or advice without verifying the benefit status is extremely dangerous and can have severe negative consequences for the beneficiary. While the BPQY can verify a substantial amount of information, most beneficiaries have additional benefits that provide critical support. You must also verify these benefits, which means the process for obtaining verification generally involves more than just obtaining the BPQY. Although you may run into some challenges finding timely or efficient ways to verify some benefits, you must be persistent in finding solutions. Establishing an effective and efficient manner for verifying benefits is essential for WIPA projects to provide the quality and depth of services beneficiaries need.

**Conclusion**

Conducting initial information-gathering interviews for individuals who will receive individualized WIPA services is a critical part of delivering high-quality WIPA services. This interview process is the means by which CWICs collect all of the information they use to conduct individualized work incentives planning, and it forms the basis for developing the BS&A. If you conduct the information-gathering process incompletely, everything that occurs from that point forward will be flawed. Analyzing work incentive use and determining the impact of employment on benefits when you’ve only gathered half the facts is a very dangerous practice — dangerous to the beneficiary you are trying to help. Hopefully, this unit has offered practical advice about what types of information you need to collect, efficient techniques for gathering the information, and ways to verify that all information you use in work incentive planning is accurate.
Conducting Independent Research

For more information regarding Representative Payees, see the Social Security’s Program Operations Manual System (POMS) instructions:

- **POMS DI 31001.000 - Representation of Claimants** - Subchapter Table of Contents
  (https://secure.ssa.gov/apps10/poms.nsf/lnx/0431001000)

- **POMS GN 00501.000 – Representative Payee General** – Subchapter Table of Contents
  (https://secure.ssa.gov/apps10/poms.nsf/lnx/0200501000)

- **POMS GN 00502.300 - Digest of State Guardianship Laws**
  (https://secure.ssa.gov/poms.nsf/lnx/0200502300)

- **Social Security Handbook’s information about Representative Payees**

Additional Resources

On the following pages, we have provided a blank copy of the recommended Initial Interview Guide and a handy Quick Reference Guide for Benefits Verification.
WIPA Initial Interview Guide

January 2020

Step 1: Start with a brief introduction to WIPA services.

My name is _______, and I am a Community Work Incentives Coordinator with (name of your agency). I’m calling because you have been referred for Work Incentives Planning and Assistance (WIPA) services. The WIPA program provides eligible Social Security disability beneficiaries with complete and accurate information about how going to work will affect any federal, state or local benefits they receive.

NOTE: If you have any doubt about whether the person is eligible for WIPA services, don’t go into lengthy explanation of the program until you have verified eligibility. Move on to the next step in the interview process.

If the individual is clearly eligible, you may need to offer more information about what WIPA services entail. Don’t assume the person knows what WIPA is.

Step 2: Check to see if the beneficiary is eligible for WIPA services.

NOTE: This step may not be necessary for people referred by the Ticket to Work (TtW) Help Line. If the TtW Help Line referred the person, you can find the type(s) of benefit in the demographics section of the referral. In these cases, you should confirm with the person what benefits show in the referral. If there are discrepancies between what the beneficiary says and what shows in the referral section, ask additional questions to clarify.

Before I can offer you services, I need to confirm that you meet Social Security’s rules for the WIPA program. First you must be at least age 14, but not yet full retirement age (is that true for you?). Second, you must already be receiving Social Security benefits based on disability.

Possible Questions to Help Determine Type of Social Security Benefits:

- Can you tell me what type of benefits you get from Social Security?

- Do you know if you get Social Security disability benefits (SSDI) or SSI?
• Do you get more than one benefit payment from Social Security each month?
• How much is your Social Security payment?
• Do you know if your benefits are based on your past work, or do you get benefits from the earnings record of a parent or a spouse?
• Do you know if you have Medicare or Medicaid health insurance? Note: If they don’t know, have them describe their insurance card. Is it white with a red white and blue stripe? Is it (whatever color of card your state uses for Medicaid.)?

Table 1: Determining Eligibility

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<tr>
<th>Eligible</th>
<th>Not Eligible</th>
<th>Unsure</th>
</tr>
</thead>
</table>
| If the person is clearly eligible, move on in the interview process to determine priority for WIPA services. | If the person is clearly not eligible, do not move forward in the interview process. Explain why the person is not eligible and ask questions to determine the presenting need. Make referrals for services based on presenting need. **Do not provide** repeated contacts to ineligible individuals. | If the beneficiary doesn’t know what benefit he/she gets and you can’t make an accurate assessment by asking the suggested questions, you have several options:  

1. You can help the person set up a “my Social Security” account and verify online with the person’s permission.  
2. You can send the person the SSA-3288s needed to request a BPQY. |
Step 3: Determine where the beneficiary currently is on the Employment Continuum and the beneficiary’s future employment and/or earnings goals. This step helps you decide if the person is a high priority for WIPA services.

Now I need to ask some questions about your employment status. This will help me figure out what information about work and benefits would help you the most and give me an idea about how quickly you need that information.

Are you currently working (or self-employed) or do you have a job offer pending?

Table 2: Determining Employment Status

<table>
<thead>
<tr>
<th>Yes, Working or Has Pending Offer</th>
<th>Not Working &amp; No Pending Offer</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What type of work (or self-employment) are you doing or will you be doing?</td>
<td>• Are you actively looking for a job (are you going on interviews or submitting applications/resumes?)</td>
</tr>
<tr>
<td>• Is your employment (or job offer) full-time or part time?</td>
<td>• Are you actively working to become self-employed or planning to start a small business?</td>
</tr>
<tr>
<td>• How many hours do you work (or will you be working) per week?</td>
<td>• Are you currently in school or participating in any kind of</td>
</tr>
<tr>
<td>• What is (or will be) your hourly wage or salary?</td>
<td></td>
</tr>
</tbody>
</table>

Do not move on in the interview process if you suspect the individual is not eligible for WIPA services. Wait until you verify. In particular, do not provide any work incentives information until you have verified the benefit.
<table>
<thead>
<tr>
<th>Yes, Working or Has Pending Offer</th>
<th>Not Working &amp; No Pending Offer</th>
</tr>
</thead>
<tbody>
<tr>
<td>• When did you (or will you) start your job (or self-employment)?</td>
<td>education or training program? If so, when do you expect to complete this program?</td>
</tr>
<tr>
<td>• Have you notified Social Security that you are working? If so, how did you make contact with SSA?</td>
<td>• Are you getting help from an agency to prepare for work or find a job?</td>
</tr>
<tr>
<td>• NOTE: For employed individuals, don’t assume that the job they currently HAVE is the one they eventually WANT. Be sure to ask about future employment goals:</td>
<td>• Do you have an open case with the state VR agency or an appointment to meet with the state VR agency?</td>
</tr>
<tr>
<td>• Are you satisfied with the job you have now?</td>
<td>• Have you done anything in particular to prepare for getting a job?</td>
</tr>
<tr>
<td>• Do you hope to increase your hours and/or earnings in the future?</td>
<td>• Are you getting career counseling to help you decide what kind of work is right for you?</td>
</tr>
<tr>
<td>• Are you considering a promotion or a job change?</td>
<td>• Would you say that you have definitely decided to try to work? If so, do you have a specific employment or earnings goal?</td>
</tr>
<tr>
<td>• Do you have a raise pending?</td>
<td>• Are you unsure about your ability to work or just starting to think about the possibility of working?</td>
</tr>
<tr>
<td>• Do you have any long term career goals?</td>
<td></td>
</tr>
<tr>
<td>• Have you thought about what you need to do in order to meet your future employment or earnings goal? For example...</td>
<td></td>
</tr>
</tbody>
</table>

**IMPORTANT NOTE:** Individuals who indicate that they don’t have a specific employment or earnings goal, haven’t done anything to prepare for employment, or are just beginning to think about working, are a LOW priority for WIPA services. In most cases, you should provide these individuals with basic information and referral services (I&R) instead of individualized WIPA services.

For beneficiaries who need only I&R services:
• You do NOT need to complete the full interview process or request a BPQY for beneficiaries who only receive I&R services. Instead, provide summary information about the effect of work on the Social Security benefits the person receives, and answer any specific questions the person asks about work and benefits.

• Provide referrals for any additional services the person is seeking;

• Ask the person to contact you again for more individualized counseling when they have a clear employment or earnings goal. Encourage the beneficiary to contact you as soon as he/she begins to interview for jobs or start a business so that there is sufficient time to provide adequate counseling.

**Step 4: Gather information about current employment (if applicable) and past work since entitlement to Social Security benefits**

**NOTE:** If the beneficiary is currently employed or self-employed, start this part of the interview by gathering details about his or her work. You need to know the following things:

1. Employing company and job title (type of business for someone who is self-employed);

2. Start date;

3. Hourly wage and average number of hours per week, monthly salary, or average monthly Net Earnings from Self Employment (NESE);

4. Pay periods or pay days; and

5. Potential for use of work incentives. For SSI recipients you should check for Student Earned Income Exclusion (SEIE), Impairment Related Work Expenses (IRWEs) and Blind Work Expenses (BWE), as applicable. For Title II disability beneficiaries, check for possible IRWEs and Subsidy/Special Conditions (unincurred business expenses and/or unpaid help for self-employed Title II beneficiaries).
If the beneficiary is NOT currently working, move on to questions about possible past work.

OK, now that we have talked about your current employment status, I need to ask you a few questions about any work you’ve done in the past since you started getting Social Security disability benefits.

When you get SSI, this information is important because earned income may cause a reduction in your cash payments. We want to make sure Social Security accounted for those past earnings. If they didn’t, I can help you manage that moving forward.

When you get SSDI, this information is important because there are certain rules called “work incentives” that protect you from having employment affect your benefits right away, but these rules have time limits. If you’ve worked in the past, you may have already used some of these work incentives. In order for me to give you accurate information about your current or future work, I need to know a little bit about any past jobs you’ve had since you started getting Social Security.

- Have you worked or been self-employed since you started getting disability benefits?
- Can you give me a general idea of when you worked and what you did?
- Do you remember what your hourly wage was and how many hours you worked in each job?
- Do you remember if you let Social Security know you were working? If so, did you get any correspondence from Social Security asking for information about your work?

**NOTE:** Be sure to explain that you will be requesting a BPQY and that past work will show up on that report. Assure the beneficiary that it’s OK if he/she is unclear about the details of the past work, as you can work on that later on if needed. For now, you just want a basic list of the different jobs the person may have had and a rough idea about when the beneficiary worked in those jobs and about how much they earned. Be aware that this conversation may cause some anxiety – be sensitive to that possibility.
Step 5: Gather information about employment services and supports the beneficiary currently has and determine unmet needs.

**NOTE:** Helping beneficiaries connect with the employment services and supports needed to achieve their career goals is an important part of a CWIC’s job. It’s important that you determine which services a beneficiary is already receiving and discuss unmet needs. You should provide information and referral services to the state VR agency, ENs, or other providers as appropriate to overcome barriers to employment. Don’t assume that a beneficiary’s needs are being met just because he/she has an open case with VR. Be sure to ask specific questions about employment barriers or unmet needs.

Earlier in our conversation I asked some questions about your current employment status. Since the WIPA program provides employment focused benefits counseling, a big part of what we do is help beneficiaries connect with the services and supports they need to successfully achieve their employment goals. I would like to ask you a few questions about the services you told me you are already getting.

**For individuals who are already receiving services:**

- Do you have an open case with state VR or blind services agency? If so, what services are you getting? Are you satisfied with the services you are currently getting?

- Are you receiving employment supports from an EN? If so, what services are you getting? Are you satisfied with the services you are currently getting?

- Are you receiving services from other community agency? If so, what services are you getting? Are you satisfied with the services you are currently getting?

- Has anyone talked with you about the Ticket to Work Program? Do you know if your ticket is assigned or “in use”? (The beneficiary may need to verify Ticket status by calling the TTW Help Line – you will have to provide that contact information).

**NOTE:** Be prepared to explain the Ticket program and probe for questions. You may also need to explain how the
state VR agency works or answer questions about other employment services providers. You should take your time with this part of the interview. Make sure you have fully explained how the employment services system for people with disabilities works so beneficiaries know what to expect.

For ALL individuals:

- Do you feel like you need any specific services or supports to achieve your employment goal?

- Do you have barriers to employment that you feel are keeping you from achieving your career goals? Check for the following:
  - Lack of reliable transportation
  - Lack of child/elder care
  - Unresolved health issues
  - Communication barriers
  - Lack of access to assistive technology or inability to use technology
  - Need for job accommodations
  - Accessibility issues
  - Family or personal crises
  - Conflicts with supervisor or co-workers

Step 6: Gather information about family members who also receive Social Security benefits.

At this point, I would like to ask you some additional questions about your living situation and household members. I need to know if you have any dependent family members in your household who also receive Social Security benefits because it’s possible for your work to affect those benefits. I want to be sure that I provide you with complete information about how work will affect the benefits of anyone in your household.

Don’t worry if you don’t know for sure what benefits your family members get or how much the benefit payments are. Some of that information will be on the BPQY report I mentioned earlier.
For Title II disability beneficiaries:

- Do you have dependents in your household such as a spouse or minor children who receive a Social Security benefit check because you receive disability benefits?

- Do any of your dependents (children, spouse, or domestic partner) receive SSI? If so, who receives this and how much is the monthly benefit?

For SSI recipients:

- Do you live in your own household, or in someone else’s household?

- If you live with someone else, do you pay your share of the household expenses, OR if not your share, do you contribute something to the household for food and/or rent/mortgage?

- If you live in your own household, does anyone help you pay your food and shelter costs? If so, can you describe the help you get?

- Are you married? If so, does your spouse live with you? Does your spouse have any income, such as earnings or cash benefits or other income? If so, can you tell me the amount of that income?

- Do any of your dependents (children, spouse, or domestic partner) receive SSI? If so, who receives this and how much is the monthly benefit?

Step 7: Gather information about health insurance and healthcare needs.

Now I need to ask you a few questions about any health insurance you may have. There are lots of different kinds of health insurance. Some are related to the Social Security benefits you receive, some aren’t.

First, do you or any of your dependent family members receive any form of government funded health insurance or healthcare? This includes Medicare, Medicaid, and the VA healthcare system.

For individuals who have Medicare:

- Are you enrolled in Medicare? If so, which parts of Medicare are you enrolled in? For example, Part A which pays for hospitalization, Part B which pays for doctor visits and outpatient
services, and Part D which pays for prescription drug coverage. Some people are enrolled in something called Medicare Advantage or Part C. Which of these apply to you?

- If you are enrolled in Part B, is your monthly premium deducted from your benefit check?
- Do you know if you get assistance in paying for the Part B premium from the state? If so, does the state also help with the other Medicare out-of-pocket costs?
- If you are enrolled in a Part D prescription drug plan, do you get help paying the premium and other out-of-pocket costs for this coverage? Social Security calls this Part D assistance “extra help” or “the low-income subsidy”.

For individuals who have Medicaid:
You told me that you have Medicaid. There are lots of ways to qualify for Medicaid and it’s possible to be enrolled in more than one Medicaid program at the same time. Different Medicaid programs are affected by working in different ways, so it’s important that I know exactly which type of Medicaid you get. It’s OK if you don’t know the answers to all my questions about your Medicaid coverage. With your permission, I will contact the state Medicaid agency to verify your Medicaid benefits.

- In most states, when you get SSI, you also qualify for Medicaid coverage. Do you know if the Medicaid coverage you have is related to your SSI benefit?
- One type of Medicaid coverage is provided to people who have really high medical expenses. That program is called “Medically Needy Medicaid” or sometimes “Spend-Down”. Do you have any out of pocket expenses each month before your Medicaid coverage begins (which is typically called a spend down or share of cost)? If so, are you able to meet these expenses each month?
- If the state has a Medicaid Buy-In program and if the person is working: Now that you are working, are you participating in the state’s Medicaid Buy-In program, which is called (Buy –In name)?
- There is a special type of Medicaid that’s provided to certain people who used to get SSI but who lost eligibility for SSI
because they started getting SSDI or Childhood Disability benefits. Did you get SSI in the past and then lost it when you started getting another type of disability benefit from Social Security?

- There are some Medicaid programs that cover services related to your disability in addition to medical services. These programs are often referred to as Medicaid waiver programs. Are you enrolled in one of these programs? (You may want to provide the names of specific waivers in your state to help the person identify if he or she is enrolled in a waiver program.)

- Do you have any other family members or dependents living in your household who receive Medicaid?

**For individuals who indicate they use the VA Healthcare System:**

- Which services from the VA healthcare system do you use? Do the services you receive from the VA meet all of your healthcare needs? NOTE: There are different levels of VA health care (i.e. some get full coverage and others just use prescription drug coverage). Be sure to ask what services the person gets from the VA.

**For all individuals, inquire into other private health insurance coverage:**

Healthcare coverage is very important, not only for you, but for others in your family (such as your dependents). I would like to ask a couple of questions to see how your employment will affect the health insurance coverage available to your family members.

- Do you have private health insurance coverage, such as coverage through a family member current employer or previous employment? If so, are you satisfied with the services you get and the cost of your coverage?

**Step 8: Gather information about any other federal, state or local benefits the person receives that paid employment could affect.**

Now, I would like to ask you about other benefits or assistance you receive. This will help me to analyze how employment might affect your other benefits and provide you with information about any changes you might expect when you go to work. Paid employment may affect the assistance you receive. Please let me know if you or any of your
dependent family members receive any of the following benefits. It’s really helpful if you can tell me how much the benefit is, but it’s OK if you aren’t sure. I can contact the agency that administers any benefit you receive to verify what you receive.

**NOTE:** Refer to the benefits verification checklist in the manual for a list of ways to verify the different benefits. You may not need releases of information for everything if the beneficiary has correspondence he/she can share, or if there are online accounts the beneficiary can use to verify benefits.

- Supplemental Nutrition Assistance (also known as Food Stamps)?
- Housing assistance or rental assistance?
- Temporary Assistance for Needy Families (TANF)?
- Low Income Energy Assistance Program (LIHEAP)?
- Workers Compensation?
- Disability insurance benefits provided by a previous employer?
- Unemployment Insurance Benefits?
- Veteran’s benefits? NOTE: If the beneficiary says he/she gets VA benefits, be sure to use the Veterans Information Gathering Tool in addition to this interview guide.
- Railroad Retirement?
- Black Lung benefits?
- Any other assistance, such as Community Action Program Assistance, etc.?

**For individuals who indicate they get some form of housing or rental assistance:**

There are lots of different housing or rental assistance programs and some offer special supports for residents who are working. I would like to review your housing information with you to see if there are any of these programs you could benefit from.

- First of all, your living situation: Do you live alone or with family/roommates? How many people are in your household?
• Do you own your home? If not, are you interested in learning about programs for homeownership?

• Are you renting? Do you receive any type of rental assistance to help pay for your housing (such as a voucher, or reduction of your rent based on your household income)? If so, do you know the name of the rental assistance program you are in? If you don’t get assistance, are you struggling to afford your rent?

• Do you know the name of the person you work with at the housing agency?

**Step 9: Gather information about other sources of income and resources, as appropriate. This step is really more important for SSI recipients than Title II beneficiaries. Use your best judgement to determine whether or not to ask these questions.**

If you receive other types of income besides wages, it may affect some benefits (like SSI). To help me understand your benefit situation, please tell me if you receive:

• Child support? If so, is it for you or for your children?

• Maintenance/Alimony/Palimony?

• Pell Grants or other forms of educational assistance?

• Do you have any other income?

In the SSI program, resources can affect your eligibility. Resources may include cash or items that have value. Right now, SSI eligible individuals may not have more than $2,000 in countable resources while eligible couples have a resource limit of $3,000. Social security doesn’t count certain resources like the home you live in and one vehicle.

• Do you currently have resources that are worth more than the current SSI limit?

**Step 10: Gather information about Representative Payee and Legal Guardianship.**

I also need to ask if you manage your benefits yourself or if someone helps you with that (such as a representative payee). If so, I need to get a release of information so that we can share the information about how employment will affect your benefits.
• Do you have a legal guardian? If so, that person will need to sign releases to verify your benefits.

• Do you have a representative payee who helps you manage your Social Security benefit?

**Step 11: Conclude the interview and explain next steps.**

Well, that concludes the information gathering process. I know this seems like a lot of questions, but the more information I have, the more comprehensive my counseling can be. The next step in the process is for me to verify your benefits to make sure I know exactly what you are getting. It’s really important that I am 100% clear in order to avoid mistakes.

• Provide instruction here about what you need in order to get the BPQY. If you are asking the beneficiary to get his/her own BPQY, be sure to provide clear instructions about how to make that request and what to do with the report when they receive it.

• If the beneficiary receives any other benefits that require verification, check to see what is available without needing a release of information. If you need a release, be sure to explain what the release form is for and what to do with it when it comes in the mail.

• Make sure the beneficiary understands that you can’t provide in-depth individualized benefits counseling without the necessary verification. Stress the importance of getting the required forms back to you promptly. Explain that the verification process can be a bit slow sometimes and encourage the beneficiary to call you as questions arise.

• Explain what the beneficiary should expect from you once you verify the benefits. You will review the BPQY with the beneficiary and you may need to get some additional questions answered at that time. You will know more once you get the BPQY and review it. You should NOT move on to BS&A development until you have gone over the BPQY with the beneficiary and identified any areas in need of additional research or development.

• The most valuable part of WIPA services is the individualized benefits analysis and work incentives counseling. Explain that
you will go over how the employment/earning goal is likely to affect all benefits received in detail. You will explain everything verbally, and then summarize it in a special report called a benefits summary and analysis or BS&A (if appropriate).

• Thank the beneficiary for taking the time to complete the interview process. End the conversation with information about when the beneficiary can expect to hear from you again. Always encourage the beneficiary to contact you with questions or concerns as they may arise.
# Benefit Verification Quick Reference Guide

## Title II Disability (SSDI, CDB, DWB)

<table>
<thead>
<tr>
<th>What to Verify</th>
<th>Ways to Verify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Title II benefits (SSDI, CDB, DWB), current benefit amount(s) (full and net)</td>
<td>BPQY, recent letter from Social Security noting updated check amount (within last 6 months) or use “my Social Security” feature (<a href="http://www.ssa.gov/myaccount">http://www.ssa.gov/myaccount</a>)</td>
</tr>
<tr>
<td>Difference between full and net amounts</td>
<td>Overpayment recovery and subsidy for Medicare Part B premium are on BPQY. All other reasons for difference must be verified with Social Security personnel.</td>
</tr>
<tr>
<td>Auxiliary benefits (if any)</td>
<td>BPQY or use “my Social Security” feature (<a href="http://www.ssa.gov/myaccount">http://www.ssa.gov/myaccount</a>)</td>
</tr>
<tr>
<td>Date of Onset and Date of Entitlement</td>
<td>BPQY, Social Security award letter</td>
</tr>
<tr>
<td>Next diaried medical CDR, representative payee status</td>
<td>BPQY</td>
</tr>
<tr>
<td>Work incentive information (current and previous use) and know earnings history</td>
<td>BPQY, recent work review decision (within last 6 months, older if no work activity since review)</td>
</tr>
</tbody>
</table>

## SSI

<table>
<thead>
<tr>
<th>What to Verify</th>
<th>Ways to Verify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current benefit amount (full and net)</td>
<td>BPQY, recent letter from Social Security noting updated check amount (within last 2 months) or use “my Social Security” feature (<a href="http://www.ssa.gov/myaccount">http://www.ssa.gov/myaccount</a>)</td>
</tr>
<tr>
<td>Difference between full and net Amounts</td>
<td>Overpayment recovery is on BPQY. All other reasons for difference must BPQY, Social Security personnel.</td>
</tr>
<tr>
<td>Date of Onset and Date of Entitlement</td>
<td>BPQY, Social Security award letter</td>
</tr>
<tr>
<td>What to Verify</td>
<td>Ways to Verify</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Next diaried medical CDR, representative payee status</td>
<td>BPQY</td>
</tr>
<tr>
<td>Work incentive information (current and previous use) and known work history</td>
<td>BPQY</td>
</tr>
</tbody>
</table>

**State Supplement**

<table>
<thead>
<tr>
<th>What to Verify</th>
<th>Ways to Verify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current benefit amount</td>
<td>Federally administered: BPQY State administered: Medicaid agency (i.e. case worker, centralized verification process, etc.), recent award or redetermination letter (within last 6 months)</td>
</tr>
</tbody>
</table>

**Ticket to Work**

<table>
<thead>
<tr>
<th>What to Verify</th>
<th>Ways to Verify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ticket assignment status, to whom the Ticket is assigned, when the Ticket was assigned, when the last Timely Progress Review was done, and if Timely Progress Requirements were met.</td>
<td>Beneficiary or Rep. Payee must call the Ticket to Work Help Line at 1-866-968-7842. No information will be provided to third parties without the beneficiary or rep. payee being on the line.</td>
</tr>
</tbody>
</table>

**Medicare**

<table>
<thead>
<tr>
<th>What to Verify</th>
<th>Ways to Verify</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part A:</strong> Is beneficiary enrolled (yes/no) and enrollment date</td>
<td>BPQY, copy of Medicare card, Medicare 1-800 # or use “my Medicare” feature at mymedicare.gov</td>
</tr>
<tr>
<td><strong>Part B:</strong> Is beneficiary enrolled (yes/no), enrollment date, premium beneficiary is paying</td>
<td>BPQY, copy of Medicare card, Medicare 1-800 # or use “my Medicare” feature at mymedicare.gov</td>
</tr>
<tr>
<td><strong>Part C:</strong> Is beneficiary enrolled (yes/no), enrollment date, premium</td>
<td>Medicare 1-800 # or use “my Medicare” feature at mymedicare.gov</td>
</tr>
<tr>
<td>What to Verify</td>
<td>Ways to Verify</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Part D</strong>: Is beneficiary enrolled (yes/no), premium beneficiary is paying</td>
<td>Medicare 1-800 # or use “my Medicare” feature at <a href="http://mymedicare.gov">mymedicare.gov</a></td>
</tr>
<tr>
<td><strong>EPMC</strong>: If cessation has occurred, number of EPMC months remaining</td>
<td>BPQYs show EPMC end date or contact Social Security personnel (WIL, Claims Representative, etc.)</td>
</tr>
</tbody>
</table>

**Medicare Savings Program (QMB, SLMB, QI)**

<table>
<thead>
<tr>
<th>What to Verify</th>
<th>Ways to Verify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently eligible (yes/no), which group enrolled in</td>
<td>Medicare 1-800#, state Medicaid agency (case worker, centralized verification process), recent award or redetermination letter (within last 6 months) or use “my Medicare” feature at <a href="http://mymedicare.gov">mymedicare.gov</a></td>
</tr>
</tbody>
</table>

**Medicare Part B State Buy-In**

<table>
<thead>
<tr>
<th>What to Verify</th>
<th>Ways to Verify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently eligible (yes/no)</td>
<td>Medicaid agency (case worker, centralized verification process)</td>
</tr>
</tbody>
</table>

**Part D Low Income Subsidy (Extra Help)**

<table>
<thead>
<tr>
<th>What to Verify</th>
<th>Ways to Verify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently eligible (yes/no), what % of LIS coverage, and if any additional premium is being deducted from Title II check (when they select a better plan than the subsidy covers)</td>
<td>Medicare 1-800 # or use “my Medicare” feature at <a href="http://mymedicare.gov">mymedicare.gov</a></td>
</tr>
</tbody>
</table>

**SSI Medicaid Eligibility Category**

<table>
<thead>
<tr>
<th>What to Verify</th>
<th>Ways to Verify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently eligible (yes/no) for SSI related Medicaid</td>
<td>For those SSI eligible in 1634 states: BPQY. All others: Medicaid agency (case worker, centralized verification process)</td>
</tr>
</tbody>
</table>
### Other Medicaid Eligibility Categories & Medicaid Waiver Programs

<table>
<thead>
<tr>
<th>What to Verify</th>
<th>Ways to Verify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently eligible (yes/no), which eligibility category or waiver program enrolled in</td>
<td>Medicaid agency (case worker, centralized verification process), award letter</td>
</tr>
</tbody>
</table>

### SNAP

<table>
<thead>
<tr>
<th>What to Verify</th>
<th>Ways to Verify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current amount</td>
<td>State agency administering SNAP (case worker, centralized verification process), recent (within last 3-6 months, depending on frequency of state recertification) award or redetermination letter. Check state SNAP website for self-service options.</td>
</tr>
</tbody>
</table>

### Housing Assistance

<table>
<thead>
<tr>
<th>What to Verify</th>
<th>Ways to Verify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which housing subsidy program enrolled in and rent or subsidy amount</td>
<td>Housing program case manager/administrator (case worker, centralized verification), recent (within last 12 months) award, redetermination letter, or rental agreement.</td>
</tr>
<tr>
<td>Number of EID months available and involvement in FSS</td>
<td>Housing program case manager/administrator case worker</td>
</tr>
</tbody>
</table>

### Veteran's Benefits

<table>
<thead>
<tr>
<th>What to Verify</th>
<th>Ways to Verify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of VA cash benefit (compensation or pension), benefit amount, individual unemployability designation, VA medical priority group</td>
<td>Award letter or use self-service &quot;eBenefits&quot; option (<a href="https://www.ebenefits.va.gov/ebenefits-portal/ebenefits.portal">https://www.ebenefits.va.gov/ebenefits-portal/ebenefits.portal</a>)</td>
</tr>
</tbody>
</table>

### Department of Defense Disability Retirement

<table>
<thead>
<tr>
<th>What to Verify</th>
<th>Ways to Verify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit amount</td>
<td>Award letter</td>
</tr>
</tbody>
</table>
### Unemployment Insurance

<table>
<thead>
<tr>
<th>What to Verify</th>
<th>Ways to Verify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly benefit amount, number of weeks left of payment</td>
<td>State agency administering Unemployment Benefits (case worker, centralized verification process). Check UI agency website for self-service options.</td>
</tr>
</tbody>
</table>

### Railroad Benefits

<table>
<thead>
<tr>
<th>What to Verify</th>
<th>Ways to Verify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type and amount benefit</td>
<td>Award letter, request copy of verification at <a href="https://secure.rrb.gov/mep/ben_services.asp">RRB website</a></td>
</tr>
</tbody>
</table>

### Worker's Compensation

<table>
<thead>
<tr>
<th>What to Verify</th>
<th>Ways to Verify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type and amount benefit</td>
<td>Award letter or other correspondence, check state Worker’s Compensation website for self-service options.</td>
</tr>
</tbody>
</table>

### Private Disability Benefit or Pension

<table>
<thead>
<tr>
<th>What to Verify</th>
<th>Ways to Verify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type and amount benefit</td>
<td>Award letter or other correspondence, check for website with self-service options or toll-free line.</td>
</tr>
</tbody>
</table>

### Black Lung Benefits

<table>
<thead>
<tr>
<th>What to Verify</th>
<th>Ways to Verify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type and amount benefit</td>
<td>Award letter, request verification through <a href="https://www.dol.gov/owcp/dcmwc/">DOL Division of Coal Mine Worker’s Compensation</a> website</td>
</tr>
</tbody>
</table>
Introduction

The primary objective of the WIPA program is to provide individualized work incentives planning and assistance services that support Social Security disability beneficiaries to succeed in their return-to-work efforts. Our mission is to ensure that beneficiaries who desire to seek, secure, or maintain employment have access to accurate and complete information that will allow them to benefit from all the current work incentives available in the Social Security disability programs, as well as other federal, state, or local programs that may assist them in their employment efforts.

The cornerstone of WIPA program is the customized analysis of benefits in relation to an individual’s unique employment goals and the personalized work incentives counseling designed to support that individual in meeting his or her goals. CWICs provide this counseling through numerous discussions with beneficiaries during which the CWIC describes specific work incentives, answers questions about benefits and work, explains advantages and disadvantages of available options, and offers expert advice. CWICs dispense a great deal of valuable information during these interactions with beneficiaries and much of it is highly complex. To help beneficiaries understand and retain this information, CWICs are trained to summarize the benefits counseling provided in a document called a Benefits Summary and Analysis or BS&A. This unit focuses on developing these BS&A reports.

Understanding the Difference between Providing Individualized WIPA Services and Developing BS&A Reports

In the WIPA program, Social Security places significant emphasis on the importance of developing high quality BS&A reports so that beneficiaries and members of their employment support teams have written
documentation of the benefits analysis and work incentives counseling CWICs provide.

It’s important for CWICs to understand, that development of BS&A reports is only part of the services they provide. CWICs should not confuse the development of the BS&A report with the actual provision of individualized WIPA services. Benefits Summary and Analysis reports merely summarize the counseling and advisement CWICs provide to beneficiaries over the course of numerous personal interactions. While the written report is a valuable component of WIPA services, it does not replace the discussions necessary to provide high quality customized work incentives planning and assistance. As you will recall from Module 1, individualized WIPA services includes ALL of the following components:

- In-depth personalized information gathering, verification and benefits analysis covering all federal, state, and local benefits;
- Customized counseling about the effect of an employment or earnings goal on all federal, state, and local benefits and development of a comprehensive Benefits Summary & Analysis (BS&A) report summarizing this counseling;
- Assistance with identifying, developing, utilizing, and managing work incentives;
- Assistance with resolving problems related to benefits;
- Assistance with identifying and resolving barriers to obtaining or maintaining employment;
- Making referrals for needed services or supports with particular emphasis on meeting employment needs;
- Coordination with members of the beneficiary’s employment support team; and
- Training and support on effective reporting procedures and benefits management techniques.

**Remember** – Developing BS&A reports is only one component of individualized WIPA service provision. Developing a BS&A report doesn’t replace personalized counseling – it merely documents the information you provide in a written format.
Overview of Benefits Summary and Analysis (BS&A) Reports

The BS&A is a written report that summarizes the beneficiary’s current benefit status and provides customized case-specific information about the past, current, and future use of work incentives that support a beneficiary’s work and earnings goal.

CWICs prepare a BS&A for beneficiaries who need individualized, case-specific benefits and work incentives information. The BS&A documents the customized information a beneficiary needs to make informed decisions about work. In keeping with the mission of the WIPA program, the BS&A report promotes employment and offers recommendations to enhance a beneficiary’s financial independence.

BS&A reports, under the WIPA program, must analyze the beneficiary’s specific earning goal(s) or range of earnings, and contain ALL of the following components:

- Confirmation of all verified benefits an individual (and dependent family members) receive that paid employment could affect;
- Confirmation of the beneficiary’s current employment and/or future earnings goal;
- Detailed descriptions of how the earning goal(s) will affect all benefits the individual (and dependent family members) receives;
- Description of specific work incentives applicable to the beneficiary;
- Recommendations for employment services that could help the beneficiary achieve the specific earning goal(s); and
- Options for resolving any benefit issues.

To create the BS&A, the CWIC follows these key steps:

1. Gather all relevant benefits information;
2. Verify the information gathered;
3. Analyze the verified benefits information as it relates to the beneficiary’s employment or earnings goal; and
4. Summarize the benefits analysis and work incentives counseling in a formal written report that meets Social Security’s specifications.

**Determining When a Beneficiary Should Receive a Benefits Summary and Analysis**

First, keep in mind that BS&A development is part of providing individualized WIPA services. This service is not intended for beneficiaries who are of low priority who will only be receiving generic I&R services. Furthermore, not every beneficiary who is a good candidate for individualized WIPA services requires a written BS&A – at least not initially. The need for a BS&A is related to three factors:

1. Whether the beneficiary has an employment and/or earnings goal;
2. How close the beneficiary is to employment; and
3. How willing the beneficiary is to complete the information gathering and verification process required for comprehensive individualized benefits counseling.

Let’s take a look at each of these determining factors separately.

**Employment and Earnings Goals for BS&A Development**

Beneficiaries in any of the following situations have an earnings goal and are appropriate candidates for BS&A development:

- The beneficiary has identified an employment goal as well as a specific monthly earnings target based on this goal.
- The beneficiary has identified an employment goal, but has no specific monthly earnings amount in mind. By gathering additional information related to how many hours the beneficiary is able to and is interested in working, and the prevailing rate of pay in the community for the particular type of work, the CWIC will be able to help the beneficiary refine his or her earnings goal.
• The beneficiary hasn’t defined an employment goal, but is able to indicate the amount of monthly earnings he or she needs to meet his or her financial obligations and goals.

• The beneficiary hasn’t defined a specific job goal, but is able to share the number of hours per week he or she would like to work and in general how much he or she thinks he or she will need to or would like to earn an hour. The CWIC can use these two pieces of information to identify the earnings goal.

• The beneficiary may or may not have identified an employment goal, but has a range of hours, a wage (or both) that he or she is considering. In these instances, the CWIC may use a range of monthly earnings in the BS&A rather than a single amount. When this happens, it’s important to keep the range as small as possible, to best reflect that beneficiary’s situation.

• The beneficiary may or may not have identified an employment goal, but is interested in understanding the impact of working at varying earnings levels. In these instances, the CWIC will assist the beneficiary to clarify the different earnings targets for analysis and will discuss each option in the BS&A.

• The beneficiary indicates that he or she would like to eliminate the need for federal disability benefits. The beneficiary would like to know how much he or she would have to earn to offset all the federal and state benefit income he or she currently receives.

When you ask about his or her earnings goal, a beneficiary may say, “I just want to know how much I can earn before I lose my benefits.” Respond by asking probing questions about his or her ideas for work, as well as his or her financial needs and goals. Shift the conversation from limiting earnings to using employment as a step toward greater financial stability and independence. Some examples of probing questions are:

• How much do you need to earn to meet your living expenses and other financial obligations?

• What level of income do you need to fully replace the benefits you (and dependent family members) receive?

• Do you have a major purchase goal, such as a home or a business?
**Proximity to Employment**

People who are the closest to employment are those whom Social Security has indicated are the highest priority for individualized WIPA services. As you will recall from Unit 1 of this module, this includes:

- Individuals who are currently working or engaging in self-employment and have both a need for and interest in receiving individualized work incentives planning and assistance services;
- Transition age youth who are interested in work (Social Security defines transition age youth as being at least 14 years old through the age of 25); and
- Beneficiaries who are actively pursuing employment or self-employment and who are interested in receiving work-related benefits counseling.

The closer a beneficiary is to employment, the more necessary BS&A development is since the beneficiary needs this information to make informed decisions about work and to understand what to expect in terms of benefit changes. Beneficiaries who are already employed at a level that could affect benefits are the highest priority for counseling and BS&A development as they may be at risk of overpayment if they do not report earnings and work incentives promptly.

**Completing the Information Gathering and Verification Process**

CWICs begin providing individualized WIPA services by gathering comprehensive information about any benefits an individual, and their dependent family members receive and how paid employment may affect those benefits. This information gathering process is time consuming, but critically important as it is the foundation upon which all subsequent work incentives counseling stands. CWICs can’t provide high quality comprehensive individualized WIPA services without first gathering and verifying all relevant information.

Unfortunately, CWICs are not always able to get the information they need to provide individualized services, including BS&A development. Some beneficiaries don’t return the release of information forms needed to access BPQYs or other benefits verification. Other beneficiaries may not be willing to participate in the initial interview process due to
discomfort with providing personal information or concerns about privacy. In these cases, you should make every effort to explain the information gathering process and why it’s necessary. Be sure to review the advantages of individualized WIPA services and address any concerns the beneficiary has. Make sure the beneficiary understands that you are unable to provide customized benefits counseling without completing the information gathering and verification process. If the beneficiary refuses to provide the information you need to provide counseling and develop a BS&A report, you will be limited to providing generic I&R services.

There will also be times that the CWIC is simply unable to get the documentation needed to verify a particular benefit. Unfortunately, some state and local agency personnel don’t cooperate fully with requests for information, even with all the required permission from the beneficiary. When you are unsuccessful in your efforts to verify a benefit, you may have to provide benefits counseling without it. It’s important to note in your BS&A that you were unable to verify the benefit and indicate that the information provided is based on what the beneficiary reported to you.

This manual details information about the information gathering and verification process in Unit 3 of this Module. We also provide a sample initial interview guide that we encourage CWICs to use.

**Addressing the Information Needs of Beneficiaries Who Don’t Require a BS&A Report**

If a BS&A report isn’t appropriate or necessary, what options do CWICs have for providing some form of written information to beneficiaries? You can meet the needs of some beneficiaries with generic fact sheets or brochures that explain the work incentives. Others may only need a summary overview of how paid employment affects either SSI or the Title II disability benefits with a brief description of applicable work incentives. For beneficiaries who don’t need an in-depth BS&A, you should consider the following alternatives:

- Fact sheets that give an overall description of work incentives by program (Title II and SSI) or by individual work incentive (i.e., Student Earned Income Exclusion, Impairment Related Work...
Approved resource materials are available on the VCU NTDC website (https://vcu-ntdc.org/resources/index.cfm). If you develop original materials, your OES Project Officer must review and approve them prior to use.

- **Social Security publications**, such as the “Red Book,” a pamphlet titled “Working While Disabled” and a publication on Plans for Achieving Self-Support (PASS).(https://www.ssa.gov/pubs/).

- Customized packets of information that include general information and referral documents.

Keep in mind that a beneficiary’s status related to employment may change at any time. A beneficiary may not require BS&A development initially, but later may start preparing for a job or initiate a job search. CWICs need to be prepared to provide individualized WIPA services at any point after enrollment in WIPA services.

**BS&A Format**

In the 2019 WIPA Terms and Conditions document, Social Security clarified that WIPA projects are expected to use standard report-writing software to generate BS&As:

“Social Security, through the National Training and Data Center (NTDC) contract, shall purchase customized Benefits Summary and Analysis (BS&A) preparation software for each WIPA project. Once provided, the WIPA project shall use this software to produce benefits analyses for beneficiaries requiring intensive benefits counseling. The purpose of this software is to produce accurate, comprehensive, and uniform BS&A reports. To use the software, WIPA grantees must provide the NTDC with accurate and comprehensive details about State and local benefits programs affecting beneficiaries within the WIPA’s service area. Staff shall participate in training provided by the NTDC, including submission of sample analyses for review and quality assurance. Social Security will provide training and additional guidance.”

Given this guidance, in the beginning of 2016, VCU’s NTDC began working on this task. After researching software options, VCU selected
“HotDocs”, also called BSADocs, as the best option given various factors, including ease of use, accessibility, and functionality. VCU rolled out the BS&A report writing software across the country between 2016 and 2019.

**Using BSADocs for BS&A Development**

Report-writing software, also known as document automation software, is designed to improve efficiency and quality in generating frequently used reports. In many industries, such as legal and insurance, professionals must create reports that are similar in many ways from one client to the next, but different in other ways. Rather than manually assembling sections of previously produced reports, this type of software compiles the report based on the data the user inputs.

Under their contract with Social Security, the VCU NTDC has created a “template” to function as a master report. The template contains a general explanation about the effect of work on each type of public benefit. Additionally, for each public benefit, there are explanations for the different effects work could have on the benefit.

To generate a BS&A report, a CWIC must complete a questionnaire about the beneficiary’s situation, earnings goal, and the CWIC’s analysis of the effect of work on each benefit within the software application. CWICs gather answers to the relevant questions during the information gathering process. The answers to the interview questions determine which explanations in the template (the master report) the software will include or not include in the final, personalized report.

Once the CWIC answers all the interview questions, he or she clicks an icon on the software and BSADocs creates the BS&A report shell in a Microsoft Word document. CWICs further customize the report by adding personalized information in sections entitled “Specific to You”. Additionally, the CWIC can save the specific set of questionnaire answers for the beneficiary’s report in the software as a “work item”. The advantage of this feature is that if the beneficiary requires an updated analysis in the future, the CWIC can open the saved work item and simply adjust the answers to reflect what has changed in the person’s situation, making the process for updating a BS&A report quick and easy.

The NTDC also makes annual updates to each state’s template. Under the WIPA Terms and Conditions, every year WIPA projects review their state-specific benefit information and confirm whether any changes have occurred in the benefit rules. If changes are needed, the WIPA projects
provide details on those changes and work with the NTDC to modify the benefit information in the template. The NTDC incorporates those state-specific benefit changes, along with any federal changes, to the template and loads the updated version onto the Hub for CWICs to use.

**BS&A Format for CWICs without Access to BSADocs**

CWICs going through the initial certification process will not have access to BSADocs until they complete their third Part II certification BS&A. Instead, CWICs in the Part II certification process are required to use the BS&A template format posted on the VCU NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=92).

**BS&A Planning and Organization**

Before beginning to write a BS&A report, make sure you have all of the information you need and plan how you want to present the relevant information. Here are some tips to help you get started and keep you organized:

1. Carefully review the information you gathered during the initial interview process, the BPQY and other verification documents, and any notes from your discussions with the beneficiary, the representative payee, or other individuals on the employment support team. Are you 100% sure you know the beneficiary’s current benefits status? Are there any outstanding benefits issues, uncertainties or questions that still need to be resolved? If the beneficiary has any dependent family members, are you sure you have all of the information about benefits those individuals receive that could be affected by your client going to work? If at all possible, don’t proceed to develop the BS&A until you have any outstanding issues clarified.

2. Using all of the information you have gathered and verified, make a list of all the benefits the individual (and any dependent family member) receives that could possibly be affected by employment. Check and double-check this list to make sure you haven’t forgotten anything. You may want to have a colleague or manager
look at the list and help you think about anything you may have missed.

3. Make sure you are clear about the beneficiary’s current employment status and any future employment or earnings goals. You can’t develop a BS&A without having some sort of earnings goal to analyze benefits against. If you are uncertain, contact the beneficiary one more time to clarify and confirm.

4. Make sure you have identified any problems the individual has with his or her benefits and list any questions the person asked about benefits that you need to address in the BS&A.

5. Begin by sorting benefits or issues you want to address under each of the categories of information required in a BS&A report. Put each benefit under the category that’s most appropriate and don’t list any benefit or issue more than once.
   - How the earnings goal will affect Social Security cash benefits (this includes SSI, Title II disability benefits, auxiliary benefits, etc.)
   - How the earnings goal will affect health insurance (Medicare, MSPs, Part D LIS, Medicaid, VA healthcare benefits, etc.)
   - How the earnings goal will affect other benefits (SNAP, HUD housing assistance, TANF, Worker’s Compensation, Unemployment Insurance, etc.)
   - Employment supports and other services that could help the beneficiary reach the earnings goal (State VR agency, ENs, other services to overcome barriers to employment);
   - Other topics you want to include based on benefits issues you identified or questions the beneficiary posed (non-employment related issues like deeming or ISM, overpayments, ABLE accounts, the EITC, referrals for other benefits the person may need, etc.)
• Important things for the beneficiary to remember (information about how to report wages or other information, important deadlines, etc.)

6. In your outline, try to list the subjects you want to cover in the order you plan to present them in the report. Think carefully about the sequence of information. Does it flow logically? If there are work incentives or provisions you want to discuss, add those in too.

**NOTE:** We have attached a sample BS&A Planning Tool at the end of this unit that you may use to outline the information you plan to include in the BS&A prior to writing the actual report. This planning tool is really just a structured outline that will help you organize the information before you begin writing. You will use this tool during Part 1 of the CWIC certification process.

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**Avoiding TMI Syndrome – Too Much Information**

One of the most difficult aspects of writing BS&As is deciding how much information to include in the report and what to leave out. Well-intended CWICs often worry about leaving something out that might possibly apply. In an attempt to cover all the bases, CWICs may discuss every conceivable work incentive that could ever possibly apply in agonizing detail.

Keep in mind that beneficiaries may be overwhelmed and intimidated by the sheer volume and complexity of the information you provide. This may intensify any fears a beneficiary has about a reduction or termination of benefits. If, after reviewing the BS&A, the beneficiary doesn’t understand how work will impact his or her benefits, he or she may choose not to work rather than take the risk. Overwhelmed with information, beneficiaries may avoid taking the next step toward employment. This is the worst possible outcome of providing too much information – the TMI syndrome.

When writing BS&A reports, TMI syndrome is characterized by two different mistakes CWICs make.
1. The first mistake is simply providing too much detail about work incentives or other benefits issues that would only marginally apply to the beneficiary, or that have a low probability of occurring.

2. Second, TMI includes discussing provisions, work incentives or other benefit effects that could happen far out in the future. The rule of thumb in developing BS&As is not to include information about anything that would occur more than one year to 18 months out.

In providing work incentives counseling, best practice is to follow the principles of “just in time” learning. The “just in time” learning theory is based on the idea that people are ready to learn and retain information only when the need to apply it exists. With “just in time” benefits counseling, the CWIC provides the right type and amount of information and support necessary to help the beneficiary move forward along the employment continuum.

So, how much information is too much? How do you know when you’ve provided enough information and at the right time? There’s no simple answer. It all depends on the beneficiary and his or her unique situation. Let’s take a look at each of the categories of information required in a BS&A report and some specific examples of what is enough and “just in time” and what would be too much.

**IMPORTANT NOTE:** "Just in time" benefits counseling assumes that CWICs have ongoing relationships with high priority beneficiaries and are making multiple contacts over time. Trying to apply the just-in-time approach won’t work if you’re only able to provide very time-limited services. Remember that the current WIPA service model is based on serving higher-priority WIPA candidates in a more intensive manner and over a longer period of time. Social Security expects CWICs to provide information over a period of weeks or months as part of the proactive follow-up process. If the beneficiary agrees, repeated contacts will be necessary, and you may need to revise the BS&A report as a beneficiary’s circumstances change over time.
What to Include in a BS&A and What to Leave Out

Remember that the sections in BS&As developed using the standard format and the BSADocs format are a little bit different. Don’t worry about the exact wording of a category or get hung up on exactly where discussion of a certain topic should appear in the report. We wrote this part of the unit to help you develop a broad understanding of what to cover in a BS&A and what to leave out.

Listing Verified Benefits

What to do:

- You should list all benefits that potentially could be affected by employment in this section with monthly amounts listed as appropriate. That includes all Social Security benefits plus other federal, state or local benefits such as SNAP, HUD housing subsidies, Workers Compensation, Unemployment Insurance, private disability insurance, etc.

- If the beneficiary has dependent family members in the household (spouse and/or children) be sure to verify and list any benefits those individuals receive that could be affected by the beneficiary’s employment. Things to watch for include eligible couples, Social Security child-in-care or child’s benefits, and Medicaid coverage.

- If the Social Security benefit is being reduced for some reason, be sure to verify that in this section. You should list the gross and net amounts of the cash payment and clearly state why the check is being reduced. Reasons for benefit reduction could include withholding for Medicare premiums, taxes, overpayment recovery or child support or SSI reductions due to ISM, deeming, unearned income, earned income, etc.

- Be sure to include all assistance the beneficiary may be getting with Medicare out-of-pocket costs such as Medicare Savings Programs (MSP) or the Part D Low Income Subsidy (LIS). Be specific by identifying which MSP the person is enrolled in (QMB, SLMB or QI) and whether the person is getting full or partial LIS.
• If the beneficiary is eligible for Medicaid through more than one Medicaid eligibility category, each category should be verified and listed separately. For example, if an SSI recipient receives SSI related Medicaid but also participates in a Medicaid waiver program, you need to list both of these eligibility categories. Be sure to use the correct name of the Medicaid program to avoid confusion.

• Be sure to check the BPQY for statutory blindness designation. If the beneficiary shows as being stat blind, that should be listed in this section of the BS&A since it has a bearing on the work incentives you will discuss in the report.

**What to avoid:**

• Only include information in this section that’s relevant to the counseling you are providing. For example, there’s no need to verify date of disability onset or date of entitlement unless that information has some bearing on the information you provide in the report. You don’t need to list every piece of information provided in the BPQY in this section – only that which is relevant.

• Don’t include information about employment services and supports the person is getting in this section. For example, there’s no need to verify here that the beneficiary has an open case with VR or has a ticket in assignment with an EN. Save all of that information for the section dedicated to employment services and supports.

• Including explanations of work incentives usage in this section would also be “too much information” or TMI. If the beneficiary had an approved PASS in the past or is currently eligible for the Student Earned Income Exclusion (SEIE) that discussion should go in other sections, not here.

• There’s no need to verify benefits the individual does NOT receive. It isn’t necessary to state that the beneficiary doesn’t get SNAP, HUD housing subsidies, etc. The only exception to this would be when a beneficiary alleged that a benefit was received, when it fact, you verified that it wasn’t.
Current Employment Situation and Future Employment Plans and/or Earnings Goals

What to do:

• Keep discussion here focused on the person’s current job and/or future employment and earnings goal if different from the current job. Be sure to include all of the relevant facts – employing company, job title, hours per week, hourly wage, estimated monthly gross earnings, and start date. **Remember – you MUST include a monthly earnings goal** in every BS&A in order to have something to analyze the benefits against.

• When you are illustrating anticipated monthly earnings, it’s helpful to show any calculations you used in determining this figure. The BSADocs software does not show calculations. If you want to provide this information, it needs to go in the “Specific to You” space.

• If the beneficiary is currently working and has been working for some time, the gross monthly wages you list in this section should be based on pay stubs or other actual wage data, rather than just an estimate. Remember, Social Security counts wages differently for SSI recipients than for Title II beneficiaries. For SSI recipients, wages count when they are received. In the Title II program, wages count in the month they were earned (with some exceptions). For Title II beneficiaries, Social Security will use a basic formula (rate of pay X # hours per week X 4.333) to determine monthly earnings.

• For Title II disability beneficiaries, it may be necessary to list past work since it may have some bearing on work incentives usage you discuss in subsequent sections of the report. Again, keep the content focused on employing company, job title, hours per week, estimated monthly gross earnings, and when the work occurred (start and end month/year). If the BPQY indicates that Social Security hasn’t fully developed the past work, list whatever information the beneficiary can provide or make a general statement that there appears to be undeveloped past work. You will have to revise the BS&A when all the past work is fully developed.
What to avoid:

- Nothing else should go in this section. Don’t include discussion of work incentives, employment services and supports, or anything else. Keep the content focused solely on current employment situation and/or future employment or earnings goal.

How Work will Affect Social Security Cash Benefits

What to do – Title II Beneficiaries:

- Beneficiaries who are working (or are planning to work) for the first time since entitlement who have projected earnings above the TWP guideline should receive specific information about TWP usage. If possible, project when the TWP is likely to end and be sure to illustrate your narrative using a TWP/EPE/EXR Tracking Chart.

- You should provide beneficiaries who have earnings goals just under SGA with some information about how it’s possible to earn more and still retain cash payments. Beneficiaries sometimes choose an earnings goal just under SGA because they are afraid of losing benefits and health insurance. You should include a brief discussion of the SGA determination process, and explain work incentives such as IRWE and subsidy. The only exception to this would be when the beneficiary has been very definite that he/she is not able or is unwilling to work above the stated earnings goal.

- Watch for earnings goals that would result in loss of benefits, but wouldn’t result in net wages that fully replace those benefits. CWICs have a duty to warn beneficiaries when an earnings goal would result in less disposable income. This is critical discussion, not TMI. Be sure to include discussion about how a higher earnings goal might result in increased financial well-being.

- If the beneficiary appears to be working above SGA or has a goal to do so, be sure to ask probing questions to see if any work incentives might apply (IRWE or Subsidy/Special Conditions). If it looks like a work incentive might apply, provide specific information about the work incentive that is customized to the beneficiary. For example, if the beneficiary plans to use
paratransit to and from work, explain that this expense may qualify as an IRWE. If possible, you should also provide an estimate of how much the IRWE or subsidy would be and explain how this would reduce the countable earned income.

• If past work is evident, you should provide specific information about TWP/EPE months used in the narrative and illustrate this information using a TWP/EPE/EXR Tracking Sheet.

**What to avoid – Title II Beneficiaries:**

• Beneficiaries with very low earnings goals (under TWP or over TWP but under SGA) do not need lengthy explanations of provisions that would result in suspended benefits, such as EXR. These beneficiaries would also not need a lengthy explanation of how SGA determinations are made with detailed discussion of the four tools Social Security uses to make SGA determinations (UWA, IRWE, Subsidy/Special Conditions, Income Averaging). A brief discussion (a few sentences) of SGA is sufficient.

• Don’t provide detailed explanations of TWP and/or EPE for beneficiaries who have already used up these work incentives. Offer a very brief summary (a sentence or two) and indicate that the work incentive is no longer available. Focus your discussion on how the earnings goal will affect benefits moving forward. If the earnings goal represents possible SGA, be sure to discuss how SGA determinations are made with detailed explanations of the 4 tools used to make these determinations. Be sure to include discussion of EXR if benefit termination is possible in the near future (i.e., within the coming 18 months).

• Don’t go into detail about how to report earnings in this section. That information goes elsewhere.

**What to do – SSI Recipients:**

• Be clear and specific in your narrative about how the current earnings or future earnings goal will affect the SSI cash payment and include SSI calculation sheets to illustrate your point. It isn’t TMI to explain the SSI calculations briefly. Don’t just refer the reader to the calculations sheets without providing any narrative explanation.
• Always emphasize the total financial outcome of work plus the reduced or eliminated SSI cash payment. Beneficiaries tend to focus on the fact that the SSI check will be reduced without understanding that the earnings more than compensate for that reduction. Clearly indicate how much disposable income is available after working as compared to being on SSI benefits alone.

• Show SSI recipients with low earnings goals how earning MORE always results in a better financial outcome – even if the countable earned income causes the SSI payment to stop. Focus your discussion on the positive financial benefits of working and earning more and the protections that 1619(b) provides for moving in and out of cash payment status. If the beneficiary has an earnings goal that would be over the BEP, show that in your calculation sheets, but focus your discussion on the positive aspects of earning more.

• Always check before assuming that no work incentives apply – particularly IRWE. If it’s possible that the beneficiary will incur IRWEs, provide a summary explanation with examples of expenses that might qualify and encourage the beneficiary to contact you when a job offer is made so you can explore further. Remember, many SSI recipients could benefit from applying IRWEs if they have expenses that would qualify.

• Any beneficiary who could qualify for the Student Earned Income Exclusion should receive a detailed explanation of this powerful work incentive.

• Any SSI recipient who is statutorily blind should receive a detailed explanation of Blind Work Expenses. You should include an SSI calculation sheet illustrating how any incentive you discuss would affect the SSI cash payment.

What to avoid – SSI Recipients:

• Do not provide detailed discussions of the break-even point or provide calculations showing how much in earnings would cause cash payments to be reduced to zero. This practice leads SSI recipients to worry that loss of cash benefits is a problem and may lead to wage suppression.
• Remember that EXR only applies to individuals who have fully terminated from benefits due to employment. In the SSI program, 1619(b) provisions protect the overwhelming majority of beneficiaries from terminating so discussion of EXR is seldom necessary.

• Don’t provide lengthy explanations of SSI work incentives (IRWE, BWE, SEIE) if they clearly would not apply to the beneficiary.

• Don’t discuss PASS with a beneficiary who is not clearly a good candidate for this complex work incentive. If the beneficiary specifically asks questions about PASS, or mentioned needing items or services to achieve an employment goal, provide a brief explanation and indicate why the person is or is not a good candidate for using a PASS.

• If the beneficiary has non-employment related reductions in the SSI cash payment, it’s fine to reference that briefly here, but don’t include lengthy explanations of the issue or possible solutions. That information goes in the “Benefits Issues” section of the BS&A. This section should only contain information related to employment.

**NOTE:** There are some unique considerations for concurrent beneficiaries that are covered in the resource document on the VCU NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=76).

### How Work Affects Health Insurance

**What to do:**

• If the beneficiary is still in the Medicare Qualifying Period (MQP), you should indicate that and verify for the person when Medicare coverage will begin. If the person is going to be working over SGA in that period and could possibly lose cash payments due to work, you should explain that the MQP will simply continue with no change. If Medicare enrollment will be soon (in the coming 6 months), be sure to explain a bit about how enrollment works. If the beneficiary seems unsure about enrolling in Parts B or D,
offer brief summary information about the consequences of not enrolling initially if this coverage is needed later on.

- If the beneficiary is enrolled in a Medicare Savings Program (MSP) and/or Part D low-income subsidy (LIS) and the employment goal would affect eligibility for these programs, be sure to discuss this fully and illustrate your discussion using MSP/LIS calculation sheets as needed. If the employment goal would NOT result in a change in these programs, simply state that but don’t get into a lengthy explanation or include MSP/LIS calculation sheets.

- If it’s likely that Social Security would determine that the beneficiary is engaging in SGA be sure to explain the EPMC. If it appears that the beneficiary would not qualify for MSP or LIS at that point, be sure to go over how the individual will pay Part B and/or D premiums are paid. Check to see if employer sponsored health insurance is (or potentially will be) an option. If so, provide counseling on this option.

- If the beneficiary has used up all of the work incentives (TWP, EPE and cessation/grace period) and is likely to engage in SGA again, describe how long the EPMC will last. If possible, you should identify when the EPMC is likely to end. Be sure to provide explanations of additional alternatives such as Premium HI for the Working Disabled, employer sponsored health insurance, Medicaid buy-in or other options available in your area.

- If an SSI recipient has an employment goal that would NOT cause the loss of cash payments, explain that Medicaid will continue unchanged and provide a brief description of 1619(b). If the employment goal would cause the loss of cash payments, provide a detailed explanation of 1619(b) including all eligibility criteria.

- If an SSI recipient’s earnings goal is likely to exceed the threshold amount for 1619(b), be sure to indicate that and explain how an individualized threshold may be established, if needed. Explore additional alternatives including Medicaid buy-in and employer sponsored coverage as needed.
• Beneficiaries who are enrolled in Medicaid waiver services must receive clear and specific information about how the employment goal will potentially affect waiver eligibility and cost sharing, if that is applicable in your state. If cost sharing will apply, include a worksheet or calculation sheet illustrating that. If the employment goal would not affect waiver eligibility or cost sharing, simply state that with a very brief discussion.

• If the beneficiary is employed and employer sponsored health insurance is an option, be sure to discuss that. If there are any anticipated interactions between various forms of health insurance (Medicare and TRICARE or employer-sponsored coverage, for example) describe those interactions and offer advice as needed.

• Be sure to check to make sure the beneficiary’s health care needs are being met with the current insurance, or anticipated insurance after employment begins. If not, offer information on other options (if any).

What to avoid:

• If the beneficiary’s employment goal would not cause the suspension or termination of Title II cash payments, don’t provide a detailed explanation of the EPMC or ways to extend Medicare coverage after the EPMC expires (Premium HI for the Working Disabled and QDWI). A brief mention (one or two sentences) of the EPMC is sufficient. The same is true if it’s going to be longer than a couple of years before the EPE would end and termination could occur. You can always address this issue in more detail later.

• Don’t discuss any healthcare options for which the beneficiary is unlikely to qualify or which are not likely to be available.

How Work Affects Other Benefits

What to do:

• Provide a discussion of how the earnings goal would affect benefits the individual currently receives. If the work goal would not affect the other benefits in any way, state that clearly. If the work goal would affect other benefits, you must be specific about how. Indicate if the benefit will be reduced or if the goal will
cause ineligibility. If possible, provide an estimate of how much the benefit in question will be reduced.

- Be sure to include information about any work incentives available under other federal/state or local programs.
- If you see potential eligibility for additional benefits the individual needs, you may provide referral information in this section, but be careful not to make referrals for benefits the person would not be likely to qualify for or which aren’t available.

**What to avoid:**

- Don’t get into lengthy explanations about how to report earnings to other agencies in this section. That discussion should appear ONCE in the BS&A if it is relevant and that would go in the section entitled “Other Topics” or “Other Important Items”.

**Employment Supports and Other Services that Could Help the Beneficiary Reach his/her Earnings Goal**

**What to do:**

- This section should include a list of any employment services or supports the beneficiary participates in or receives. This could include having an open case with the state VR agency, getting supported employment or job placement services from a community rehabilitation provider, or participating in a career education program. You should ask what type of service or support the agency is providing if it isn’t clear.

- You should ask beneficiaries about employment barriers they face or unmet need for employment services or supports. Provide specific information about, and referrals to services that will meet identified needs. Don’t provide information about services the beneficiary would not be eligible for or doesn’t indicate a need for. Customize information you provide in this section to fit with what each person needs. If the beneficiary is clear that all needs are being met, just state that and encourage him/her to contact you if the situation changes.
What to avoid:

- You should not provide detailed discussions of the Ticket to Work program to all beneficiaries. Not all beneficiaries will benefit from Ticket assignment and even those with a Ticket assigned or in use with the state VR agency may not benefit from a detailed discussion of the Ticket program. Reserve detailed discussion primarily for people who would benefit most from the medical CDR protections and who plan to work at a level that would preclude cash benefits. Individuals who are already working at a level that would not cause loss of cash payments with no plans to work more are not good Ticket candidates and would not benefit from detailed information about this work incentive. For individuals who have their Ticket in use with the state VR agency, be sure to explain timely progress reviews and what to expect when those reviews are done.

Other Topics Based on Benefits Issues Identified or Questions posed by the Beneficiary

What to do:

- For SSI recipients, if the SSI check is being reduced for any reason other than earned income, provide an explanation of that here. This would include deemed income, unearned income, in-kind support and maintenance, overpayment recovery, etc. If there are options for increasing the cash payment by resolving the problem, provide clear and specific explanations of those options and offer advice about how to proceed.

- If the beneficiary informs you of a pending life change that could affect benefits, be sure to address it here and provide specific information about what to expect. This could include a change in residence, change in marital status, changes in resources, etc.

- If you see benefits changes that are likely to occur in the near future (12-18 months), be sure to identify those and explain them briefly. Provide any specific instruction to the beneficiary that they may need to manage the impending change. This would also include discussion of changes that could affect eligibility for additional Social Security benefits including retirement, death or retirement of a parent, or generating sufficient work credits to establish eligibility for SSDI.
Remember not to project out too far – focus on events that are likely to occur in the coming 12 to 18 months.

- If the beneficiary posed any questions related to benefits that were unrelated to working, address those questions in this section.

- This section is a great place to include information about other benefits, services, or programs the individual could take advantage of. This might include ABLE accounts, the Earned Income Tax Credit, referrals for additional assistance, or similar information.

**What to avoid:**

- Don’t include duplicate information about work incentives or discussion of how work will affect benefits that you have addressed elsewhere in the BS&A. This section is reserved for benefits issues or other assorted topics that are unrelated to employment.

- Don’t discuss potential issues or problems that are unlikely to occur or which have a very low probability of occurring unless the beneficiary asks a specific question.

- Don’t provide detailed discussion of possible issues or problems which might occur in the distant future – more than 12-18 months out. Save that discussion for a later date.

**Important Things for the Beneficiary to Remember**

**What to do:**

- Many people who are not yet employed, have little if anything that needs to be addressed in this section. If there is nothing to address, simply state that.

- For an employed beneficiary or someone with a job offer pending, it’s important to explain HOW to correctly report earned income – that is not considered TMI. Beneficiaries often are unclear about how to communicate with Social Security and other agencies that administer benefit programs. Include all agencies that the beneficiary needs to contact with contact information and offer specific instructions about reporting. A useful handout that provided reporting tips to beneficiaries is

- Keep in mind that SSI recipients are required to report lots of different things in addition to earned income. This is a good place to offer reminders and instructions about what the beneficiary needs to report and how to report.

**What to avoid:**

- Do not provide lengthy explanations of how to report wages when the beneficiary is in the early stages of preparation for employment or job search. You should provide the Reporting Tips handout from the manual and reiterate that Social Security requires beneficiaries to report all earned income. Instruct the beneficiary to re-contact you when a job offer is pending or when circumstances change.

**Including Attachments with the BS&A Report**

You should include companion documents to support your analysis, as appropriate. SSI Calculation Sheets and TWP/EPE/EXR Tracking Charts are an essential part of the BS&A. For example, you should create an SSI Calculation Sheet for each possible scenario in a BS&A for an SSI-only or concurrent beneficiary. In addition to the narrative that explains how income is treated in the SSI program, include a separate calculation sheet to illustrate each of the following:

- How unearned income reduces the SSI payment.
- How earned income affects the SSI payment, including the earned income exclusion.
- How each additional deduction applies to the SSI formula (SEIE, IRWE, BWE, and PASS).
- How in-kind support reduces the SSI payment.

When you develop the BS&A, refer to Module 3 for calculation examples. You can find a blank copy of the SSI Calculation Sheet on the VCU-NTDC website. The beneficiary may want to see a comparison of different wage amounts before deciding on a level of work. Lay out the calculations side by side to provide a visual aide for the beneficiary.
For Title II beneficiaries, you should analyze the person’s status with regard to the Trial Work Period, the Extended Period of Eligibility, Expedited Reinstatement, and continuation of Medicare coverage. The TWP/EPE/EXR tracking chart shows progression of these work incentives phases, so the beneficiary will know when to expect changes in his or her benefits.

**BS&A Quality Considerations**

While problems CWICs encounter with not covering enough information or covering too much are the most common when developing BS&A reports, there are several other quality considerations worth discussion. Of these, the most important are:

- customizing the report to the beneficiary’s unique circumstances,
- maintaining a positive and encouraging tone, and
- warning beneficiaries when they are considering an action that might affect their benefits or health care coverage in a negative way.

Let’s take a look at these individually.

**Customizing the Report to Meet the Beneficiary’s Unique Circumstances**

The value of WIPA services and the BS&A report that summarizes the counseling provided lies exclusively in the individualized nature of that counseling. High quality work incentives counseling specifically addresses the beneficiary’s primary concern - “how will my earnings goal affect my benefits?”

When you write BS&As, a good rule of thumb is to follow any description of a work incentive of provision with a discussion about how this work incentive or provision applies specifically to the beneficiary and his or her unique situation. For example, after providing an explanation of the Trial Work Period, provide discussion of the beneficiary’s current work or earnings goal in terms of how it would or would not use TWP months. If any TWP months have been used in the past, be sure to mention that. Explain how a particular work incentive or benefit provision applies to the person for whom you are developing the report. If you use the BSADocs
software to develop BS&As, the template includes a “Specific to You” section at the end of each main topic area. This is where you provide original writing about exactly how the information provided in the template applies to the beneficiary given his or her unique goals and circumstances. Be sure to look over the sample BS&As we provide at the end of the unit to see how the authors tied information about work incentives back to the beneficiary in a customized way.

**Maintaining a Positive and Encouraging Tone**

Some things you might write in a BS&A report could worry the beneficiary. For example, if the beneficiary has an earnings goal that would cause the SSI cash payment to cease, he or she might fear that Medicaid coverage will also stop. Similarly, if an SSDI beneficiary has an employment goal and you determine that the work would probably represent SGA, the beneficiary might fear the sudden loss of the monthly cash payment. When writing BS&A reports, make sure you aren’t describing events in ways that cause beneficiaries to unnecessarily fear working above SGA, earning wages over the SSI break-even point, or earning more than the 1619(b) threshold amount. When writing narrative for BS&A reports, be extra cautious about the words you choose. Telling a beneficiary that he or she is “at risk” of termination or suspension will likely cause concern. While it’s important to be frank and honest, you also need to be positive and encouraging.

While it may not be in the best interests of some beneficiaries to terminate from benefits due to work, this is certainly NOT the case for all beneficiaries, or even most beneficiaries. Terminating from benefits isn’t a universally “bad” thing and isn’t harmful in the majority of cases. Don’t present this outcome in a negative fashion when you counsel beneficiaries. In fact, beneficiaries with the capacity to generate earnings sufficient to cause termination are frequently better off financially by doing so as long as they meet their health care needs and earn enough to fully replace all benefits. Remember, the intent of WIPA services isn’t to keep beneficiaries on disability benefits indefinitely but rather to promote employment and enhance financial independence. Counseling techniques or messages that discourage beneficiaries from working or frighten them into retaining attachment to public benefits are contrary to everything WIPA services are trying to achieve.

If you share potentially worrisome news in the BS&A, follow that news with something encouraging. For example, if you explain that the
beneficiary’s earnings goal will cause the SSI cash payment to be reduced to zero (potentially worrisome), immediately point out how the beneficiary will have more disposable income overall by working instead of relying solely on benefits (something encouraging).

**Remember this simple rule:** Always follow potentially negative news with positive news!

You can do that by focusing on the four positive messages you learned in the first unit of Module 2:

1. Paid employment and Social Security disability benefits aren’t mutually exclusive — beneficiaries don’t have to choose between work and benefits.
2. It’s possible to work (even full-time) and keep Medicaid, Medicare, or both in almost every case.
3. It’s possible to work and come out ahead financially, even if public benefits diminish or disappear.
4. It’s possible to receive disability benefits again if they’re lost due to employment.

Your objective is to help the beneficiary see the bigger picture of increased financial independence in the future rather than simply focusing in on an immediate reduction of benefits.

Another common situation that calls for your encouragement is when beneficiaries set a very low employment or earnings goal. For an SSI recipient, it could be a goal of working at less than $85 per month to avoid any reduction in cash payments. For a Title II beneficiary, it might be an earnings goal under the current TWP figure or just below the current SGA guideline. While there certainly are beneficiaries who simply can’t work above a very limited level, you shouldn’t assume that’s always the case. A low earnings goal may indicate that the person is afraid of benefits loss. We don’t want beneficiaries to choose low employment goals if they have the capacity to earn more but are afraid of how it would affect benefits. Don’t just accept the stated earnings goal at face value — probe gently to uncover how the beneficiary arrived at the goal. You should provide specific, individualized information in the BS&A about how higher wages might be possible to make certain that the beneficiary makes a fully informed choice. The objective is to show beneficiaries the positive possibilities rather than simply discussing a limited work goal.
selected out of fear. The intent isn’t to judge, but merely to fully inform beneficiaries and present their options.

**Understanding the Duty to Warn**

Some work situations can actually cause a beneficiary to be less financially stable than remaining on benefits alone. Our goal is to help beneficiaries improve their financial security by working. Employment situations that could cause a beneficiary to have less disposable income aren’t desirable, and you have a duty to warn the beneficiary when this potential exists.

Possible examples of this include:

- A Title II beneficiary receiving $1,200 in monthly benefits is considering a job offer resulting in gross wages of $1,300 a month. Social Security probably would consider this level of wages SGA if no potential for work incentives exists. The beneficiary’s net wages after all deductions would be substantially less than $1,200 (the amount of the SSDI cash payment), which would represent a LOSS of disposable income to the beneficiary once the SSDI payments ceased. The risk increases if the beneficiary has already used his or her TWP, EPE or both.

- Remember too that some beneficiaries have dependent family members who also receive a Social Security benefit based upon that person’s work record. Let’s take the example above of an SSDI beneficiary getting $1,200 each month and add the receipt of an additional $600 in benefits to dependent children. If that person accepted a job paying $1,300 a month, that would probably be considered SGA and that might cause the eventually loss of the total family benefit of $1,800. It’s really important that you help beneficiaries determine what they would need to earn to fully replace all benefits that could be lost or reduced. This is a very important discussion to include in BS&A reports.

- A Title II beneficiary receiving QMB coverage to pay the Medicare Part B premiums and other out-of-pocket costs accepts a part-time job making just enough to cause ineligibility for this benefit (or SLMB) while resulting in net wages of less than the value of this help. After the Medicare premium is deducted from
the SSDI cash payment, the beneficiary would have less disposable income than before going to work.

• A Title II or SSI beneficiary is planning to work at a level that would cause him or her to lose eligibility for Medicaid waiver services with no ability to replace the services through another source.

When an employment or earnings goal would potentially financially harm a beneficiary, you have an obligation to point this out. Keep in mind that you should never tell a beneficiary not to work or not to accept a job offer, or suggest that a beneficiary quit a job. The best approach: Show the beneficiary the consequences of various actions, and let the individual decide on a course of action. You should clearly explain the cost and benefit of each option and compare the financial outcomes of the various options so the beneficiary understands the differences.

In these cases, it’s really important to help beneficiaries determine how much they need to meet their living expenses and how much they would require to replace ALL public income supports when they determine an employment or earnings goal. Working at a level that wouldn’t fully replace the benefits lost isn’t the outcome we want to achieve. In these cases, show the beneficiary that working and earning MORE is really in his or her best interest. It’s up to the beneficiary to make employment decisions based upon accurate and complete information you provide.

**Quality Control for BS&As**

WIPA project staff should establish a protocol for supervisor and peer review and editing of BS&As before beneficiaries see the documents. It’s also good practice for new CWICs to ask their VCU NTDC technical assistance liaison to review the first few BS&A reports and provide feedback and suggestions for improvement. CWICs with more experience should submit BS&As for review on an ongoing, periodic basis as well.

**IMPORTANT:** Before releasing the BS&A to a beneficiary, check for the following common errors:

• The BS&A contains incorrect or outdated information about a benefit (such as listing the previous year’s income or resource limit).

• The BS&A doesn’t capture all of the relevant work incentive issues that would apply to the beneficiary, or it offers incomplete
information about applicable work incentives. It’s NOT appropriate to merely identify a specific work incentive and direct the beneficiary to look in the Social Security Red Book on a certain page for more information.

- The BS&A doesn’t provide work incentives information tailored to the beneficiary’s current or anticipated employment or earnings goal.
- The BS&A contains only generic descriptions of the work incentives because the beneficiary has no defined employment or earnings goal.
- The BS&A contains too much information and doesn’t consider where the beneficiary is on the road to employment and what his or her specific informational needs are at the present time.
- Information in the BS&A is disorganized, confusing, or presented out of order (for example, the BS&A switches back and forth between benefits and issues without any apparent planning or logic).
- The BS&A doesn’t address problems that are evident, or it mentions problems without offering specific advice about how to resolve them.
- The BS&A doesn’t address how working may affect other benefits besides Social Security disability benefits, such as food stamps, HUD housing subsidies, veteran’s benefits, etc.
- The BS&A doesn’t address how employment may affect the beneficiary’s health care coverage. This includes Medicare and associated Medicare Savings Programs (QMB, SLMB, QI, and QDWI) as well as Medicaid, including all Medicaid eligibility categories.
- The BS&A doesn’t address applicable near future events such as marriage penalties, establishing insured status for Title II benefits, etc.
- The BS&A doesn’t include SSI calculation sheets or TWP/EPE tracking sheets to illustrate the narrative on work incentives.
The BS&A is poorly written, with incomplete paragraphs and sentences, incorrect grammar and punctuation, misspelled words, typographical errors, etc.

**Reviewing BS&As with Beneficiaries**

Always provide the beneficiary with a copy of the BS&A and schedule time to review the contents of the report by phone. Remember, the heart of WIPA services isn’t the BS&A, but rather the discussions that occur with a beneficiary about their benefits and work goals. Plan to spend at least an hour going over the BS&A and answering questions. The beneficiary may want to include other concerned parties in the discussion, so be prepared to honor that request. Remember that you aren’t authorized to send a copy of the BS&A to anyone (except the beneficiary) without a signed consent form. When you’re reviewing BS&A reports with beneficiaries, keep the following strategies in mind:

- Avoid the use of Social Security technical jargon and acronyms whenever possible — keep it simple!
- Present ALL relevant options, and discuss the pros and cons of each.
- Offer suggestions and recommendations.
- Speak directly to the beneficiary, not to other individuals who may be present.
- Offer to share the BS&A with other members of the employment support team for feedback.
- Be sensitive to the beneficiary’s level of comprehension.
- Be patient — you may need to review certain concepts multiple times before the beneficiary understands them.
- Don’t send copies of the BS&A to others working with the beneficiary without the beneficiary’s prior authorization and signed releases.

As stated earlier, you’ll need to update the BS&A and review of any new options as the beneficiary moves forward in achieving his or her employment, earning, and self-sufficiency goals. The BS&A will be one of your main tools to frame counseling sessions.
Developing Work Incentives Plans (WIP)

A Work Incentives Plan (WIP) is a written document the CWIC develops in collaboration with the beneficiary and appropriate members of his or her employment support team. It delineates an individualized action plan for furthering the beneficiary’s employment and financial independence goals.

CWICs develop WIPs after they’ve written and reviewed the BS&A report with the beneficiary. The BS&A offers options or choices for the beneficiary to consider, while the WIP is designed to provide a “to-do” list of action steps based on the recommendations described in the BS&A. The CWIC regularly updates the WIP as the beneficiary’s circumstances change and as the CWIC updates the BS&A.

How the Work Incentives Plan Relates to the BS&A Report

CWICs are often confused about how WIPs differ from BS&A reports. While both are written documents dealing with employment, benefits, and work incentives issues, they’re not the same thing, and you can’t use them interchangeably.

The WIP is essentially the “to-do” list for the beneficiary and their employment support team. The WIP details specific action steps they should take based upon the CWIC’s findings and recommendations in the BS&A and the beneficiary’s choices. For each action step listed, the WIP indicates the person responsible and a target date for completion. The WIP also includes a follow-up contact schedule, listing the frequency and type of contact to be made and who is responsible for initiating contact.

In addition to identifying action steps for the beneficiary and the CWIC to complete, the WIP should also include other parties as appropriate. For instance, the representative payee needs to be involved in any reporting-related steps; or, if the beneficiary decides to pursue a PASS, the VR counselor or EN employment specialist might have a role in facilitating this work incentive.

The WIP includes measurable action steps related to the content found in the BS&A. These include:

- Managing Social Security benefits and work incentives
• Planning for future health care needs
• Managing federal, state, or local benefit programs
• Accessing employment services and supports
• Resolving existing benefit problems
• Creating a follow-up contact plan

Determining Which Beneficiaries Need a WIP

Once you develop the BS&A report, review it with the beneficiary. Together you’ll decide if the beneficiary needs ongoing services and if the beneficiary wants your involvement moving forward. Remember, the WIP is a “to-do” list. Beneficiaries who don’t have benefits related tasks to complete, or anything to do that requires your assistance would not need a WIP. If there are actions that need to be taken for the beneficiary to achieve his or her employment goal or resolve benefits issues, it’s likely that the beneficiary will want to move forward with a WIP. In some cases, the beneficiary may not be ready to move forward, or will want to move forward without your help. Involvement in a WIP is voluntary and it’s up to the beneficiary to decide if he or she wants this support. People who require very limited short-term services typically won’t need a WIP.

Measurable Action Steps

A helpful approach to developing measurable action steps is the S.M.A.R.T. acronym, which stands for:

Specific
Measurable
Action-Oriented
Realistic
Time- and Resource-Constrained

For steps listed on the WIP, the action, or “to-do,” step should be specific enough that all parties know what needs to be done; measurable, so all parties can tell exactly when they’ve reached the goal; action-oriented, to indicate an activity that will produce results; realistic, in that it’s practical and achievable; and, time- and resources-constrained, meaning that it has a definite deadline for completion and realizes limited availability of
resources. For example, the action step “Provide pay stub documentation
to the CWIC and meet to cooperatively develop and document monthly
earnings report for Social Security” is an example that follows these rules.
It’s more specific than “Report earnings
to Social Security.” Simply telling someone to report doesn’t give
sufficient instruction on how, to whom, and with what documentation.
Finally, identify the target date for completing the action step.

You should write action steps concisely, but in a manner that gives
sufficient direction to the person responsible for completing the task.

Example of action steps:

Ralph is pursuing a degree in Accounting. He has Pell grants to pay for
his education; however, he incurs out-of-pocket costs for everything
other than his tuition expense. Ralph is a concurrent beneficiary. You’ve
written a BS&A for Ralph and have offered the following options to assist
him with his additional school expenses:

- Contact the local VR office for services related to educational
  expenses, or
- Develop a PASS to pay for the educational expenses.

After reviewing the BS&A, Ralph decides to pursue a PASS, because he
previously had a bad experience with VR.

As you develop the WIP with Ralph, you create the measurable action
steps identified in the “Managing Social Security Benefits” section:

1. Meet with the CWIC to begin identifying necessary
   information for PASS development.
2. Provide documentation of out-of-pocket expenses currently
   incurred for school.
3. Provide documentation of expenses covered by the Pell
   grants.
4. Submit the completed PASS application to the regional
   PASS Cadre for approval.

The steps in the example above are specific and provide clear direction to
the beneficiary. If the step had simply been stated as “Develop a PASS,”
the beneficiary wouldn’t have known how to start or what to do. By
providing specific instructions on the WIP, the CWIC enables the
beneficiary to take an active role in reaching his or her own employment or earnings goal.

**General Guidelines for Developing the WIP**

1. Develop a WIP if the beneficiary requires any ongoing services after you complete the BS&A and review it with the beneficiary.

2. Develop a WIP with the beneficiary, his or her representative, or, if applicable, both the beneficiary and the representative. Because this is intended to be a collaborative effort, you should encourage the beneficiary to direct the action steps and involvement of others. You should point out action steps that need to be included to bring about the desired result, but shouldn’t direct the entire plan. The objective is to involve the beneficiary as much as possible to build ownership of and investment in the WIP.

3. To the greatest extent possible and practical, include members of the beneficiary’s employment support team in the development of the WIP. CWICs can’t expect other members of the employment support team to take an active role in the steps identified in the WIP if they haven’t taken part in to the development of it. At the very least, you must review the completed WIP with other members of the employment support team who have a role in any of the action steps. Partners identified in the plan should also have a copy of the BS&A for reference.

4. The WIP focuses on ALL federal, state, and local benefits and associated work incentives, in addition to Social Security disability program benefits. The WIP also includes action steps to help the beneficiary access needed employment services and supports. Check the BS&A for recommendations in this area.

5. Create an action step for every work incentive you’ve recommended in the BS&A and every issue you’ve identified as important to address. Refer back to the BS&A as you develop all action steps, and make sure you aren’t leaving out anything that requires action.
6. Write action steps only for specific tasks that need to be accomplished, and double check to make sure action steps are clear, measurable, or observable. Action steps are short and simple directives and shouldn’t include unnecessary information, such as how the step should be completed, why the step is needed, or why the action is needed (include discussion and explanations in the BS&A, not the WIP).

7. Break down action steps into as few increments as possible; otherwise, the WIP will be too long and difficult to follow.

8. Only include action steps involving issues and needs within the purview of the WIPA project.

**Updating the Work Incentives Plan**

Work Incentive Plans aren’t intended to be static. CWICs must periodically review, revise, and update them to reflect changes in the beneficiary’s situation. A WIP represents a snapshot in time and supports the beneficiary’s ongoing movement toward achieving the desired employment outcome, just as the BS&A report does. Each time the CWIC revises the WIP, he or she enters a new date and estimates when the CWIC will review the plan again in the future. You might develop action steps, check progress as target dates are reached, and establish new action steps indefinitely, depending on the beneficiary’s unique circumstances. Some beneficiaries will need you to update their plans frequently, while others won’t. The process for updating WIPs is highly individualized and driven by the beneficiary’s employment goals.

For example, Doug is a CDB who wanted training to become a truck driver. Once the CWIC wrote the BS&A and recommended PASS as an option to fund his training, the CWIC worked with Doug to develop a WIP. The CWIC included the following steps in the “Managing Social Security Benefits” section of Doug’s WIP:

- Meet with the CWIC to identify what information to collect for PASS development.
- Provide documentation of all expenses related to the CDL training program (cost of tuition, books, and transportation).
• Submit completed PASS application to the regional PASS cadre for approval.
• Submit completed PASS application to the local Social Security office and apply for SSI.

The Social Security office approved Doug’s PASS, so it’s time for the CWIC to update the WIP with the next steps. In the same section, the CWIC adds the following steps for Doug to take:

• Log your mileage to and from school each day.
• Collect and save all receipts for approved expenditures in the PASS.
• Meet with the CWIC to prepare documentation for the PASS cadre review.

You may need to provide additional guidance and “to-do” steps to assist the beneficiary with continuing progress towards his or her employment goal. Regular updates keep all parties on track. If you define too many steps at once, they may not have meaning and will lose relevance. Just as professionals use “to-do” lists to define their daily and weekly tasks and help them manage their time, a WIP helps define the tasks and continue a beneficiary’s progress.

**Conclusion**

The BS&A report and the WIP are an important component of WIPA services. These documents reflect the advice CWICs offer to beneficiaries using their considerable expertise. In addition, the documents become the beneficiary’s roadmap for effectively using work incentives and overcoming potential barriers to achieving employment goals.

Without a written BS&A, the beneficiary has nothing tangible that clearly explains all the benefits issues related to employment. Without the WIP, there’s no formal plan to follow for handling benefits issues related to employment. CWICs should update each of these documents on a regular basis as a beneficiary moves forward along the road to employment. Producing high-quality BS&A reports and WIPs will contribute significantly to the present and future employment prospects of Social Security disability beneficiaries. You can find samples of BS&A reports and WIPs at the end of this unit.
Conducting Independent Research

Accessing Social Security publications (https://www.ssa.gov/pubs/)

SSI Spotlights (http://www.ssa.gov/ssi/links-to-spotlights.htm)

Social Security Red Book (http://www.ssa.gov/redbook/)

Additional Resources

You’ll find a link to a blank version of the BS&A Planning Tool and the standard BS&A format:

BS&A Planning Sheet
(https://vcu-ntdc.org/resources/viewContent.cfm?contentID=94)

BS&A Format
(https://vcu-ntdc.org/resources/viewContent.cfm?contentID=92)

On the following pages, you’ll also find several real-life examples of completed BS&As and WIPs.
Sample BS&A #1 – Job Search Stage Using BSADocs

**Note:** Katy is currently searching for a job in retail after working for a brief time earlier in 2019. This is an example of a Title II disability beneficiary in the job search stage whose earnings goal is above the TWP level but less that the SGA benchmark. It includes information about some work incentives that the CWIC believes she would use if her gross earnings were above the SGA benchmark. This BS&A was created using the report writing software, BSADocs, and the template from the state of Texas. Some state-specific details are included, which could be different depending on where Katy lives.

**Benefits Summary & Analysis**

**Name:** Katy Dyd

**Date:** February 26, 2020

It was a pleasure speaking with you about your work goals. This report will show how you can work and get ahead.

**Summary of Your Current Situation & Employment Goals**

**Current Situation:** I verified with Social Security, Centers for Medicare and Medicaid Services and Texas Health and Human Services (HHS) that you are receiving the following benefits:

- Social Security Childhood Disability Benefits (CDB) - net $820.00/month

- Medicare (Part A-hospital, Part B-outpatient and Part D-prescription) based on entitlement to CDB
  - HHS pays your Part B premium and helps pay your Part A and B deductibles and coinsurance
  - Full Extra Help helps pay the Part D premium and keeps co-pays to a low amount

**Employment Details:**

- You are not currently working.

- Your goal is to earn $950.00/month as a retail worker.
How Work Affects Your Cash Benefits

Childhood Disability Benefits: CDB has 3 phases of work rules, each with work incentives to support your efforts to work. Some of the work incentives allow you to maintain CDB when working, while others allow you to easily restart the benefit if it stops. Below are the key details given your situation and goals.

Phase 1- Trial Work Period (TWP): During the TWP, you will receive your CDB regardless of how high your earnings might be, as long as you still have a disability. Your TWP ends when you use 9 TWP months within a 5-year period. Social Security will count a month as a TWP month if your gross earnings are more than $910 (2020 rate). Social Security confirmed you have 9 TWP months available. I estimate you have used 5 since your last work review, which means you likely have 4 TWP months available as of this report.

Phase 2-Extended Period of Eligibility (EPE): The month after your TWP ends, you begin a 36-month Extended Period of Eligibility. During the EPE, Social Security will give you CDB for months your countable earnings are below Substantial Gainful Activity (SGA), but they will suspend CDB for months your countable earnings are SGA. An explanation of SGA is provided below. During the EPE, Social Security can easily restart your CDB if your countable earnings fall below SGA. You don’t have to reapply. This is a great safety net.

Understanding SGA: After the TWP is over Social Security will decide whether your work activity is Substantial Gainful Activity (SGA). To make this decision they compare your monthly countable earnings to a guideline of $1,260 (2020 rate). The word “countable” is important because Social Security may not count all of your gross wages when deciding if your work is SGA. For example, they deduct paid time off, the value of extra help or reduced productivity on the job because of your disability, and impairment-related expenses you pay for that are necessary for you to work. Based on what you shared, it appears you will not need these work incentives because your gross earnings will be below SGA. I am sharing the following details with you in case you decide to earn more in the future.

- Impairment Related Work Expenses (IRWE): An IRWE is an expense that you pay for, is not reimbursed, is related to an impairment being treated by a healthcare provider, and enables you to work. Social Security may deduct the cost of these
expenses from your gross monthly wages to determine your countable earnings.

- **Subsidy and Special Conditions:** Social Security may deduct the value of extra support or reduced productivity on the job because of your disability. To determine this amount, Social Security may ask your employer to identify the value of the extra support or reduced productivity. If you get support on the job from an employment agency, Social Security may deduct your hourly wage for each hour you receive that help.

**Phase 3-Post EPE:** This phase begins after the 36th month of your EPE. If your work is below SGA, your CDB continues. If your work is SGA, your CDB will terminate. However, there is a work incentive called Expedited Reinstatement (ExR) that may be used to quickly restart the CDB if you can’t maintain SGA level work. I will provide more details about this work incentive when you are closer to this phase.

**Specific to You:**

- **Earning $950.00/month:** Based on the information above, I estimate you will use your Trial Work Period months. After your TWP ends, I estimate your CDB will likely continue because your work is expected to be below the SGA guideline.

I have attached a TWP/EPE Tracking Chart to this report that shows how these work incentives fit together. Keep in mind the changes noted above are only an estimate. Social Security makes final decisions about your CDB.

**How Work Affects Your Health Insurance**

**Medicaid (Medicaid Buy-In):** When you work, you can request eligibility for Medicaid through Medicaid Buy-In (MBI). Medicaid Buy-In provides medical assistance to people who have a disability and earned income from wage or self-employment. To be eligible, your countable earned income must be less than 250% of the Federal Poverty Level and your resources must be equal to or less than $5,000. Unearned income, such as Social Security cash benefits, is not counted. A premium is charged if you receive any unearned income greater than $783 in 2020 or net earnings exceed 150% of the Federal Poverty Level. If you are found eligible for Medicaid Buy-In and charged a premium, you must pay this
premium to activate your coverage and continue to pay it monthly to maintain your coverage.

**Specific to you:**

- **Earning $950.00/month:** Based on the information above, I estimate you will meet the Medicaid Buy-In eligibility criteria. Given your earning goal, I estimate your premium will be $129.00/month.

- Medicaid Buy-In would be a good option for you to consider because:

  - Medicaid Buy-In works like a secondary insurance to your Medicare, helping to cover the Medicare Part A and B deductibles and co-insurance. This will replace the help you currently receive in paying for these expenses through the Medicare Savings Program, explained below. After discussing your medical care needs, you determined that the estimated Medicaid Buy-In Premium ($129) will be cheaper than what you would pay in out-of-pocket medical expenses if you did not have Medicaid Buy-In as secondary coverage.

  - Having Medicaid Buy-In makes you automatically eligible for Medicare Part D Extra Help program so you would have financial help with the Part D out of pocket expenses.

  - Medicaid Buy-In may cover some medical costs that Medicare doesn’t, such as personal care services.

Keep in mind the details above are only an estimate. Texas Health and Human Services (HHS) makes final decisions about your eligibility for Medicaid.

**Medicare:** Medicare is a federal health insurance program that offers inpatient coverage (Part A), outpatient coverage (Part B), and prescription drug coverage (Part D). You are eligible for Medicare because you have been entitled to CDB for more than 24 months. You continue to be eligible for Medicare as long as you are eligible for CDB. If your CDB terminates due to work, you can use work incentives to keep Medicare. If you chose to earn more in the future, I can share details about these work incentives with you.
**Specific to You:**

- **Earning $950.00/month:** Based on the information above, I estimate your Medicare eligibility will continue because your CDB eligibility is expected to continue.

Keep in mind the details above are only an estimate. Social Security makes the final decisions about your Medicare eligibility.

**Medicare Parts A and B Financial Assistance:** Beneficiaries with Medicare Parts A (hospital) and B (outpatient) usually have to pay a Part B premium, plus deductibles and coinsurance. However, Texas Health and Human Services (HHS) has two programs that help pay these costs: Medicaid and the Medicare Savings Program (MSP). Medicaid helps pay your Part A and B deductibles and coinsurance, plus the state may pay your Part B premium depending on the Medicaid group you use. MSP will pay your Part B premium, plus it may help pay your Part A and B deductibles and coinsurance if your countable income is at or below 100% of the Federal Poverty Level (FPL).

To get help through Medicaid you must be found eligible for one of the Medicaid eligibility groups. To get help through the MSP your countable income must be below 135% of the FPL (below 120% if you have Medicaid). But, HHS doesn’t count all your income; they exclude the first $20 of unearned income and over half of your earnings. The MSP also has a resource limit of $7,560.

**Specific to You:**

- **Earning $950.00/month:** Based on the information above, I estimate the MSP will pay your Part B premium because your estimated countable income is below 120% of the FPL and Medicaid Buy-In will help pay your Part A and B deductibles and coinsurance when you enroll. Therefore, your financial help with all of your Part A and B coverage will continue as it is now when you are not working.

Attached are MSP calculation worksheets. Keep in mind the details above are only an estimate. HHS makes the final decisions about your eligibility for help with Part A and Part B costs.

**Medicare Part D Financial Assistance:** Medicare Part D (prescription drug coverage) out-of-pocket costs can include a premium, a deductible and copays that vary depending on the plan you choose. Extra Help, also
known as the Low Income Subsidy program, helps pay those out-of-pocket expenses. The program has two levels of assistance, Full Extra Help and Partial Extra Help.

Full Extra Help pays all or most of the Part D premium, the annual deductible, and keeps copays to a low amount ($0 - $8.95 per prescription in 2020). People who get SSI, Medicaid, or help from Texas Health and Human Services (HHS) with any Medicare Part A and B costs are automatically enrolled. When working, if you fall under one of those groups you can get or keep Full Extra Help.

Specific to You:

• Earning $950.00/month: Based on the information above I estimate you will continue to be automatically eligible for Full Extra Help because HHS will pay your Medicare Part B premium and because of your enrollment in the Medicaid Buy-In Program (MBI).

Keep in mind the details above are only an estimate. Social Security and Centers for Medicare and Medicaid Services make final decisions about eligibility for Extra Help.

Employment and Other Services to Help You Reach Your Goal

You are currently receiving employment services from Texas Workforce Solutions-Vocational Rehabilitation Services (TWC) and a supported employment program (Just Jobs) that contracts with TWC to provide you with services. TWC is part of Ticket to Work, which is a Social Security funded program designed to help beneficiaries reach self-sufficiency. If you have a signed service plan that has been accepted by Social Security and you meet Timely Progress Requirements (details attached), Social Security may not conduct a medical continuing disability review (CDR). You can contact the Ticket to Work Help Line at 1-866-968-7842 to confirm whether you are currently meeting the Timely Progress Requirements. If you would like support, I can assist you in contacting them.

You shared that all of your employment support needs are being met and you don’t need additional services. However, you did express some concern about transportation to and from a job and we discussed several options. Your Supported Employment Specialist at Just Jobs has agreed to train you to use public transportation to and from your job once you
begin work. You are also interested in learning to drive and plan to save for a used car once you start getting a paycheck. Your TWC counselor has also agreed to pay for driving lessons once you begin working. I will follow up with you after you get a job offer to make sure everything is going as planned.

**Other Topics**

Reporting Earnings to Social Security (CDB): You must report to Social Security when you begin working, if your work activity goes above or below SGA, or if you stop working. To report this type of change, mail a copy of your pay stub to your local Social Security office at 333 Main Street, Austin, Texas 78757 or bring a copy of your pay stub to your local Social Security office at 333 Main Street, Austin, Texas 78757. Ask for a receipt that documents you reported. If you have low wages Social Security may not ask you to do anything more except report if your earnings increase. If you have earnings above SGA, Social Security may send you a Work Activity Report (form SSA-821). I can help you complete that form so please call me when you receive it. Once Social Security has listed the employer on your record, I recommend you log into your [my Social Security account](http://www.ssa.gov/myaccount) and report your earnings each month.

**Important Things for You to Remember**

**Issues requiring immediate action:**

- Report your past work activity in 2019 to Social Security immediately. You should provide them with a copy of your pay stubs and request a receipt.

**Important dates or deadlines:**

- When you get a job offer, you should call me immediately so we can talk about how to report your earnings to Social Security and Texas Health and Human Services (HHS). It is extremely important that you inform both of these agencies about any earnings you receive.

- Once you begin working, you will want to apply for the Medicaid Buy-In Program through Texas Health and Human Services (HHS). I can assist you in filling out this application and submitting it.
**Recordkeeping reminders:** Please keep this Benefits Summary and Analysis in your records. Remember to keep letters you get about your benefits. Keep notes and receipts whenever you report changes and be sure to keep everything together in one place so you can find it. Notes should include: the agency where you made the report, the date you made the report, who you talked to, what you told them, and what papers you submitted.

It is your responsibility to promptly report all relevant changes to Social Security and any other federal, state, or local entity administering the benefits you receive.

**Using this report:** You should keep this report and refer back to it when you have questions about how your employment plans may affect your benefits. It is also important for you to share this report with other people who are helping you achieve your employment goals.

Changes in the situation described above may seriously affect the accuracy of the information provided in this correspondence. Please contact your CWIC immediately to discuss any changes in your benefits situation or employment plans or to answer any additional questions you have about how employment may affect your benefits.

---

**CWIC:** Super CWIC

**Agency:** CWIC, Inc.

**Phone:** 333-333-3333

**Email:** super@cwicinc.org
Snapshot

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Changes to benefits noted above are estimates. Only benefit agency staff can make a formal determination of how working will affect that benefit. It is your responsibility to report changes in income to each agency. These estimates do not take into account all expenses, such as payroll taxes. Additionally, these estimates are based on your present situation, which means as your life changes this information can become outdated quickly. If you do not use this information in the next 2-3 months, please contact me and I can update this report.
**TWP / EPE Tracking Chart**

**Customer:** Katy Dyd

**Date:** 2/26/2020

**Work Incentives Counselor:** Super CWIC

**Scenario Description:** Part-time work at $950 per month beginning in April. This scenario assumes SSA will determine February-June 2019 to be Trial Work Period months based upon the pay stub information you provide.

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<tr>
<td>Benefit Status</td>
<td>Check Continues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**MSP Calculation Sheet**

**Name:** Katy Dyd

**Scenario Description:** Earning $950 per month and retaining eligibility for CDB of $830

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned Income</td>
<td>$820</td>
</tr>
<tr>
<td>General Income Exclusion (GIE) $20</td>
<td>$-20</td>
</tr>
<tr>
<td>Countable Unearned Income</td>
<td>= $800</td>
</tr>
<tr>
<td>Gross Earned Income</td>
<td>$950</td>
</tr>
<tr>
<td>Student Earned Income Exclusion</td>
<td>$-0</td>
</tr>
<tr>
<td>Remainder</td>
<td>$950</td>
</tr>
<tr>
<td>GIE (if not used above) $20</td>
<td>$-0</td>
</tr>
<tr>
<td>Remainder</td>
<td>$950</td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE) $65</td>
<td>$-65</td>
</tr>
<tr>
<td>Remainder</td>
<td>$885</td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE)</td>
<td>$-0</td>
</tr>
<tr>
<td>Remainder</td>
<td>$885</td>
</tr>
<tr>
<td>Divide by 2</td>
<td>$442.50</td>
</tr>
<tr>
<td>Blind Work Expenses (BWE)</td>
<td>$-</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>= $442.50</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td>$800</td>
</tr>
<tr>
<td>Total Countable Earned Income + $442.50</td>
<td>$1242.50</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>$-0</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>$1242.50</td>
</tr>
</tbody>
</table>

You will likely continue to be eligible for a Medicare Savings Program, but this program will pay the Part B premium only when you are working. Your countable income of $1242.50 will be higher than the income limit for the Medicare Savings Program that pays all of your other Part A and B expenses. However, Medicaid Buy-In will assist you in paying these other Part A and B expenses when you enroll.
**Work Incentives Plan**

**Beneficiary Name:**  Katy Dyd  
**Date:**  3/01/2020

Employment Goal: Working 20 hours a week in a retail setting, earning approximately $950 a month.

### Accessing Employment Services and Supports

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Completed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue to meet with Supported Employment Specialist at Just Jobs</td>
<td>Katy</td>
<td>Ongoing until a job is secured</td>
<td></td>
</tr>
</tbody>
</table>

### Resolving Existing Benefit Issues

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Completed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>No benefits issues to address at this time</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Managing Social Security Benefits and Work Incentives

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Completed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gather pay stubs from previous work and report earnings to Social Security.</td>
<td>Katy</td>
<td>3/15/20</td>
<td></td>
</tr>
</tbody>
</table>

<p>| Call CWIC as soon as Work Activity Report is received and complete report together over the phone. | Katy/CWIC | 4/15/20 |</p>
<table>
<thead>
<tr>
<th>Action Step</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Completed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create benefits binder to keep receipts for work-related expenses, letters from Social Security</td>
<td>Katy/CWIC</td>
<td>4/30/20</td>
<td></td>
</tr>
<tr>
<td>Continue to track TWP months</td>
<td>Katy</td>
<td>When job starts</td>
<td></td>
</tr>
<tr>
<td>Report beginning of work to Title 2 claims representative and submit paystubs monthly</td>
<td>Katy</td>
<td>After receipt of a month of paystubs</td>
<td></td>
</tr>
<tr>
<td>Report changes in monthly income to Title 2 claims representative</td>
<td>Katy</td>
<td>On-going after initial report</td>
<td></td>
</tr>
</tbody>
</table>

**Managing Federal, State or Local Benefit Programs**

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Completed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>No action needed at this time.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Planning for Future Healthcare Needs**

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Completed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apply for Medicaid Buy In</td>
<td>Katy</td>
<td>When job starts</td>
<td></td>
</tr>
<tr>
<td>Action Step</td>
<td>Person Responsible</td>
<td>Target Date</td>
<td>Completed Date</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>-------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Report wages to Texas Health and Human Services for Medicare Savings Program</td>
<td>Katy</td>
<td>When job starts</td>
<td></td>
</tr>
</tbody>
</table>

**FOLLOW-UP CONTACT PLAN**

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Completed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call CWIC when job offer is made.</td>
<td>Katy/CWIC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call CWIC when Work Activity Report is received</td>
<td>Katy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Beneficiary Signature:** Date:  
**CWIC Signature:** Date:
Sample BS&A # 2 - SSI Employment Stage Using BSADocs

Note: Benjamin has been working at a sheltered workshop but will soon start a new job at a retail store. He receives In Kind Support and Maintenance using the VTR rule because he lives at home with his parents and does not pay for rent or groceries. This Benefits Summary & Analysis was created using the report writing software, BSADocs, and the template from the state of North Carolina. Some state-specific details are included, which could be different depending on where Benjamin lives.

Benefits Summary & Analysis

Name: Benjamin Johnson

Date: January 17, 2020

It was a pleasure speaking with you about your work goals. This report will show how you can work and get ahead.

Summary of Your Current Situation & Employment Goals

Current Situation: I verified with Social Security and the local Department of Social Services (DSS) that you are receiving the following benefits:

- Supplemental Security Income (SSI) - net $464.50/month. Your SSI is less than the maximum amount ($783.00) because of earnings posted on your SSI record ($200.00) and free food and/or shelter you receive ($261.00).
- Medicaid (based on SSI eligibility)
- Community Alternatives Program for Disabled Adults - a Medicaid funded program that provides you with certain services so you can live in your community

Employment Details:

- You are working as a stocker at Independent Industries and are earning about $200.00/month. You have been doing this work since 10/17.
- Your goal is to get a different job working as a stocker at a local retail store and earning $1,200.00/month.
Supplemental Security Income (SSI): SSI is a cash benefit for people with disabilities who have low income and resources. The amount you get is reduced if you have other income. Many people think they’ll have less money if they work, but, that’s a myth.

Social Security doesn’t count all of your income when calculating your SSI amount. They deduct $20 from your unearned income; if you don’t have unearned income they deduct it from your gross earnings. Then they deduct $65 of your gross earnings and divide the remainder of those earnings in half. The amount of income left after the deductions is called total countable income. Social Security subtracts your total countable income from your base SSI rate; the remainder is your new SSI amount. Because of these deductions you have more money when working.

The following are additional deductions that appear to fit your situation:

- **Impairment Related Work Expenses (IRWE):** When Social Security calculates the SSI amount they may deduct expenses that: you pay for, are not reimbursed, are related to an impairment being treated by a healthcare provider, and enable you to work. Social Security deducts the IRWEs from your gross wages before dividing your wages in half. The IRWE deduction lets you keep more of your SSI when working. **You indicated you have the following expenses that could be IRWEs:** specialized transportation. When you report earnings to Social Security ask them to apply the IRWE deduction and provide receipts. They may ask you for proof that the expenses are related to a medical condition.

If your earnings cause the SSI to drop to $0 you can keep your SSI claim open by using a work incentive called 1619(b). With 1619(b) you just contact Social Security when your income is low enough to get SSI again and they will restart your benefit; you don’t have to reapply. Below I will explain how you can also keep Medicaid through 1619(b) and provide more details about the eligibility criteria.

**Specific to You:**

- **Earning $1,200.00/month:** Based on the information above, I estimate your SSI will be $0.00 per month, using the automatic income deductions. You can see in the Snapshot section of this
report that you have more money when earning $1,200.00/month, even with your SSI paused. Assuming you have $150.00/month in IRWEs, I estimate your SSI would instead be $39.50/month. If approved, this work incentive could help offset your cost for these expenses. It appears you’ll meet the 1619(b) criteria when your SSI is $0.00, which allows you to keep SSI eligibility status. This is another great safety net.

Attached are SSI calculation worksheets that show the details for these estimated changes. Keep in mind the changes noted above are only estimates. Social Security makes the final decisions about your SSI eligibility and payments.

**How Work Affects Your Health Insurance**

**Medicaid (SSI Beneficiary):** Medicaid is a health insurance program that covers certain groups of people who have low income and resources. As an SSI beneficiary, your state automatically enrolled you in Medicaid. Special rules make it possible to keep Medicaid when you work. If you are eligible to receive an SSI payment when you work, you keep Medicaid. If earnings make your SSI drop to $0, you can still keep Medicaid by using 1619(b). To use 1619(b), you must be ineligible for an SSI payment because of earnings, still have a disability, have countable resources below $2,000, need Medicaid, and have annual earnings under $34,571 (2019). Social Security allows you to use a higher annual earnings limit in some situations.

**Specific to You:**

- **Earning $1,200.00/month:** Based on the information above, I estimate your Medicaid eligibility will continue through the 1619(b) work incentive.

Keep in mind the details above are only an estimate. Social Security makes the final decisions about your eligibility for SSI-based Medicaid.

**Home and Community Based Services Waiver:** You are enrolled in the following Home and Community Based Services Waiver: Community Alternatives Program for Disabled Adults (CAP/DA). The waiver provides a number of services to support you in living in the community. To maintain financial eligibility for the waiver when you are working you must be eligible for one of the Medicaid eligibility groups approved by this waiver.
Specific to you:

- **Earning $1,200.00/month:** Based on the information above, I estimate your eligibility for waiver services will continue because you’ll be eligible for one of the Medicaid eligibility groups approved under this waiver (SSI/1619b).

Keep in mind the details above are only an estimate. DSS makes final decisions about your eligibility for Medicaid waivers.

---

**Employment and Other Services to Help You Reach Your Goal**

You are currently receiving employment services from the Division of Vocational Rehabilitation Services. You may benefit from other employment services because you are interested in increasing your earnings to a level at which you can rent your own apartment and live on your own. You may find the following employment services helpful given your needs.

**Ticket to Work:** A few months after you have reached your employment goal your services with the Division of Vocational Rehabilitation Services (DVR) will close. If you would like continued employment services or to prevent Social Security medical continuing disability reviews (CDR) for a few more years, you could use Social Security’s Ticket to Work program. The program provides funding to Employment Networks (EN) to support you in reaching and maintaining self-sufficiency. ENs are organizations that provide free employment services. When you sign an Individual Work Plan (IWP) with an EN, Social Security will assign your Ticket to them. When that happens, Social Security will not conduct a medical CDR as long as you are meeting the Timely Progress Requirements (attached). To use Ticket to Work, you need to choose an EN and sign an IWP with them after you close services with DVR. If you would like to work with an EN, call the Ticket Help Line at 1-866-968-7842 or see a list of ENs at choosework.ssa.gov (http://www.choosework.ssa.gov).

**Other Topics**

**In Kind Support and Maintenance:** The Supplemental Security Income (SSI) benefit is intended to help you meet needs for food and shelter. If another person pays some or all of those expenses for you, your SSI benefit can be reduced. Social Security calls this free food and shelter “In Kind Support and Maintenance” (ISM). If you have ISM, Social Security reduces your SSI by the actual amount of help you get, up
to 1/3 of the highest SSI payment. Currently, Social Security is reducing your SSI because of ISM. If you pay more of your food and shelter costs, you may be able to get more in SSI. If you would like to do this, I can explore the options with you. If you compare SSI Calculation Sheet #3 to SSI Calculation Sheet #4, it shows how you would receive more in SSI if you did not have ISM.

**ABLE Accounts:** The ABLE account provides a way for people, whose disability began before the age of 26, to save money and maintain eligibility for public benefits. The beneficiary and other people can deposit a combined total of $15,000/year. A beneficiary who is working can deposit up to $12,140 more in 2019 if he or she isn’t participating in an employer-sponsored retirement plan.

Money deposited by other people and investment gains are not counted as income for federally funded need-based benefits. Money in an ABLE account is also excluded from the resource limit for federally funded need-based benefits like Medicaid and Supplemental Security Income (SSI), but with SSI only $100,000 is excluded. Money in an ABLE account can be used for qualified disability expenses which include things like, education, transportation, employment training and support, assistive technology, and health care expenses.

The North Carolina State Treasurer administers a version of the ABLE account called NC ABLE. To start an account with NC ABLE, you are required to make an initial deposit of $25. You can learn more about NC ABLE at their website or by visiting or by calling (888) 627-7503 (https://savewithable.com/nc/home.html). Other states have created ABLE programs that allow non-residents to participate. If you are interested in finding out more about setting up an out-of-state account, visit [www.ablenrc.org](http://www.ablenrc.org). This website has a tool that helps you compare ABLE accounts administered by different states so you can decide which one might best fit your needs.

**Reporting Earnings to Social Security (SSI):** You must always report gross monthly wages from your work by the 10th of the following month. I recommend you bring a copy of your first pay stubs from your new job to your local Social Security office at 333 Main Street, Raleigh, NC 27601 to report your new work. Then you must continue reporting earnings every month. To report gross wages on an ongoing basis, I recommend you call, mail, or bring a copy of your pay stubs to the local Social
Security office no later than the 10th day of the month after you receive earnings. Be sure to ask for a receipt to document you reported.

**Important Things for You to Remember**

**Issues Requiring Immediate Attention:**
- Explore the option of increasing your SSI by paying some or all of your share of the food and shelter costs to your parents.

**Important dates or deadlines:**
Once your new job begins:
- Report your monthly earnings to Social Security and ask for a receipt. I will help you monitor your SSI payments to be sure the amount is correct.
- Submit your paratransit costs to Social Security for approval as an IRWE. You will need to keep receipts for all trips to and from your job.
- Explore the possibility of setting up an ABLE account in order to save more money without an impact on your eligibility for SSI or Medicaid.

**Recordkeeping reminders:** Please keep this Benefits Summary and Analysis in your records. Remember to keep letters you get about your benefits. Keep notes and receipts whenever you report changes and be sure to keep everything together in one place so you can find it. Notes should include: the agency where you made the report, the date you made the report, who you talked to, what you told them, and what papers you submitted.

*It is your responsibility to promptly report all relevant changes to Social Security and any other federal, state, or local entity administering the benefits you receive.*

**Using this report:** You should keep this report and refer back to it when you have questions about how your employment plans may affect your benefits. It is also important for you to share this report with other people who are helping you achieve your employment goals.

Changes in the situation described above may seriously affect the accuracy of the information provided in this correspondence. Please contact your CWIC immediately to discuss any changes in your benefits.
situation or employment plans or to answer any additional questions you have about how employment may affect your benefits.

**CWIC:** Super CWIC  
**Agency:** CWIC Inc.  
**Phone:** 333-333-3333  
**Email:** super@cwicinc.org
**SSI Calculation Sheet #1**

**Name:** Benjamin Johnson  
**Date:** January 17, 2020  
**Work Incentives Counselor:** Super CWIC  
**Scenario Description:** Current Situation - Earning $200 per month with In Kind Support and Maintenance.

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unearned Income</strong></td>
<td>0</td>
</tr>
<tr>
<td>General Income Exclusion (GIE) $20</td>
<td>−$20</td>
</tr>
<tr>
<td><strong>Countable Unearned Income</strong></td>
<td>=0</td>
</tr>
<tr>
<td>Gross Earned Income</td>
<td>$200</td>
</tr>
<tr>
<td>Student Earned Income Exclusion</td>
<td>−0</td>
</tr>
<tr>
<td>Remainder</td>
<td>=$200</td>
</tr>
<tr>
<td>GIE (if not used above) $20</td>
<td>−$20</td>
</tr>
<tr>
<td>Remainder</td>
<td>$180</td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE) $65</td>
<td>−$65</td>
</tr>
<tr>
<td>Remainder</td>
<td>=$115</td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE)</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>=$115</td>
</tr>
<tr>
<td>Divide by 2</td>
<td>$57.50</td>
</tr>
<tr>
<td>Blind Work Expenses (BWE)</td>
<td>−0</td>
</tr>
<tr>
<td><strong>Total Countable Earned Income</strong></td>
<td>=$57.50</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td>0</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>+$57.50</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>−0</td>
</tr>
<tr>
<td><strong>Total Countable Income</strong></td>
<td>= $57.50</td>
</tr>
<tr>
<td>Base SSI Rate</td>
<td>$522</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>−$57.50</td>
</tr>
<tr>
<td><strong>Adjusted SSI Payment</strong></td>
<td>=$464.50</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>$464.50</td>
</tr>
<tr>
<td>Gross earned income received</td>
<td>+$200</td>
</tr>
<tr>
<td>Gross unearned income received</td>
<td>+0</td>
</tr>
<tr>
<td>Step</td>
<td>Calculations</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Total Income Received</td>
<td>=$664.50</td>
</tr>
<tr>
<td>PASS, BWE or IRWE Expenses</td>
<td>-0</td>
</tr>
<tr>
<td><strong>Total Financial Outcome</strong></td>
<td>=$664.50</td>
</tr>
</tbody>
</table>
**SSI Calculation Sheet #2**

**Name:** Benjamin Johnson  
**Date:** January 17, 2020  
**Work Incentives Counselor:** Super CWIC  
**Scenario Description:** Earning $1200 per month with In Kind Support and Maintenance continuing and without IRWE approved.

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned Income</td>
<td>0</td>
</tr>
<tr>
<td>General Income Exclusion (GIE) $20</td>
<td>-$20</td>
</tr>
<tr>
<td><strong>Countable Unearned Income</strong></td>
<td>=0</td>
</tr>
<tr>
<td>Gross Earned Income</td>
<td>$1,200</td>
</tr>
<tr>
<td>Student Earned Income Exclusion</td>
<td>-0</td>
</tr>
<tr>
<td>Remainder</td>
<td>=$1,200</td>
</tr>
<tr>
<td>GIE (if not used above) $20</td>
<td>-$20</td>
</tr>
<tr>
<td>Remainder</td>
<td>$1,180</td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE) $65</td>
<td>-$65</td>
</tr>
<tr>
<td>Remainder</td>
<td>=$1,115</td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE)</td>
<td>- 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>=$1,115</td>
</tr>
<tr>
<td>Divide by 2</td>
<td>$557.50</td>
</tr>
<tr>
<td>Blind Work Expenses (BWE)</td>
<td>-0</td>
</tr>
<tr>
<td><strong>Total Countable Earned Income</strong></td>
<td>=$557.50</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td>0</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>+$557.50</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>-0</td>
</tr>
<tr>
<td><strong>Total Countable Income</strong></td>
<td>= $557.50</td>
</tr>
<tr>
<td>Base SSI Rate</td>
<td>$522</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>−$557.50</td>
</tr>
<tr>
<td><strong>Adjusted SSI Payment</strong></td>
<td>=0</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>0</td>
</tr>
<tr>
<td>Gross earned income received</td>
<td>+$1,200</td>
</tr>
<tr>
<td>Gross unearned income received</td>
<td>+0</td>
</tr>
<tr>
<td>Step</td>
<td>Calculations</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Total Income Received</td>
<td>= $1,200</td>
</tr>
<tr>
<td>PASS, BWE or IRWE Expenses</td>
<td>− $150</td>
</tr>
<tr>
<td><strong>Total Financial Outcome</strong></td>
<td>= $1,050.50</td>
</tr>
</tbody>
</table>

*Note in this example IRWE was not submitted for approval. It is still paid out of pocket. This demonstrates the benefit of establishing the IRWE.*
**SSI Calculation Sheet #3**

**Name:** Benjamin Johnson  
**Date:** January 17, 2020  
**Work Incentives Counselor:** Super CWIC  
**Scenario Description:** Earning $1200 per month with In Kind Support and Maintenance continuing and with IRWE approved.

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned Income</td>
<td>0</td>
</tr>
<tr>
<td>General Income Exclusion (GIE) $20</td>
<td>−$20</td>
</tr>
<tr>
<td><strong>Countable Unearned Income</strong></td>
<td>=0</td>
</tr>
<tr>
<td>Gross Earned Income</td>
<td>$1,200</td>
</tr>
<tr>
<td>Student Earned Income Exclusion</td>
<td>−0</td>
</tr>
<tr>
<td>Remainder</td>
<td>=$1,200</td>
</tr>
<tr>
<td>GIE (if not used above) $20</td>
<td>−$20</td>
</tr>
<tr>
<td>Remainder</td>
<td>$1,180</td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE) $65</td>
<td>−$65</td>
</tr>
<tr>
<td>Remainder</td>
<td>=$1,115</td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE)</td>
<td>−$150</td>
</tr>
<tr>
<td>Remainder</td>
<td>=$965</td>
</tr>
<tr>
<td>Divide by 2</td>
<td>$482.50</td>
</tr>
<tr>
<td>Blind Work Expenses (BWE)</td>
<td>−0</td>
</tr>
<tr>
<td><strong>Total Countable Earned Income</strong></td>
<td>=$482.50</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td>0</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>++$482.50</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>−0</td>
</tr>
<tr>
<td><strong>Total Countable Income</strong></td>
<td>= $482.50</td>
</tr>
<tr>
<td>Base SSI Rate</td>
<td>$522</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>−$482.50</td>
</tr>
<tr>
<td><strong>Adjusted SSI Payment</strong></td>
<td>=$39.50</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>$39.50</td>
</tr>
<tr>
<td>Gross earned income received</td>
<td>++$1,200</td>
</tr>
<tr>
<td>Gross unearned income received</td>
<td>+0</td>
</tr>
<tr>
<td>Step</td>
<td>Calculations</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Total Income Received</td>
<td>$1,239.50</td>
</tr>
<tr>
<td>PASS, BWE or IRWE Expenses</td>
<td>–$150</td>
</tr>
<tr>
<td><strong>Total Financial Outcome</strong></td>
<td><strong>$1,089.50</strong></td>
</tr>
</tbody>
</table>
**SSI Calculation Sheet #4**

**Name:** Benjamin Johnson  
**Date:** January 17, 2020  
**Work Incentives Counselor:** Super CWIC  
**Scenario Description:** Earning $1200 per month with no Kind Support and Maintenance and with IRWE approved.

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned Income</td>
<td>0</td>
</tr>
<tr>
<td>General Income Exclusion (GIE) $20</td>
<td>−$20</td>
</tr>
<tr>
<td><strong>Countable Unearned Income</strong></td>
<td>=0</td>
</tr>
<tr>
<td>Gross Earned Income</td>
<td>$1,200</td>
</tr>
<tr>
<td>Student Earned Income Exclusion</td>
<td>−0</td>
</tr>
<tr>
<td>Remainder</td>
<td>=$1,200</td>
</tr>
<tr>
<td>GIE (if not used above) $20</td>
<td>−$20</td>
</tr>
<tr>
<td>Remainder</td>
<td>$1,180</td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE) $65</td>
<td>−$65</td>
</tr>
<tr>
<td>Remainder</td>
<td>=$1,115</td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE)</td>
<td>− $150</td>
</tr>
<tr>
<td>Remainder</td>
<td>=$965</td>
</tr>
<tr>
<td>Divide by 2</td>
<td>$482.50</td>
</tr>
<tr>
<td>Blind Work Expenses (BWE)</td>
<td>−0</td>
</tr>
<tr>
<td><strong>Total Countable Earned Income</strong></td>
<td>=$482.50</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td>0</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>+$482.50</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>−0</td>
</tr>
<tr>
<td><strong>Total Countable Income</strong></td>
<td>= $482.50</td>
</tr>
<tr>
<td>Base SSI Rate</td>
<td>$783</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>−$482.50</td>
</tr>
<tr>
<td><strong>Adjusted SSI Payment</strong></td>
<td>=$300.50</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>$300.50</td>
</tr>
<tr>
<td>Gross earned income received</td>
<td>+$1,200</td>
</tr>
<tr>
<td>Gross unearned income received</td>
<td>+0</td>
</tr>
<tr>
<td>Step</td>
<td>Calculations</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Total Income Received</td>
<td>= $1,500.50</td>
</tr>
<tr>
<td>PASS, BWE or IRWE Expenses</td>
<td>− $150</td>
</tr>
<tr>
<td><strong>Total Financial Outcome</strong></td>
<td>= $1,350.50</td>
</tr>
</tbody>
</table>
**Work Incentives Plan**

**Customer Name:** Ben Johnson  
**Date:** 01/27/2020  
**Employment Goal:** Work in retail as a stocker, earning $1200 per month.

**Accessing Employment Services and Supports**

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Completed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work with supported employment specialist to start position at retail store.</td>
<td>Ben</td>
<td>1/27/2020</td>
<td></td>
</tr>
</tbody>
</table>

**Resolving Existing Benefit Issues**

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Completed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meet with parents to discuss the fair share of household expenses and explore options for eliminating or reducing ISM.</td>
<td>Ben/CWIC</td>
<td>2/15/2020</td>
<td></td>
</tr>
<tr>
<td>Contact Social Security if you begin paying for food and shelter.</td>
<td>Ben/parents</td>
<td>As soon as change occurs</td>
<td></td>
</tr>
</tbody>
</table>
## Managing Social Security Benefits and Work Incentives

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Completed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create benefits binder to keep receipts for work-related expenses, letters from Social Security</td>
<td>Ben/CWIC</td>
<td>2/15/2020</td>
<td></td>
</tr>
<tr>
<td>Collect receipts for monthly paratransit costs once position at the new store begins.</td>
<td>Ben</td>
<td>Once new job begins</td>
<td></td>
</tr>
<tr>
<td>Complete IRWE request template and submit to local Social Security office for review and approval.</td>
<td>Ben/CWIC</td>
<td>By 10th of the month after first month of work</td>
<td></td>
</tr>
<tr>
<td>Report wages and IRWEs monthly to Social Security by mailing or delivering paystubs; keep copies of paystubs.</td>
<td>Ben</td>
<td>By the 10th of each month after work begins</td>
<td></td>
</tr>
</tbody>
</table>
**Managing Federal, State or Local Benefit Programs**

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Completed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explore opportunity to set up ABLE Account</td>
<td>Ben/parents</td>
<td>Three months after new job begins or sooner if resources nearing $2000</td>
<td></td>
</tr>
</tbody>
</table>

**Planning for Future Healthcare Needs**

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Completed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>None at this time</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Follow-Up Contact Plan**

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Completed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact CWIC when start date at new store is determined.</td>
<td>Ben</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact CWIC when notified by Social Security of adjusted SSI payment</td>
<td>Ben</td>
<td>When new job starts and wages are reported</td>
<td></td>
</tr>
<tr>
<td>Contact CWIC if there are changes in IRWE amount or wages</td>
<td>Ben</td>
<td>Ongoing</td>
<td></td>
</tr>
</tbody>
</table>
Beneficiary Signature:
Date:

CWIC Signature:
Date:
Sample BS&A # 3 – Concurrent (SSDI/SSI) Employment Stage Using BSADocs

Note: William will begin a new job as an office administrator in February. He will earn approximately $2200 per month. After the interview, the CWIC determined that William has no IRWEs or subsidy/special condition. This Benefits Summary & Analysis was created using the report writing software, BSADocs, and the template from the state of Indiana. Some state-specific details are included, which could be different depending on where William lives. For example, Indiana’s Medicaid program currently pays the Medicare Part B premium for those in SSI/1619b Medicaid.

Benefits Summary & Analysis

Name: William Smith

Date: January 17, 2020

It was a pleasure speaking with you about your work goals. This report will show how you can work and get ahead.

Summary of Your Current Situation & Employment Goals

Current Situation:

I verified with Social Security and Centers for Medicare and Medicaid Services that you are receiving the following benefits:

- Social Security Disability Insurance (SSDI) - net $400.00/month

- Supplemental Security Income (SSI) - net $403.00/month. Your SSI is less than the maximum amount ($783.00) because of SSDI benefits.

- Medicare (Part A-hospital, Part B-outpatient and Part D-prescription) based on entitlement to SSDI
  - Indiana Division of Family Resources (DFR) pays your Part B premium and helps pay your Part A and B deductibles and coinsurance
  - Full Extra Help helps pay the Part D premium and keeps co-pays to a low amount

- Medicaid (based on SSI eligibility)
Employment Details:

- You are not currently working.
- You have been offered a full-time position as an office administrator earning approximately $2200 per month beginning in February.

How Work Affects Your Cash Benefits

Social Security Disability Insurance: **SSDI has 3 phases of work rules, each with work incentives to support your efforts to work. Some of the work incentives allow you to maintain SSDI when working, while others allow you to easily restart the benefit if it stops. Below are the key details given your situation and goals.**

**Phase 1- Trial Work Period (TWP):** During the TWP, you will receive your SSDI regardless of how high your earnings might be, as long as you still have a disability. Your TWP ends when you use 9 TWP months within a 5-year period. Social Security will count a month as a TWP month if your gross earnings are more than $910 (2020 rate). Social Security confirmed you have 9 TWP months available.

**Phase 2-Extended Period of Eligibility (EPE):** The month after your TWP ends, you begin a 36-month Extended Period of Eligibility. During the EPE, Social Security will give you SSDI for months your countable earnings are below Substantial Gainful Activity (SGA), but they will suspend SSDI for months your countable earnings are SGA. An explanation of SGA is provided below. During the EPE, Social Security can easily restart your SSDI if your countable earnings fall below SGA. You don’t have to reapply. This is a great safety net.

**Understanding SGA:** After the TWP is over Social Security will decide whether your work activity is Substantial Gainful Activity (SGA). To make this decision they compare your monthly countable earnings to a guideline of $1,260 (2020 rate). The word “countable” is important because Social Security may not count all of your gross wages when deciding if your work is SGA. For example, they deduct paid time off, the value of extra help or reduced productivity on the job because of your disability, and impairment-related expenses you pay for that are necessary for you to work. Based on what you shared, it appears none of those deductions would help you at this time.
There is one final detail about SGA. After the TWP, the first time you have a pattern of work that is SGA Social Security pays your SSDI for 3 months. This is called the Grace Period, the first month of which is known as the cessation month. This can occur during Phase 2 or Phase 3.

**Phase 3-Post EPE:** This phase begins after the 36th month of your EPE. If your work is below SGA, your SSDI continues. If your work is SGA, your SSDI will terminate. However, there is a work incentive called Expedited Reinstatement (ExR) that may be used to quickly restart the SSDI if you can’t maintain SGA level work. I will provide more details about this work incentive when you are closer to this phase.

**Specific to You:**

- **Earning $2,200.00/month:** Based on the information above, I estimate your SSDI will pause after the Trial Work Period (likely ending October 31, 2020) and the Grace Period (likely November 1, 2020 - January 31, 2021) because your work is expected to be above the SGA guideline. If your work activity drops below SGA for any reason during Phase 2 (likely November 1, 2020 - October 31, 2023), you should report the change to Social Security right away. You can receive the benefit again if Social Security determines your work is no longer SGA. This is a great safety net to support you as you return to work.

I have attached a TWP/EPE Tracking Chart to this report that shows how these work incentives fit together. Keep in mind the changes noted above are only an estimate. Social Security makes final decisions about your SSDI.

**Supplemental Security Income (SSI):** SSI is a cash benefit for people with disabilities who have low income and resources. The amount you get is reduced if you have other income. Many people think they’ll have less money if they work, but that’s a myth.

Social Security doesn’t count all of your income when calculating your SSI amount. They deduct $20 from your unearned income; if you don’t have unearned income they deduct it from your gross earnings. Then they deduct $65 of your gross earnings and divide the remainder of those earnings in half. The amount of income left after the deductions is called total countable income. Social Security subtracts your total countable
income from your base SSI rate; the remainder is your new SSI amount. Because of these deductions you have more money when working.

If your earnings cause the SSI to drop to $0 you can keep your SSI claim open by using a work incentive called 1619(b). With 1619(b) you just contact Social Security when your income is low enough to get SSI again and they will restart your benefit; you don’t have to reapply. Below I will explain how you can also keep Medicaid through 1619(b) and provide more details about the eligibility criteria.

**Specific to You:**

- **Earning $2,200.00/month:** Based on the information above, I estimate your SSI will be $0.00 per month when you first reach this goal and after your SSDI stops, using the automatic income deductions. When this happens you will still have more money by working. You can see these details at the end of this report, in the Snapshot section. It appears you’ll meet the 1619(b) criteria when your SSI is $0.00, which allows you to keep SSI eligibility status. This is another great safety net.

Attached are SSI calculation worksheets that show the details for these estimated changes. Keep in mind the changes noted above are only estimates. Social Security makes the final decisions about your SSI eligibility and payments.

**How Work Affects Your Health Insurance**

**Medicaid (SSI Beneficiary):** Medicaid is a health insurance program that covers certain groups of people who have low income and resources. As an SSI beneficiary, your state automatically enrolled you in Medicaid. Special rules make it possible to keep Medicaid when you work. If you are eligible to receive an SSI payment when you work, you keep Medicaid. If earnings make your SSI drop to $0, you can still keep Medicaid by using 1619(b). To use 1619(b), you must be ineligible for an SSI payment because of earnings, still have a disability, have countable resources below $2,000, need Medicaid, and have annual earnings under $38,506 (2019). Social Security allows you to use a higher annual earnings limit in some situations.
Specific to You:

- **Earning $2,200.00/month:** Based on the information above, I estimate your Medicaid eligibility will continue through the 1619(b) work incentive.

Keep in mind the details above are only an estimate. Social Security makes the final decisions about your eligibility for SSI-based Medicaid.

**Medicare:** Medicare is a federal health insurance program that offers inpatient coverage (Part A), outpatient coverage (Part B), and prescription drug coverage (Part D). You are eligible for Medicare because you have been entitled to SSDI for more than 24 months. You continue to be eligible for Medicare as long as you are eligible for SSDI. If your SSDI terminates due to work, you can keep Medicare by using a work incentive called the Extended Period of Medicare Coverage (EPMC). The EPMC ends at least 7 years and 9 months after your Trial Work Period. You do not have to request EPMC, it will start automatically.

Specific to You:

- **Earning $2,200.00/month:** Based on the information above, I estimate your Medicare eligibility based on SSDI entitlement will continue until October 31, 2023 when your EPE will end and your SSDI will terminate. After this, I estimate your Medicare will continue because of the EPMC work incentive.

Keep in mind the details above are only an estimate. Social Security makes the final decisions about your Medicare eligibility.

**Medicare Parts A and B Financial Assistance:** Beneficiaries with Medicare Parts A (hospital) and B (outpatient) usually have to pay a Part B premium, plus deductibles and coinsurance. However, the state will pay your Part B premium when you are enrolled in certain Medicaid eligibility groups. Medicaid also acts like a supplemental insurance and can help pay your Part A and B deductibles and coinsurance.

Specific to You:

- **Earning $2,200.00/month:** Based on the information above and the Medicaid eligibility group you are expected to use with this goal, I estimate the state will continue to pay your Part B premium and help pay your Part A and B deductibles and coinsurance.
Keep in mind the details above are only an estimate. The Indiana Division of Family Resources (DFR) makes the final decisions about your eligibility for help with Part A and Part B costs.

**Medicare Part D Financial Assistance:** Medicare Part D (prescription drug coverage) out-of-pocket costs can include a premium, a deductible and copays that vary depending on the plan you choose. Extra Help, also known as the Low Income Subsidy program, helps pay those out-of-pocket expenses. The program has two levels of assistance, Full Extra Help and Partial Extra Help.

Full Extra Help pays all or most of the Part D premium, the annual deductible, and keeps copays to a low amount ($0 - $8.95 per prescription in 2020). People who get SSI, Medicaid, or help from the Indiana Division of Family Resources (DFR) with any Medicare Part A and B costs are automatically enrolled. When working, if you fall under one of those groups you can get or keep Full Extra Help.

**Specific to You:**

- **Earning $2,200.00/month:** Based on the information above I estimate you will be eligible for Full Extra Help because of your enrollment in Medicaid.

Keep in mind the details above are only an estimate. Social Security and Centers for Medicare and Medicaid Services make final decisions about eligibility for Extra Help.

**Employer-Sponsored Health Insurance:** When you become an employee, your employer may offer health insurance. Depending on the plan, premium, deductible, and coinsurance, this may or may not be a cost-effective option. You should read over the plan details to make this decision. Here are a few details to consider about the interaction of employer-sponsored health insurance and your other insurance.

- **Medicaid:** You should report to the Indiana Division of Family Resources (DFR) if you become eligible for other health insurance. Medicaid is a payer of last resort. As a result, any other health insurance plan you have must be billed first. Depending on the cost of the service and the provider Medicaid may cover what the other insurance does not. In certain circumstances DFR will assist you in paying for your private
insurance premium. This is called the Health Insurance Premium Payment Program (HIPP).

Once you are offered employer-sponsored health insurance we can review these considerations in more detail.

**Employment and Other Services to Help You Reach Your Goal**

You are not receiving employment services at this time and you shared that you are not interested in receiving any services. If you change your mind, please let me know so I can refer you to agencies that assist with getting and keeping a job.

**Other Topics**

**Reporting Earnings to Social Security:** Since SSDI and SSI are two separate programs, you must report to each program separately.

- **Reporting for SSDI:** You must report to Social Security when you begin working, if your work activity goes above or below SGA, or if you stop working. To report this type of change, bring a copy of your pay stub to your local Social Security office at 333 Main Street, Indianapolis, Indiana 46201. Ask for a receipt that documents you reported. If you have low wages Social Security may not ask you to do anything more except report if your earnings increase. If you have earnings above SGA, Social Security may send you a Work Activity Report (form SSA-821). I can help you complete that form so please call me when you receive it. Once Social Security has listed the employer on your record, I recommend you log into your my Social Security account (http://www.ssa.gov/myaccount) and report your earnings each month.

- **Reporting for SSI:** When you begin working, you must report gross wages from your first month of work by the 10th of the following month. I recommend you bring a copy of your pay stub to your local Social Security office at 333 Main Street, Indianapolis, Indiana 46201 to report your new work. You must continue reporting earnings every month. To report gross wages on an ongoing basis, I recommend you use the SSI mobile wage reporting application (if you are approved by Social Security to do so) no later than the 6th day of the month after you receive earnings.
Important Things for You to Remember

Important dates or deadlines:

- Report your income to Social Security when you begin working. Remember that you must report your income to both your Title II claims representative (SSDI) and your Title XVI claims representative (SSI).

- Request approval to report your wages for SSI through the SSI wage reporting app and then download the app to phone.

- Track your Trial Work Period months.

- Near the end of your Trial Work Period, you should fill out a Work Activity Report and submit it to Social Security to facilitate Social Security pausing your SSDI check and to avoid an overpayment. I will assist you with this process.

Recordkeeping reminders: Please keep this Benefits Summary and Analysis in your records. Remember to keep letters you get about your benefits. Keep notes and receipts whenever you report changes and be sure to keep everything together in one place so you can find it. Notes should include: the agency where you made the report, the date you made the report, who you talked to, what you told them, and what papers you submitted.

It is your responsibility to promptly report all relevant changes to Social Security and any other federal, state, or local entity administering the benefits you receive.

Using this report: You should keep this report and refer back to it when you have questions about how your employment plans may affect your benefits. It is also important for you to share this report with other people who are helping you achieve your employment goals.

Changes in the situation described above may seriously affect the accuracy of the information provided in this correspondence. Please contact your CWIC immediately to discuss any changes in your benefits situation or employment plans or to answer any additional questions you have about how employment may affect your benefits.

CWIC: Super CWIC

Agency: Aspire Indiana, Inc

Date:
Phone: 333-333-3333
Email: super@cwicinc.org
### Snapshot

<table>
<thead>
<tr>
<th>Item</th>
<th>Current Situation</th>
<th>Earning Goal $2,200.00 (Before SSDI stops)</th>
<th>Earning Goal $2,200.00 (After SSDI stops)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross Wages</td>
<td>$0.00</td>
<td>$2,200.00</td>
<td>$2,200.00</td>
</tr>
<tr>
<td>SSDI</td>
<td>$400.00</td>
<td>$400.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>SSI</td>
<td>$403.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td><strong>$803.00</strong></td>
<td><strong>$2,600.00</strong></td>
<td><strong>$2,200.00</strong></td>
</tr>
<tr>
<td><strong>Expenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Medicare Part B premium</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td><strong>$0.00</strong></td>
<td><strong>$0.00</strong></td>
<td><strong>$0.00</strong></td>
</tr>
<tr>
<td><strong>Remaining Money</strong></td>
<td><strong>$803.00</strong></td>
<td><strong>$2,600.00</strong></td>
<td><strong>$2,200.00</strong></td>
</tr>
</tbody>
</table>

Changes to benefits noted above are estimates. Only benefit agency staff can make a formal determination of how working will affect that benefit. It is your responsibility to report changes in income to each agency. These estimates do not take into account all expenses, such as payroll taxes. Additionally, these estimates are based on your present situation, which means as your life changes this information can become outdated quickly. If you do not use this information in the next 2-3 months, please contact me and I can update this report.
**TWP / EPE Tracking Chart**

**Name:** William Smith  
**Date:** 1/17/2020  
**Work Incentives Counselor:** Super CWIC  
**Scenario Description:** Earning $2200 per month beginning February 2020.

<table>
<thead>
<tr>
<th><strong>YEAR 1</strong></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>April</th>
<th>May</th>
<th>Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Countable Earnings</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$2200</td>
<td>$2200</td>
<td>$2200</td>
<td>$2200</td>
<td>$2200</td>
<td></td>
</tr>
<tr>
<td><strong>Benefit Status</strong></td>
<td>TWP #1</td>
<td>TWP #2</td>
<td>TWP #3</td>
<td>TWP #4</td>
<td>TWP #5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
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<th><strong>YEAR 1</strong></th>
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<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Countable Earnings</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td>$2200</td>
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<tr>
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<td>TWP #6</td>
<td>TWP #7</td>
<td>TWP #8</td>
<td>TWP #9</td>
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<tr>
<th><strong>YEAR 2</strong></th>
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<th>Feb</th>
<th>Mar</th>
<th>April</th>
<th>May</th>
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<tbody>
<tr>
<td><strong>Countable Earnings</strong></td>
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<td>EPE/Grace Period</td>
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<table>
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<th>April</th>
<th>May</th>
<th>Jun</th>
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<tbody>
<tr>
<td>Countable Earnings</td>
<td>$2200</td>
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<table>
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<tbody>
<tr>
<td>Countable Earnings</td>
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<table>
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<tr>
<th>YEAR 4 2023</th>
<th>Jan</th>
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<th>Mar</th>
<th>April</th>
<th>May</th>
<th>Jun</th>
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<tbody>
<tr>
<td>Countable Earnings</td>
<td>$2200</td>
<td>$2200</td>
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<tr>
<td>Countable Earnings</td>
<td>$2200</td>
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<td>$2200</td>
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</tr>
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<td>EPE</td>
<td>EPE</td>
<td>EPE</td>
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<tr>
<td>YEAR 5 2024</td>
<td>Jan</td>
<td>Feb</td>
<td>Mar</td>
<td>April</td>
<td>May</td>
<td>June</td>
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<td>Benefit Status</td>
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<tr>
<td>YEAR 5 2024</td>
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<td>Sept</td>
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<td>Nov</td>
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<tr>
<td>Countable Earnings</td>
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<td></td>
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</tr>
<tr>
<td>Benefit Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# SSI Calculation Sheet #1

**Beneficiary Name:** William Smith  
**Date:** January 17, 2020  
**Work Incentives Counselor:** Super CWIC

**Scenario Description:** Current Situation - No Earnings and receiving $400 of SSDI

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned Income</td>
<td>$400</td>
</tr>
<tr>
<td>General Income Exclusion (GIE) $20</td>
<td>−$20</td>
</tr>
<tr>
<td><strong>Countable Unearned Income</strong></td>
<td>= $380</td>
</tr>
<tr>
<td>Gross Earned Income</td>
<td>$0</td>
</tr>
<tr>
<td>Student Earned Income Exclusion</td>
<td>−0</td>
</tr>
<tr>
<td>Remainder</td>
<td>0</td>
</tr>
<tr>
<td>GIE (if not used above) $20</td>
<td>−0</td>
</tr>
<tr>
<td>Remainder</td>
<td>0</td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE) $65</td>
<td>−$65</td>
</tr>
<tr>
<td>Remainder</td>
<td>0</td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE)</td>
<td>− 0</td>
</tr>
<tr>
<td>Remainder</td>
<td>0</td>
</tr>
<tr>
<td>Divide by 2</td>
<td>0</td>
</tr>
<tr>
<td>Blind Work Expenses (BWE)</td>
<td>−0</td>
</tr>
<tr>
<td><strong>Total Countable Earned Income</strong></td>
<td>=0</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td>$380</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>+0</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>−0</td>
</tr>
<tr>
<td><strong>Total Countable Income</strong></td>
<td>= $380</td>
</tr>
<tr>
<td>Base SSI Rate</td>
<td>$783</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>−$380</td>
</tr>
<tr>
<td><strong>Adjusted SSI Payment</strong></td>
<td>=$403</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>$403</td>
</tr>
<tr>
<td>Gross earned income received</td>
<td>+0</td>
</tr>
<tr>
<td>Gross unearned income received</td>
<td>+$400</td>
</tr>
<tr>
<td>Step</td>
<td>Calculations</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Total Income Received</td>
<td>=$803</td>
</tr>
<tr>
<td>PASS, BWE or IRWE Expenses</td>
<td>−0</td>
</tr>
<tr>
<td><strong>Total Financial Outcome</strong></td>
<td>=$803</td>
</tr>
</tbody>
</table>
**SSI Calculation Sheet #2**

**Beneficiary Name:** William Smith

**Date:** January 17, 2020

**Work Incentives Counselor:** Super CWIC

**Scenario Description:** Earning $2200 per month and still receiving $400 of SSDI (Trail Work Period and Grace Period)

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unearned Income</strong></td>
<td>$400</td>
</tr>
<tr>
<td>General Income Exclusion (GIE) $20</td>
<td>−$20</td>
</tr>
<tr>
<td><strong>Countable Unearned Income</strong></td>
<td>= $380</td>
</tr>
<tr>
<td>Gross Earned Income</td>
<td>$2,200</td>
</tr>
<tr>
<td>Student Earned Income Exclusion</td>
<td>−0</td>
</tr>
<tr>
<td>Remainder</td>
<td>=$2,200</td>
</tr>
<tr>
<td>GIE (if not used above) $20</td>
<td>−0</td>
</tr>
<tr>
<td>Remainder</td>
<td>=$2,200</td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE) $65</td>
<td>−$65</td>
</tr>
<tr>
<td>Remainder</td>
<td>=$2,135</td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE)</td>
<td>−0</td>
</tr>
<tr>
<td>Remainder</td>
<td>=$2,135</td>
</tr>
<tr>
<td>Divide by 2</td>
<td>$1,067.50</td>
</tr>
<tr>
<td>Blind Work Expenses (BWE)</td>
<td>−0</td>
</tr>
<tr>
<td><strong>Total Countable Earned Income</strong></td>
<td>=$1,067.50</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td>$380</td>
</tr>
<tr>
<td>Total Countable Earned Income + $1,067.50</td>
<td></td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>−0</td>
</tr>
<tr>
<td><strong>Total Countable Income</strong></td>
<td>= $1,447.50</td>
</tr>
<tr>
<td>Base SSI Rate</td>
<td>$783</td>
</tr>
<tr>
<td>Total Countable Income − $1,447.50</td>
<td></td>
</tr>
<tr>
<td><strong>Adjusted SSI Payment</strong></td>
<td>=0</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>0</td>
</tr>
<tr>
<td>Gross earned income received</td>
<td>+$2,200</td>
</tr>
<tr>
<td>Gross unearned income received</td>
<td>+$400</td>
</tr>
<tr>
<td>Step</td>
<td>Calculations</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Total Income Received</td>
<td>=$2,600</td>
</tr>
<tr>
<td>PASS, BWE or IRWE Expenses</td>
<td>−0</td>
</tr>
<tr>
<td><strong>Total Financial Outcome</strong></td>
<td>=$2,600</td>
</tr>
</tbody>
</table>
# SSI Calculation Sheet #3

**Beneficiary Name:** William Smith  
**Date:** January 17, 2020  
**Work Incentives Counselor:** Super CWIC  
**Scenario Description:** Earning $2200 per month with SSDI paused (After Trial Work Period and Grace Period)

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned Income</td>
<td>0</td>
</tr>
<tr>
<td>General Income Exclusion (GIE) $20</td>
<td>$-20</td>
</tr>
<tr>
<td><strong>Countable Unearned Income</strong></td>
<td>=0</td>
</tr>
<tr>
<td>Gross Earned Income</td>
<td>$2,200</td>
</tr>
<tr>
<td>Student Earned Income Exclusion</td>
<td>0</td>
</tr>
<tr>
<td>Remainder</td>
<td>=$2,200</td>
</tr>
<tr>
<td>GIE (if not used above) $20</td>
<td>$-20</td>
</tr>
<tr>
<td>Remainder</td>
<td>=$2,180</td>
</tr>
<tr>
<td>Earned Income Exclusion (EIE) $65</td>
<td>$-65</td>
</tr>
<tr>
<td>Remainder</td>
<td>=$2,115</td>
</tr>
<tr>
<td>Impairment Related Work Expense (IRWE)</td>
<td>0</td>
</tr>
<tr>
<td>Divide by 2</td>
<td>$1,057.50</td>
</tr>
<tr>
<td>Blind Work Expenses (BWE)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Countable Earned Income</strong></td>
<td>=$1,057.50</td>
</tr>
<tr>
<td>Total Countable Unearned Income</td>
<td>0</td>
</tr>
<tr>
<td>Total Countable Earned Income</td>
<td>+$1,057.50</td>
</tr>
<tr>
<td>PASS Deduction</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Countable Income</strong></td>
<td>= $1,057.50</td>
</tr>
<tr>
<td>Base SSI Rate</td>
<td>$783</td>
</tr>
<tr>
<td>Total Countable Income</td>
<td>$-1,057.50</td>
</tr>
<tr>
<td><strong>Adjusted SSI Payment</strong></td>
<td>=0</td>
</tr>
<tr>
<td>Adjusted SSI Payment</td>
<td>0</td>
</tr>
<tr>
<td>Gross earned income received</td>
<td>+$2,200</td>
</tr>
<tr>
<td>Gross unearned income received</td>
<td>+0</td>
</tr>
<tr>
<td>Step</td>
<td>Calculations</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Total Income Received</td>
<td>=$2,200</td>
</tr>
<tr>
<td>PASS, BWE or IRWE Expenses</td>
<td>-0</td>
</tr>
<tr>
<td><strong>Total Financial Outcome</strong></td>
<td><strong>=$2,200</strong></td>
</tr>
</tbody>
</table>
**Work Incentives Plan**

**Beneficiary Name:** William Smith

**Date:** 1/17/2020

**Employment Goal:** Earning $2200 per month as an office administrator.

### Accessing Employment Services and Supports

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Completed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>No employment services needed now.</td>
<td></td>
<td></td>
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</table>

### Resolving Existing Benefit Issues

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Completed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>No benefits issues to address at this time</td>
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<td></td>
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</tbody>
</table>

### Managing Social Security Benefits and Work Incentives

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Completed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create benefits binder to keep pay stubs, reporting receipts, and letters from Social Security</td>
<td>William/CWIC</td>
<td>2/15/20</td>
<td></td>
</tr>
<tr>
<td>Report beginning of work to Title 2 claims representative and submit paystubs monthly</td>
<td>William</td>
<td>3/10/20</td>
<td></td>
</tr>
<tr>
<td>Track TWP months</td>
<td>William</td>
<td>2/1/20 and on-going</td>
<td></td>
</tr>
<tr>
<td>Action Step</td>
<td>Person Responsible</td>
<td>Target Date</td>
<td>Completed Date</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>--------------------</td>
<td>----------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Report changes in monthly income to SSDI claims representative</td>
<td>William</td>
<td>On-going after initial report</td>
<td></td>
</tr>
<tr>
<td>Report beginning of work to SSI claims representative</td>
<td>William</td>
<td>3/10/20</td>
<td></td>
</tr>
<tr>
<td>Request approval to use SSI reporting app</td>
<td>William</td>
<td>3/10/20</td>
<td></td>
</tr>
<tr>
<td>Report wages monthly through SSI reporting app</td>
<td>William</td>
<td>On-going after initial report</td>
<td></td>
</tr>
</tbody>
</table>

Managing Federal, State or Local Benefit Programs

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Completed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>No action needed at this time.</td>
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<td></td>
<td></td>
</tr>
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</table>

Planning for Future Healthcare Needs

<table>
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<tr>
<th>Action Step</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Completed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirm 1619b status with Social Security</td>
<td>William and CWIC</td>
<td>4/1/20</td>
<td></td>
</tr>
<tr>
<td>Monitor continued eligibility for help with Medicare costs through state</td>
<td>William and CWIC</td>
<td>On-going</td>
<td></td>
</tr>
<tr>
<td>Action Step</td>
<td>Person Responsible</td>
<td>Target Date</td>
<td>Completed Date</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Explore employer-sponsored health insurance</td>
<td>William</td>
<td>First week of February</td>
<td></td>
</tr>
<tr>
<td>Contact DFS when offered employer-sponsored health insurance</td>
<td>William</td>
<td>When offered health insurance</td>
<td></td>
</tr>
</tbody>
</table>

**FOLLOW-UP CONTACT PLAN**

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Completed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact CWIC to confirm job has started and projected earnings are still accurate</td>
<td>William</td>
<td>After first paycheck received</td>
<td></td>
</tr>
<tr>
<td>Contact CWIC to review TWP usage</td>
<td>William and CWIC</td>
<td>8/1/20</td>
<td></td>
</tr>
<tr>
<td>Notify CWIC if employer-sponsored health insurance is offered to discuss Medicare/Medicaid interaction</td>
<td>William</td>
<td>When employer-sponsored health insurance offered</td>
<td></td>
</tr>
<tr>
<td>Contact CWIC to discuss status of work CDR and receipt of Work Activity Report</td>
<td>William</td>
<td>10/1/20</td>
<td></td>
</tr>
</tbody>
</table>

**Beneficiary Signature:**
**Date:**

**CWIC Signature:**
**Date:**
Competency Unit 5 – Providing Individualized WIPD Services and Ongoing Follow-up

Introduction

CWICs sometimes are unsure about what it means to provide ongoing follow-up to beneficiaries. They may be confused about who should receive ongoing services, how often they should make follow-up contact, the purpose for making repeated contacts over time, and when they should stop follow-up.

To sort this out, begin by defining what follow-up means within the context of WIPA service delivery. Standard dictionaries define the phrase follow-up as “1. Continuation; 2. Further action or investigation or a subsequent event that results from and is intended to supplement something done before.” What this means is that WIPA services don’t stop once you complete the initial Benefits Summary & Analysis report and Work Incentives Plan. Services you deliver from this point forward involve actually implementing the WIP. That means helping the beneficiary use the work incentives and other recommendations to reach his or her employment goal. Follow-up is necessary to ensure that the beneficiary completes the action steps and to check in with the beneficiary to make sure everything is progressing as he or she planned.

Determining Who Receives Follow-up Services and for How Long

CWICs work with so many beneficiaries that it would be virtually impossible to provide ongoing follow-up services to every eligible individual. Fortunately, not all beneficiaries who receive services will want or need ongoing follow-up services. The question then becomes, “How do I determine which individuals need regular follow-up as opposed to those needing ‘check-ins’ on a very intermittent basis?”
The answer to this question requires a review of what follow-up means within the context of WIPA services. Follow-up is the act of implementing, or facilitating the implementation of, the Work Incentives Plan (WIP). Individuals who will need or benefit from ongoing contacts have completed the BS&A process and have indicated a desire or need to move on to the Work Incentives Planning phase. As indicated in the last unit, not everyone who gets a BS&A will work with the CWIC to develop a Work Incentives Plan (WIP). Some people will either not be ready to complete this planning phase, or won’t want or require assistance from the CWIC to move forward toward employment.

Quite simply, the WIP is the plan that drives follow-up contact. The action steps you outline in the WIP will determine the type, intensity, and duration of your follow-up services. Each beneficiary’s plan will be unique. You should outline the length of time you spend working with a beneficiary and the exact supports you provide in the current WIP. Action steps you detail in the WIP may involve intense assistance for a short period of time, lower levels of support spread out over months or years, or in some cases - both. There’s no minimum or maximum time frame for follow-up. It all depends on the beneficiary’s needs and preferences.

**When to Follow Up with Beneficiaries — Proactive versus Reactive Contacts**

High-quality WIPA follow-up services are “proactive” rather than reactive. Proactive services happen on a scheduled basis as a form of prevention. They identify and avert problems before they occur. Proactive follow-up has the following characteristics:

- Services are pre-planned;
- Contact occurs at scheduled intervals as agreed upon by you and the beneficiary;
- Interaction between you and the beneficiary, or other key stakeholders, is predicated on action steps identified in the WIP;
- Interaction provides an opportunity to reassess the individual’s employment and benefit status and revise the WIP if necessary; and
• Follow-up anticipates changes and reduces the occurrence of negative effects or benefit complications.

The following best practices are indicators that you are providing follow-up services in a proactive manner:

• Developing a WIP and keeping it updated and current;
• Conducting periodic “wellness” checks to determine if the plan is progressing without problems and to ensure that you don’t miss critical issues;
• Talking to the beneficiary at critical transition points. These are points in time or events that would potentially cause changes in benefit status and require your assistance. Examples include the start of a job, the end of the TWP, nearing the 18th birthday, an impending marriage, etc. Critical transition points are identified in the BS&A and addressed in the WIP when they become relevant to the beneficiary.
• Routine contact in the form of letters, phone calls, email messages, and benefits updates to keep the lines of communication open. The more contact a beneficiary has with you, the more likely he or she is to ask questions or provide status updates.
• Encouraging beneficiaries to contact you whenever they receive correspondence from Social Security. You can explain what the correspondence means and what actions are required (if any).

More on Critical Touch-points

Critical touch-points are points in time that would require your intervention. To identify critical touch points, you should identify the “when,” “what,” and “why” for each event or change:

• When will an event or change occur?
• Why is this a critical contact point?
• What information do you need to present or update with the beneficiary as a result of this event?
Consider Jaime, a married concurrent beneficiary who has recently started working. Jaime receives $320 in SSDI and $865 in earnings, and she and her husband each receive a reduced SSI payment. She is considering doubling her hours. Some of the potential “whens,” “whys,” and “whats” for Jaime include:

**When:** Her earnings increase and put her over the break-even point.  
**Why:** She will move into 1619(b) status and her husband will lose his Medicaid eligibility unless he also works.

**What:** Discuss the SSI calculation, transition to 1619(b) and the criteria for eligibility, and the impact to her husband’s benefits and medical coverage (including options).

**When:** She completes her TWP months.  
**Why:** She will now be subject to SGA determinations and may experience a change in her SSDI.  
**What:** She will need to understand how Social Security makes SGA determinations and what potential work incentives might apply in her situation.

**When:** She engages in SGA.  
**Why:** Social Security will suspend her SSDI check, and she may move back into cash payment status for SSI.  
**What:** She will need to understand that the loss of the SSDI check will result in a resumption of the SSI cash payment. This will also affect her husband’s SSI eligibility; if he has been in suspension less than 12 months, Social Security can reinstate him without a new application.

Keep these questions in mind as you are developing WIPs and scheduling ongoing follow-up contacts. The following are some of the critical events that require contact between you and the recipient.

**Common critical touch-points for SSI recipients:**

- Start or end of employment
- Changes in earned or unearned income
- Reaching the Break-Even Point (BEP)
- Transition to 1619(b) status
• Identification and use of IRWE or BWE
• Changes in student status or attainment of age 22 for Student Earned Income Exclusion (SEIE)
• Approval of a PASS and subsequent review points
• Attainment of age 18
• Reaching insured status for Title II benefits (SSDI, CDB, DWB, Retirement Insurance Benefits [RIB])
• Changes in living arrangement, marital status, or resources

**Common critical touch-points for Title II beneficiaries:**

• Completion of the TWP
• Beginning and end of the EPE
• Identification and use of IRWE, Subsidy, or Un-incurred Business Expenses and Unpaid Help (if self-employed)
• Work CDRs and SGA determinations
• Beginning and end of Extended Period of Medicare Coverage
• Attainment of dual entitlement (CDB becomes insured on own record)
• Transition to retirement benefits (early retirement or Full Retirement Age)

**Common critical touch-points that affect both SSI recipients and Title II beneficiaries:**

• Cessation of benefits due to medical improvement
• Expedited Reinstatement eligibility
• Overpayments or underpayments

Follow-up is necessary at these critical touch-points to provide updates and develop new options that present themselves at each benefit-changing event.
Reactive Follow-Up and Crisis Management

In contrast to proactive services, a reactive follow-up approach is nothing more than crisis management. It occurs when a beneficiary (or CWIC) doesn’t plan for or isn’t prepared for a problem that arises. While a reactive approach is certainly not desirable, there will be times when it’s unavoidable. Even the most skilled and attentive CWIC will encounter unexpected situations. When a problem arises, here are some important elements to consider:

- Is this really a problem or crisis situation?
- Is the nature of the situation based on financial, social, medical, or vocational factors?
- Are others affected by this situation?
- Is this a work incentive or safety net issue?
- Does this situation involve other individuals?
- Is expertise needed outside of work incentives planning and assistance?
- Who is available to network with on this issue?
- The following list demonstrates some helpful “dos and don’ts” of crisis management.

Do’s and Don’ts of Crisis Management

DO

- Try to buy time in order to investigate the situation.
- Be sensitive to the individual’s problem and “legitimize” the complaint.
- Assure the individual that you’ll take steps to work with them to solve the problem. You are the “expert” — inspire confidence in your ability.
- Develop and implement an intervention plan that treats root causes of the crisis.
- Investigate the situation thoroughly, utilizing all available information services.
• Use the least intrusive method of intervention; move up the list of possible interventions.
• Use existing supporters and stakeholders in the intervention plan to maximize involvement.
• Be creative and have back-up plans prepared.

DON'T
• Abandon the person requesting your support if he or she requests your immediate attention.
• Accept the individual’s perceptions of the situation at face value without investigation.
• Evade the situation, come across as “wishy-washy,” sound unsure of your ability, or make excuses.
• Attempt to solve major problems by treating symptoms of a pervasive underlying cause.
• Assume you know how to handle the situation without investigation, or commit yourself to a specific plan of action without gathering information.
• Jump in with the most intrusive intervention strategy.
• Try to solve the crisis all by yourself without investing others in the solution.
• Assume that your first plan will always be successful.

Providing Effective Follow-up Services

Effective follow-up services are those that achieve the primary mission of WIPA — to promote employment and enhance financial stability for Social Security disability beneficiaries. This section describes common characteristics of follow-up services that successfully support beneficiary progression along the employment continuum.

Using a Future Orientation

Due to time constraints, you may be tempted to simply address the initial question or concern that the beneficiary presents. The problem with this limited approach is that the initial question is often just the surface of the
problem. In many cases, there are numerous issues or problems that you need to address, or there is information that the beneficiary needs but didn’t know enough to ask about. In order to be truly effective, you must provide services using a future orientation. A well-trained and experienced CWIC uses his or her benefits expertise to anticipate changes and plan for them before they happen. Future orientation means educating beneficiaries on the options that are available in the future such as possible eligibility for Impairment Related Work Expenses (IRWEs) or use of a Plan to Achieve Self-Support (PASS).

A future orientation is especially critical when you are counseling younger beneficiaries, such as those transitioning from school to adult life. Discussions about adult life issues and their implications for benefits, including living situation, marriage, death of a parent, or plans for post-secondary education, are important. All of these life issues relate to public benefits in one way or another. Having future orientation educates beneficiaries, their families, and disability professionals on the need to plan and think ahead in order to use work incentives to their greatest advantage.

Applying a future orientation does have its limits. You must strike a delicate balance between alerting beneficiaries about potential future events and confusing beneficiaries by discussing events that are years away or are very remote possibilities. A good rule of thumb is to only address issues that have a high probability of occurring and keeping discussions of those issues within the relative near future (one year to 18 months). If you are maintaining ongoing contact with the beneficiary, there’s really no need to cover every conceivable issue in one or two phone calls. The advantage of ongoing follow-up is that it provides you with lots opportunities to explain important issues as they appear on the horizon.

**Using a Customized Approach**

In delivering services, no two individuals are alike. It’s important to remember that every person you serve has a unique set of circumstances and needs. To be effective, follow-up services require customization. As with the types and intensity of services a beneficiary needs, the duration of follow-along planning and assistance services won’t only vary from person to person, but may also vary for a particular individual over time. For example, an individual whose case was inactive after several months of your assistance regarding a work or benefit transition may identify the
need for support in developing a PASS, or responding to a CDR notice at a later point in time. It’s important that WIPA services remain flexible and allow beneficiaries and recipients to move in and out of active service status as needed.

The dynamic interplay between employment, financial status, and benefits requires that you continually draw on an array of tools throughout the process of supporting benefits management. You may need to update to the BS&A and the WIP.

**Collaborating With Other Members of the Employment Support Team**

Proactive follow-up also includes contact and collaboration with other members of the individual’s employment support team. As previously mentioned, you can’t operate in isolation of other entities that are involved in the individual’s pursuit of employment. All partners in the beneficiary’s network should be regularly communicating. Each update and revision of the WIP will require collaboration with other stakeholders to identify additional tasks that you and they will need to complete in order to achieve the employment goal, and to take an active role in completing those tasks as laid out in the plan.

Members of the employment support team may include:

- Representative payees, authorized representatives, family members, other caregivers;
- Case Managers or Service Coordinators from either the MH or the ID/DD systems;
- VR counselors;
- Supported employment personnel;
- Residential services staff; and
- Advocates.

When you delegate action steps to other team members, your role shifts to that of facilitator or coordinator. You serve as the central point of contact for all benefits and work incentives issues and monitor progress the team and beneficiary make on action steps in the WIP. This is an efficient way for you to oversee follow-up services.
Sharing Responsibility with the Beneficiary

It’s important for beneficiaries to be responsible for their own plan and take initiative to complete action steps. Rather than foster dependency, you should encourage and support the beneficiary to complete necessary tasks, such as initiating contact with employment support team members, whenever possible. It’s important to be clear about action steps and expectations, and then check in with beneficiaries who miss due dates or fail to provide updates.

The Most Important Follow-Up Role for CWICs: Facilitating the Use of Work Incentives

The mission of WIPA is to promote employment and to enhance financial stability. To fulfill this mission, your core function is to identify the appropriate work incentives that apply in each individual’s unique situation, and to help him or her to use the recommended work incentives at the appropriate times. Work with the beneficiary to develop the documentation he or she needs to successfully use specific work incentives. Acting as a guide, teach beneficiaries how to manage their own benefits in the future. Benefits literacy is one of the keys to enhanced financial stability. You must keep your role of “facilitator” at the forefront.

Strategies for Success in Assisting Beneficiaries with Work Incentives Use

Assisting beneficiaries to use work incentives to further their vocational goals is a defining activity for CWICs and a service that is typically unavailable elsewhere in the local service array. Because this function is so critical, you must do it well. To get started on the right foot, you should adopt the following strategies:

1. Be Prepared

Advance preparation will ease the stress of making sure the appropriate work incentives are applied at the proper time. The beneficiary’s BS&A and WIP provide the framework for your work incentives assistance. Once beneficiaries become employed, teach them to save paycheck stubs, collect and keep receipts for any work-related expenses, and document any supports they receive on the job. Although they may not
need these documents, it’s essential for the beneficiaries to begin building good habits and recordkeeping.

2. Regularly Update the WIP

Update the WIP as soon as the beneficiary becomes employed, and map out future critical points that may involve further reporting, potential change in benefits status, end of the TWP or EPE, age 18 re-determinations, change in student status, change in marital status or living arrangement, and other situations. At this time, you should discuss all available options for each upcoming touch-point. If necessary, you should prepare an updated BS&A that outlines the new options the transition points present.

3. Keep Open Lines of Communication

Regular communication with beneficiaries is critical. You shouldn’t step back once you’ve prepared the WIP and assigned the action steps. Ongoing case management is essential, and regular follow-up with the beneficiary is of utmost importance. Although the WIP identifies critical transition points and appropriate action steps, unexpected events happen, and you must be in regular contact with the beneficiary to address changes as they occur. Remind the beneficiary that unless communication lines are open both ways, you can’t effectively and proactively assist with work incentives use.

4. Coordination is Key

Being a CWIC requires strong coordination skills. Actively collaborate with other members of the individual’s employment and support teams as the benefits or employment situation changes and you adjust the Work Incentives Plan to reflect those changes. Keep all key stakeholders informed about how the upcoming changes affect not only Social Security benefits and medical coverage, but also all other federal, state, and local benefits the beneficiary receives. Include other partners in the WIP actions as support to the beneficiary, but don’t assign action steps to parties without consulting them and getting their agreement.

5. Work Closely with Local Work Incentives Liaisons (WILs)

It’s helpful to develop and maintain a good working relationship with the WIL in each local Social Security office. This could help to pave the way for assisting beneficiaries with work incentives usage. In most offices, the WIL is the main point of contact for CWICs. Be aware that in many
offices, this is an added responsibility for Social Security employees who are already very busy. Your approach should be respectful of the WIL’s circumstances and appreciative of his or her assistance.

WILs can assist with proper work incentives application and facilitate contact with the appropriate Claims Representative for wage reporting by specific individuals. Each Social Security office is structured a little differently, and the WIL can help you understand the best approach for reporting wages, resolving issues, etc.

Tips for getting to know the local WIL include the following:

- Call to arrange an introductory meeting. It’s a good idea for this to be a face-to-face meeting, if possible. If the WIL isn’t available to meet face to face or the office is too far for a personal visit to be practical, introduce yourself by phone.

- When you meet with the WIL for the first time, ask about other key players within the office (post-entitlement CR, SSI CRs, back-up WIL, and Public Affairs Specialist).

- Give a brief description of your services and how you see interaction between your services and Social Security. Focus on discussing ways that your role with beneficiaries can be an asset to Social Security. Many of the things you do will make the jobs of Social Security employees easier.

- Ask for the WIL to identify the appropriate contact and preferred methods of communication for BPQYs and other types of requests for information.

- Ask if you can give a brief presentation during the next field office staff meeting. Periodically the WIL conducts informational staff meetings to relay important work incentive information to the other members of the Social Security office. This is a great time to talk about your services and introduce yourself.

- Offer to collaborate with the WIL and the Public Affairs Specialist on any presentations that they conduct in the area.

- Maintain regular contact with your WILs.
Work Incentives Development and Management

Regardless of whether the beneficiary uses work incentives during the initial eligibility process or once Social Security has established his benefits, a decision by a beneficiary to work and use work incentives should involve thorough up-front evaluation and planning to ensure an overall positive impact. First, make projections on the immediate effect of the earnings and the work incentive plan on cash benefits and the overall financial situation. Second, investigate the long-term effect of changes in both earnings and work incentive use.

Some basic questions you’ll need to address include the following:

- What happens if earnings increase or decrease?
- If the beneficiary reaches the vocational goal, will his or her benefits cease all together?
- What will be the effect on medical coverage?
- If the beneficiary will be using a work incentive to pay for a work expense that’s the result of his or her disability, will the IRWE or PASS be more financially advantageous?
- Will the work incentive allow for funding of a needed service on a long-term basis, or will it be necessary to explore other funding options?
- If the beneficiary accumulates money or resources under a PASS and the plan is interrupted, how will eligibility for SSI be affected?

Successful use of work incentives and smooth benefit transitions ultimately depend on a cooperative effort between beneficiaries, families, advocates, and Social Security. Proactive communication with Social Security will ensure that the beneficiary bases any decisions he or she makes about employment and work incentives on accurate information and projections.

The following sections provide specific instruction about the CWIC’s role in facilitating the use of the various work incentives associated with Social Security disability benefit programs. For a complete description of each individual work incentive, please refer back to Module 3 or Module 5.
Title II Disability Benefit Work Incentives

Trial Work Period (TWP)

You must carefully track TWP months. During this period the beneficiary will retain cash payments regardless of how much he or she earned. When the TWP ends, it’s possible that the benefits may cease due to work.

You should contact the beneficiary at regular intervals during the TWP as prescribed in the WIP to calculate monthly earnings and track TWP usage. Although a beneficiary may have a regular work schedule, don’t assume that he or she will use TWP months consistently. Actual pay period wages may fluctuate and cause earnings to differ from month to month. Use pay stubs to identify what the beneficiary earned, not just what the employer paid.

IMPORTANT NOTE: The Bipartisan Budget Act of 2015 simplifies post-entitlement SGA determinations by allowing Social Security to presume earnings were earned in the month they were paid. However, prior to applying this paid versus earned assumption, Social Security personnel will evaluate any readily available earnings verification sources and determine when earnings were earned. If Social Security has no other readily available evidence to determine when earnings were earned, the agency will use other sources of earnings verification even if the earnings source only documents when earnings are paid. This change in policy makes development of wages when earned during the TWP even more important for CWICs. Whenever possible, support beneficiaries to report wage information when earned as opposed to when paid.

When the TWP ends, assist the beneficiary with compiling the information he or she needs to complete the SSA 821 – Work Activity Report. Once he or she has completed the report, the beneficiary should submit it to the proper person in the local Social Security office.

You should also review the effect of having both earnings and the disability payment during the TWP on any other federal, state, and local benefits that the individual may be receiving. The ability to have unlimited earnings AND disability benefits during the TWP could result in changes to other benefits. Prepare the beneficiary for this potential
effect. Make suggestions for how to use his or her money during the TWP. Point out that this is a time he or she can either use the disability check to begin building savings and assets, or take care of past debts. Of course, be aware of other benefit programs that have asset limits, and remind the beneficiary to stay below these limits or look for allowable ways to save. The TWP isn’t only a time for testing the ability to work; it’s also a good time to start developing financial literacy.

**Strategies for Success**

- Verify any previous TWP use via the BPQY before developing the BS&A. Don’t assume that the BPQY is accurate. Request development of past earnings when appropriate.

- Be sure that you have researched any and all past employment and have charted for potential TWP use.

- Maintain contact with the beneficiary on a regular basis to review and track earnings on the TWP/EPE Tracking Chart.

- Educate the beneficiary about continued reporting, how to calculate earnings, and maintaining proper documentation for future use of other work incentives.

- Prepare the beneficiary for the next steps after completion of the TWP.

**Extended Period of Eligibility (EPE)**

Once beneficiaries conclude their TWP, maintain regular monitoring of their monthly earnings. Because this is the point at which Social Security may determine SGA, the start of the EPE is a critical transition point, and beneficiaries should learn how to calculate and report their monthly earnings to Social Security. Also at this time, communicate with the beneficiary about other work incentives that might apply to reduce “countable” earnings during the SGA determination. If applicable, work with the individual, the employer, or other providers to identify and document appropriate deductions. Remind the beneficiary that eligibility continues during the 36-month period; however, payment status may change based on countable earnings.

**Strategies for Success**

- Continue tracking wages with the beneficiary.
• Assist the beneficiary in completing of the SSA-821 - Work Activity Report immediately after what you calculate to be the ninth TWP month, or when Social Security requests it.

• If the beneficiary appears to be performing SGA, prepare him or her for the official letter that arrives from Social Security upon their review of the SSA-821. The first sentence begins, “...based on your report of earnings, you are no longer disabled...” Too often, the reaction to this letter is negative; the beneficiary may think the solution is to immediately quit the job — this isn’t the outcome that Social Security desires, and may not be to the beneficiary’s advantage. Proactive preparation can help to ease this moment of confusion and concern. If you anticipate that an overpayment is possible, prepare the beneficiary by explaining appeal rights and the ability to repay the overpayment over time.

• Educate the beneficiary on the advantages of the EPE and when to expect benefits payments. If Social Security ceases benefits during the EPE, explain how to get benefits back again if earnings fall below the SGA guideline.

• Update the WIP appropriately, and identify upcoming critical touch points for ongoing contact.

**Work CDRs and SGA Determinations**

Work CDRs occur when Social Security is aware that a beneficiary is working and has reason to believe that the work might represent Substantial Gainful Activity (SGA). Most often, this is initiated by the beneficiary’s report that earnings have changed. A work CDR is often preceded by a request that the beneficiary complete a Work Activity Report (SSA-821 or 820) or when Social Security interviews the individual and completes the work report in the eWork system. Social Security uses this report to gather comprehensive information about an individual’s work activity in initial, continuing disability, and reconsideration cases. The Work Activity Report is important. The way a beneficiary answers pertinent questions on the SSA - 820 and 821 can have a significant effect on whether or not Social Security determines the beneficiary is engaging in SGA-level work.

Many people think that SGA is simply a number — an objective, concrete dollar figure that Social Security establishes each year that represents the
upper limit a beneficiary can earn before the agency ceases his or her benefits. In fact, SGA is far more than just a number, and the SGA determination process is often far from being a simple “black or white” decision. Like all decisions, SGA determinations require that Social Security personnel gather the applicable facts, apply the appropriate rules and procedures, and use their best judgment to make a final decision. SGA determinations involve the interpretation of complex regulations as they may apply to a unique set of circumstances, so some degree of subjectivity is always at play. This gives Social Security personnel some flexibility, which usually works in the beneficiary’s favor.

By assisting the beneficiary during a work CDR, the CWIC can ensure that Social Security has the appropriate information to make the SGA decision. The CWIC should use the following strategies during the work CDR and SGA determination process:

**Strategies for Success**

- Ensure that the beneficiary knows what to expect when he or she is earning at various levels and help him or her understand how Social Security assesses work activity when making an SGA determination.

- Help beneficiaries complete the Work Activity Report accurately to give Social Security the most complete and useful information. Because it’s important in the SGA decision, failure to complete the Work Activity Report or filling it out incorrectly may have a negative outcome for the beneficiary.

- Social Security has a variety of tools that they can use to accurately assess countable earnings during the SGA determination process. CWICs need to be aware of these tools and how to use them so that they can help facilitate an accurate SGA determination. Remember that Social Security’s decision isn’t final until Social Security has notified the beneficiary of the proposed decision and he or she has had a chance to submit further information if appropriate. Refer to Unit 3 of Module 3 to review the tools Social Security uses in the SGA decision. The CWIC can assist with the process by helping to develop the beneficiary’s work history, if time permits. This could include gathering wage data, tracking countable wages on a month-by-month basis, and determining which months may qualify as TWP months, EPE months, and cessation and grace months (if
applicable). By providing this assistance, Social Security can make the SGA determination quickly and with results that are more accurate.

- If there is an adverse SGA determination, carefully examine the employment situation and probe for any unidentified work incentives that Social Security could have applied. The CWIC may uncover subsidy or IRWE that Social Security didn’t catch and the beneficiary didn’t report.

CWICs are an asset to Title II beneficiaries and busy Social Security employees in that they can help Social Security have the documentation they need to complete work CDRs and make correct and timely SGA determinations. This is a high-priority function in WIPA services.

**Developing Subsidies and Special Conditions**

Subsidy is difficult to explain to beneficiaries, employment support workers, and employers. When Social Security is determining if a subsidy applies, it’s important that the beneficiary realize that Social Security isn’t evaluating his or her work performance. Instead, Social Security is assessing if the disability has an effect on the “value of the work effort,” whether the value of the beneficiary’s work is commensurate with what the person is actually being paid, and whether the beneficiary’s work is comparable to work performed by non-disabled peers performing the same functions. It’s a subtle but important difference.

To determine if an employer subsidy exists, Social Security will ask the employer to compare the beneficiary’s work to that of a non-disabled co-worker. Workers with disabilities may need extra supervision or additional time to perform job functions. They may not be able to perform all of the duties listed in their job description, or they may need accommodations such as a flexible schedule, working from home, etc. The employer may be reluctant to describe the beneficiary’s work as being “worth less” than other employees for fear of offending the worker. You can help the employer understand the concept of Subsidy so they can assign a dollar value or percentage to the extra supervision, job duties not being performed, or lost productivity, when evaluating “value of the work effort” of the beneficiary, if applicable.

Special conditions are easier to document in that the evidence consists of support provided to the beneficiary by an agency or other third party.
Again, the beneficiary needs to know that the presence of a job coach or other on-the-job supports doesn’t lower the value of his or her work.

You may assist the beneficiary request approval of subsidy by preparing the proper documentation for Social Security. A template for the Subsidy Request is provided in the Conducting Independent Research section at the end of this Unit.

**Strategies for Success**

- Begin by asking probing questions about the individual’s employment situation.

- Investigate all possible indicators of subsidy or special conditions, and facilitate the development of appropriate documentation.

- If necessary, contact with the employer or supervisor to explain subsidy thoroughly, and give pointers on how to describe the actual employment situation to Social Security. Be sure that you have the beneficiary’s permission to speak with the employer.

- Remind the employer that any accommodations or subsidies they may be providing aren’t negatively affecting the beneficiary in the eyes of Social Security.

- Assure the individual that reporting indications of subsidy or special conditions is beneficial; he or she shouldn’t view it as negative.

- Use the Subsidy Request template provided at the end of this unit when helping a beneficiary document a subsidy.

**NOTE:** Social Security may apply special forms of subsidy in self-employment cases. These incentives are known as “unincurred business expense” and “unpaid help.” These forms of subsidy are developed differently than either an employer subsidy or special conditions. In self-employment cases, you may need to help beneficiaries track the costs of items a third party (VR or other source) purchased for their business, and you’ll need to explain that they should record and assign a value to any paid help friends or relatives provided the business. For more
information about these work incentives, refer to Module 3, Unit 8.

**Work Incentives that Apply to Both Title II Disability Benefits and SSI**

**Impairment Related Work Expenses (IRWE)**

There’s no limit to the types of expenses that may qualify as IRWE. Help the beneficiary identify qualified expenses and describe them in a manner that facilitates Social Security’s approval. When discussing potential IRWEs with beneficiaries, talk about methods of justifying and documenting the expense to Social Security. If there is doubt about whether or not the expense meets all of the tests for approval, make the best argument possible and submit it to the local Social Security office for review. Use the Impairment Related Work Expense Request template to gather the necessary information and submit it to Social Security. Assist the beneficiary with completing the template. The template is located in the Conducting Independent Research section of this unit.

If the Title II beneficiary is earning over the SGA level, explain that he or she may still meet the disability criteria if he or she has IRWEs significant enough to reduce his or her gross monthly earnings below the SGA level. Make sure Title II beneficiaries understand that Social Security doesn’t “reimburse” them for the IRWE. The work incentive merely allows Social Security to continue their benefits even if they earn more than the SGA guideline. A review of the calculation for an SSI recipient who has a qualified IRWE is also appropriate at this time. SSI recipients need to understand that Social Security will disregard half the out-of-pocket IRWE expense.

**Strategies for Success**

- Use the five criteria necessary for IRWE to pre-screen potential IRWEs. Refer to the list on the IRWE Request template at the end of this unit.

- Think “outside the box” when assisting individuals with identifying potential IRWEs. Not every possible allowable expense is listed in the Red Book or the POMS. If it fits the five required criteria, submit it for review.

- Remind the individual about the documentation he or she needs to collect and submit with the request.
• Use this opportunity to educate the beneficiary about future use of IRWEs and self-management of benefits.

• Continuously review when and how IRWEs apply and affect earnings for both Title II beneficiaries and SSI recipients. Remember, things change periodically and require updates of information.

• Be prepared for changes. Some IRWEs won’t last forever, some will change, and new expenses may qualify. Help the beneficiary prepare for changes that may come about in the future.

**Ticket to Work**

The Ticket to Work is an important employment support program for Social Security beneficiaries. WIPA services are critically important for educating beneficiaries about how to use the Ticket, in addition to other work incentives, to achieve their employment goals. CWICs should have in-depth knowledge of how Employment Networks (EN) operate, the services they provide, and eligibility procedures and criteria. CWICs can also give information to beneficiaries on assigning or re-assigning their Ticket, moving a Ticket in or out of inactive status, understanding the medical CDR protections, and the requirements for meeting Timely Progress. For a detailed discussion of these issues, refer to Unit 10 of Module 3.

**Strategies for Success**

• Screen all beneficiaries to identify eligible individuals who would benefit from or be strong candidates for Ticket use or assignment.

• Explain how the Ticket program functions and the benefits individuals receive. Encourage strong candidates to consider assigning their Ticket.

• Provide information about ENs in the area, and help the beneficiaries select an EN that best matches their service or support needs and preferences.

• Counsel beneficiaries on what constitutes “timely progress” for each 12-month review period in the Ticket program.

• Have current and complete knowledge of all ENs serving your service area and which ENs are currently accepting Tickets.
• Know what services the various ENs provide, their eligibility requirements, and any restrictions on services or eligibility.

• Refer beneficiaries to ENs based on individual service or support needs and preferences.

**SSI Work Incentives**

**Student Earned Income Exclusion (SEIE)**

The CWIC can facilitate a beneficiary’s use of SEIE by helping students, their families, and teachers understand how the exclusion works and when it applies. Refer to Unit 6 of Module 3 for detailed examples.

You should also ensure that Social Security correctly documents the beneficiary’s student status on their record so that they apply the exclusion correctly. Students often have varying class schedules, and sometimes those schedules include practicums or vocational components. Due to these complicated schedules, it can become questionable as to whether or not the student is still meeting the “regular attendance” requirement. See POMS citation SI 00501.020 Student (https://secure.ssa.gov/apps10/poms.nsf/lnx/0500501020).

**Strategies for Success**

• Verify student status with Social Security at time of BPQY request. If they don’t indicate that the recipient is a student, assist the individual in obtaining the appropriate documentation, and with subsequent submission of documentation.

• Maintain periodic contact with the student to monitor earnings, and update the projected length of the SEIE exclusion based on actual monthly earnings.

• Stress the enhanced financial outcome for the student by use of SEIE.

• Remind the student of critical times that he or she would need to notify Social Security of any changes in status, and prepare the student for the effect of change in status to the SSI benefit.

• Remind students that the SSI resource limits still apply while the SEIE is in effect. If the student saves too much earned income, ineligibility for SSI or 1619(b) may result. Keep PASS in mind as a possible strategy for beneficiaries if their assets might exceed
the resource limit and they need to purchase goods or services for a vocational goal.

**Blind Work Expenses (BWE)**

It’s safe to assume that any SSI-eligible individual who receives benefits due to blindness and has more than $65.00 in earnings has deductible Blind Work Expenses (BWEs). Encourage beneficiaries to keep receipts for any potentially applicable deductions. Thoroughly review the expenses that could qualify as BWE deductions. Similar to the IRWE request template, facilitate the beneficiary’s use of the BWE Request template when reporting to Social Security. When working with concurrent beneficiaries, remember that BWEs only apply to SSI, but the Title II benefits have a higher SGA level for an individual who is blind, and items that qualify as BWE may qualify as an IRWE deduction for Title II. Refer to the comparison chart in SI 00820.555 – List of Type and Amount of Deductible Work Expenses (https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820555).

**Strategies for Success**

- Use the criteria necessary for BWE qualification to pre-screen potential expenses. Refer to the list on the BWE Request template at the end of this unit.
- Think “outside the box” when assisting individuals in identification of potential BWEs. Not every expense that qualifies as a BWE will be listed in the Red Book or in the POMS.
- Remind the individual what kind of documentation he or she will need to collect and submit with the request.
- Use this opportunity to educate the recipient about future use of BWEs and self-management of benefits.
- Continuously review when, and how BWEs apply and the effect of earnings for SSI recipients.
- Be prepared for changes. Some BWEs won’t last forever, some will change, and new things may qualify.

An ancillary role for the CWIC is to help the individual to communicate with Social Security if the BPQY doesn’t indicate blindness as the disability. In some cases, an individual meets the statutory blindness definition, but isn’t coded as such in Social Security’s system. See DI
26001.001 – Definition of Blindness

If Social Security’s record doesn't show the beneficiary meets the
definition of statutory blindness, but the beneficiary is blind according to
his or her doctor, Social Security can add blindness as one of the
disability diagnoses. Social Security will do this only when it’s material to
the determination Social Security is making. For example, when the
person has wages above the non-blind SGA level, but under the blind
SGA level, Social Security would ask the state DDS to make a decision
regarding the person’s blindness. Similarly, an SSI beneficiary with
earnings from work would always be better off if Social Security uses
BWE, so it would be appropriate for Social Security to make a
determination in that situation.

Work Incentives Related to Medical Coverage and Other
Considerations

Extended Medicare Coverage

As was discussed in Module 4, Unit 2 - Understanding Medicare, only
Social Security can tell a beneficiary when his or her premium free
Medicare coverage will end. The rules governing EPMC are very complex,
and different rules apply depending on when the beneficiary engaged in
SGA. To estimate the month that Medicare will end, the CWIC would
have to know when the TWP ended and exactly when SGA occurred (the
cessation month). Social Security employees use a software program
known as the Medicare Wizard to determine the month in which the EPMC
may end if earnings continue as the beneficiary predicts.

Strategies for Success

- Explain to beneficiaries that when earnings cause the loss of
cash payment, premium-free Part A will continue because of the
EPMC.

- Counsel beneficiaries that they will have to pay Medicare Part B
premiums out of pocket once cash payments end. Social
Security will bill the individual once per quarter for these Part B
premiums, or the individual may pay the premiums monthly as a
deduction from a bank account. Beneficiaries need to prepare
for this additional expense, because Medicare bills the first
quarter of coverage in advance.
• Beneficiaries may be eligible for a Medicare Savings Program like QMB or SLMB (see Module 4). Even though the beneficiary has earnings, he or she may continue to be eligible for help paying his or her Medicare premiums. Part of your responsibility is to identify whether or not beneficiaries may access this support.

• Beneficiaries can continue to participate in Part D prescription drug coverage as long as entitlement to Part A or Part B continues. Like the Part B premium, individuals may continue to be eligible for full or partial “Extra Help” with their Part D premiums and co-pay amounts. Refer to Module 4, Unit 2 for a review of who qualifies for the Extra Help and how to apply.

• CWICs need to stress that even after EPMC coverage expires, beneficiaries can purchase Medicare coverage. This program is called Medicare for the Working Disabled. If the person meets financial requirements and isn’t eligible for Medicaid coverage, he or she may receive help paying the Part A premiums by accessing the Qualified Disabled Working Individuals option. See Module 4, Unit 2 for details.

1619(b) Extended Medicaid Coverage

The 1619(b) Extended Medicaid provision is explained in detail in Module 4, Unit 1. Eligibility for 1619(b) begins when the beneficiary’s countable income is high enough to cause the SSI payment to be reduced to zero. This is referred to as the “break-even point.” Calculating the break-even point (BEP) is the first step in helping SSI recipients understand 1619(b). The BEP may be different for each person because Social Security bases it on the amount of earned and unearned income the person has. For SSI recipients who have no unearned income, the break-even point is determined by reversing the countable income calculations. Instead of subtracting $20, $65, and dividing wages by two, you would take the Federal Benefit Rate (FBR), multiply it by two, and add the $65 and $20 exclusions.

If the person has any unearned income, including deemed income or in-kind support and maintenance, the “break-even” point is lower. The application of work incentive deductions would also cause a change in the BEP calculation. An example of determining an individual’s BEP is provided below:
Example of how to calculate BEP:

Louis receives $200 in Childhood Disability Benefits. He also receives SSI, and lives alone. To calculate Louis’ BEP, first calculate his benefit not considering his earnings:

- $200 – $20 general income exclusion = $180 countable unearned income.
- $783 (FBR in 2020) – $180 (Louis’ countable earned income excluding wages) = $603.
- To calculate Louis’ BEP, multiply this total by 2, and add $65. The $20 exclusion wasn’t added because it applies to his unearned income. Louis’ BEP would be $(603 \times 2) + $65, or $1,271.

Not everyone who loses eligibility for SSI cash benefits will be eligible for 1619(b) Medicaid coverage. To be eligible for this important work incentive, individuals must meet five criteria and must continue to meet these criteria to retain Medicaid over time. It’s imperative that beneficiaries understand that they must meet ALL 1619(b) eligibility criteria for extended Medicaid coverage to continue uninterrupted. These criteria are explained at length in Unit 1 of Module 4.

In addition, CWICs need to understand that 1619(b) coverage doesn’t occur automatically when cash benefits cease due to earned income — even when the beneficiary meets all five eligibility criteria. Social Security personnel must enter a special code on the SSI record at the same time the SSI payment stops in order for 1619(b) status to begin. CWICs need to warn beneficiaries to check with Social Security when they reach their BEP to make certain that Social Security has established their eligibility for 1619(b) and noted it in the State Data Exchange (SDX). The state Medicaid agency uses these computerized files to determine who is eligible for Medicaid. If Social Security hasn’t made the notation in the SDX rolls, Medicaid eligibility could mistakenly end.

Some individuals will achieve earnings that are above the state charted threshold amount (see 1619(b) discussion in Module 4). Even though earnings exceed the state threshold, these beneficiaries may retain eligibility to Medicaid under the 1619(b) provisions by asking Social Security to develop an “individualized threshold.” To do this, Social Security gathers the person’s actual Medicaid costs, as well as the costs of publicly funded attendant care. They also look at the use of work
incentives such as PASS, IRWE, and Blind Work Expenses. If any of these factors permit the threshold to go above the charted amount for the state for that year, the person may be able to retain essential medical coverage. It’s critical that you know the 1619(b) threshold for your state, and that you inform beneficiaries with high earnings about their possible access to this safety net. In particular, advise beneficiaries with higher-than-average medical costs that they may be entitled to an individualized threshold for 1619(b).

**Other 1619(b) Considerations:**

While 1619(b) provisions offer excellent Medicaid coverage for individual SSI recipients who work, there are some complications for SSI-eligible couples (meaning two SSI recipients married to one another). Because 1619(b) is a work incentive, BOTH members of the eligible couple must be engaged in work in order for both to benefit from 1619(b) extended Medicaid. If only one member of the couple is working, only that individual continues Medicaid coverage under 1619(b). The other individual loses both cash payment and SSI-related Medicaid when the working partner causes the couple to exceed the BEP. You must warn couples about this issue to avoid potential loss of critical health insurance when only one member of a couple works. The non-working member may qualify for a different category of Medicaid, or another type of health coverage altogether.

**“Extra Help” – the Low Income Subsidy**

Many beneficiaries served will be participating in Medicare Part D prescription programs and will be receiving the Low Income Subsidy (LIS) or “extra help.” It’s critical that you explain how a beneficiary’s employment might affect his or her low-income subsidy. As was explained in Module 4, individuals can apply for the subsidy or they can be “deemed” eligible because they already have an attachment to Medicaid. It’s important to identify which category the person is in and advise him or her appropriately on the potential effect of earnings.

**Strategies for Success**

- Counsel beneficiaries on what are “subsidy changing events” versus “other events.”
- Prepare beneficiaries for their reporting and follow-up responsibilities following one of those events.
• Project changes to the low-income subsidy, i.e., reduction in the percentage of extra help, termination, or renewed eligibility.

• Remind those who are dual eligible of potential changes if their “deemed” eligibility status changes.

• Show the beneficiary how Social Security counts earning when they calculate extra help eligibility and percentage of help amounts. Remember to include the IRWE or BWE deductions if applicable.

Use the LIS calculation sheets supplied in the initial training handouts to conduct your analysis of continued eligibility for the low-income subsidy, either full or partial, if “deemed” eligibility doesn’t apply. The LIS calculation sheet is also available on the VCU NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=185)

**QMB, SLMB, and QI – the Medicare Savings Programs**

Many beneficiaries get help with the Part B premium through a Medicare Savings Program and need to understand the potential changes in eligibility when they begin working. CWICs must have up-to-date information on their state programs regarding income and resource limits in order to counsel beneficiaries appropriately. Changes in earnings can very quickly change a beneficiary’s status in regards to the various MSPs. Remember that helping someone to see the total financial picture means advising him or her on all benefits.

**Strategies for Success**

• Know the parameters for your state regarding income and resource limits for QMB, SLMB, and QI, or know if a “state buy-in” exists for people who have SSI-related Medicaid.

• Be alert to changes in income that will move an individual from one MSP coverage category to another, or will cause ineligibility for any of the MSP categories.

• Prepare the beneficiary for the anticipated changes and offer alternatives.

• Be sure to show the beneficiary the overall financial outcome. It may seem that he or she is losing more than he or she is gaining; however, seeing the total dollars and cents of all benefits will put the beneficiary’s mind at ease.
• Use the MSP calculation sheet supplied in the initial training handouts to conduct your analysis of continued eligibility for the Medicare Savings Program. **The MSP calculation sheet** is also available on the VCU NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=184)

**Eligibility for the State Medicaid Buy-In**

Many states have a Medicaid Buy-In program for people with disabilities who work. You must know about eligibility requirements, income and resource limits, and how beneficiaries can access these programs. This is a critical work incentive that needs to be part of your benefits advisement. Loss of medical coverage is one of the main fears that prevent beneficiaries from pursuing work. Offering accurate advisement on how to access additional coverage is critical to the beneficiary’s overall self-sufficiency.

**Strategies for Success**

- Understand all the requirements for your state’s Medicaid Buy-In.
- Be aware of the coverage that is provided and share that with the beneficiary — consider if participation in the Buy-In automatically covers part B premiums, deductibles, and co-payments; what premiums must a beneficiary pay to participate, etc.
- Remember that participation in the Buy-In is a door into Medicaid that makes the person “deemed” eligible for the part D Low Income Subsidy.
- Regularly update the WIP to reflect changes based on earnings and resources.

**Other Protections for Title II Disability Beneficiaries and SSI Recipients**

**Expedited Reinstatement (EXR)**

Beneficiaries have two options to become entitled to payments again if they lose benefits due to work activity: reapplication and Expedited Reinstatement, (EXR). Under both Title II and Title XVI, beneficiaries may receive provisional payments under EXR while they await a disability
decision. Under the SSI program, the difference between reapplying and requesting EXR is minimal outside of the advantage of those provisional payments. Under the Title II disability programs, computation issues, or possible entitlement on a CDB or DWB’s own work history, make the decision more complex. It’s important for beneficiaries under both programs to understand that EXR is an option and a protection. A document called “Comparison of EXR and Reapplication” is provided at the end of this unit, and compares the various advantages and disadvantages of each option. This chart can be a helpful tool when you’re discussing EXR as an option.

Title II disability beneficiaries should discuss this choice with a Social Security employee before making a final decision because of the potential consequences to the person’s benefit amount. The beneficiary should take proof of the prior year’s wages and the latest paystub for the current year to the meeting with Social Security. Provide the beneficiary with specific information about how to request this work incentive from the local Social Security office. Prepare beneficiaries to use the Red Book to make sure Social Security personnel understand what the beneficiary is requesting.

**Strategies for Success**

- Prepare the beneficiary to clearly describe how the disability of record (or a related condition) contributed to the current inability to engage in SGA.

- Make sure the individual understands that provisional benefits (if awarded) only last for a maximum of six months. If Social Security hasn’t completed the disability determination by the end of the six months, payments and health insurance will stop until they make a determination.

- Make sure the beneficiary takes current medical records or contact information, including accurate addresses for healthcare providers, with them to the interview.

- Explain to the beneficiary that provisional payments are unlikely to create an overpayment even if he or she has medically improved and Social Security denied reinstatement. Keep in mind, however, that provisional payments can be overpayments if the Family Maximum is involved, or if the person is otherwise
ineligible for benefits. An example might be a beneficiary incarcerated due to a felony conviction.

- Explain that once Social Security makes 24 months of EXR payments to the beneficiary, a new TWP and EPE will be available if the beneficiary decides to return to work.

Section 301

While Section 301 isn’t a work incentive, per se, it’s possible that a beneficiary pursuing work might need the protection this provision offers. Remember, the opportunity to use Section 301 only arises when a beneficiary has had an adverse medical review and he or she is participating in an approved vocational rehabilitation program that will result in the likelihood of remaining off benefits. You may be working with beneficiaries pursuing employment when Social Security makes a decision of medical improvement, and will need to advise the beneficiary on the potential applicability of Section 301 and the protections afforded by it. Section 301 is also critically important to the SSI child who doesn’t qualify for SSI as an adult. For detailed information about Section 301 provisions, refer to the resource document posted on the VCU NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=37).

Strategies for Success

- Inform and educate youth and parents prior to the age-18 redetermination.

- Be alert for medical diary dates indicated on the BPQY and offer information and options to beneficiaries in a timely manner.

- Be aware of the beneficiary’s employment support team and connection to a vocational program.

- Remind Title II beneficiaries that work incentives don’t apply if they begin receiving Section 301 benefits.

- Ensure that the beneficiary and their stakeholders understand when or why they are no longer eligible for WIPA services.
Benefits Literacy — Teaching Self-Management of Benefits

The concept of “benefits literacy,” part of an individual’s “financial literacy,” has risen out of the current emphasis on teaching individuals to manage their finances. The phrase “benefits literacy” means acquiring a basic understanding of the internal workings of public income maintenance programs such as Social Security disability benefits, Medicaid or Medicare, SNAP, HUD rental assistance, or any other income support a beneficiary receives. Far too often, beneficiaries aren’t aware of the rules governing eligibility and benefit amount for these programs. Because of this, they sometimes make decisions that inadvertently cause financial harm. Unfortunately, public support programs typically don’t take an educational approach with users. Government workers who deal with public income maintenance programs generally have enormous caseloads and have little time to make sure beneficiaries understand the complex regulations surrounding benefits. If beneficiaries aren’t familiar with the rules, they are unable to direct the course of their benefits.

To truly be empowered, Social Security disability beneficiaries need training and technical assistance on managing their public benefits. The first step in this educational process is helping beneficiaries understand the basic eligibility requirements of the various programs. Because most of these programs are means-tested, the training would focus on understanding how income and resources affect entitlement and payment amounts. The next step is to teach individuals about the effect of earned income on the benefits. This would include information on the work incentives built into the various programs. Ultimately, the goal is to provide information that encourages work and enhances financial independence through informed choice.

Another area of concern to beneficiaries, family members, and service providers is knowing what information the beneficiary needs to report to the various governmental agencies. Failure to report critical information in a timely fashion may cause an overpayment in benefits. You must teach beneficiaries what to report, when to report, and how to report. As part of this, you must teach beneficiaries how to keep records and documentation, and how to stay organized. They also need to understand how to communicate information to governmental agencies to ensure agencies act on the information the beneficiary provides.
In addition, beneficiaries and their representative payees need to understand their responsibilities in terms of entitlement to benefits. Beneficiaries often think that whatever payment they receive must be correct because the governmental agency understands the rules and must be applying them correctly. Instead, they need to accept primary responsibility for knowing what they should be receiving and behaving proactively to recognize and correct mistakes if they occur.

Finally, many beneficiaries need targeted training and support on how to avoid the most common benefits problems. Many of the minor problems that occur can be fixed with a minimum amount of time and effort. In some cases, it may be necessary to get help from a trained CWIC, but this isn’t always the case. You can empower individuals to take active control of their benefits. Teaching beneficiaries to help themselves lessens their dependency on you and expands the capacity of WIPA services.

**Strategies for success in advancing benefits literacy include:**

- Consistently keep the individual involved in the process.
- Give plenty of supporting examples and resource materials for future reference.
- Empower the beneficiary to take the lead on interaction with Social Security.
- Show beneficiaries how to request benefit providers to apply work incentives and how to collect appropriate documentation.
- Act as a mentor and guide the beneficiary through difficult processes.
- Give positive feedback and encouragement.
- Recognize achievements and accomplishments in mastering tasks such as documentation, earnings reports, communications with Social Security, etc.
- Be available to answer questions.

The following best practices are indicators that CWICs are actively working to improve the benefits literacy of the individuals for whom they are providing services:
- Use informational mailers, periodic newsletters, fact sheets, or other written updates to share information with beneficiaries.

- Develop creative ways to help beneficiaries gather wage information. This may be as simple as putting paycheck stubs into a shoebox, or as complex as using specially designed Work and Wage Calendars. Whatever method you choose, take the time to actively teach beneficiaries to use it correctly, and make periodic checks to ensure that information gathering continues uninterrupted.

- Enclose cover letters with pay stubs you mail to Social Security or other agencies to make certain the information gets to the right person in a timely fashion. In addition, using cover letters is a good way to highlight the use of special work incentives. An example of a useful form for reporting employment related information is in the Conducting Independent Research section of Unit 4 in this Module.

- Help beneficiaries stay organized by providing them with a benefits planning binder, notebook, or folder. This binder will serve as a repository for all benefits information such as BPQYs, BS&A reports, WIPs, correspondence to and from Social Security, and other relevant information. You can set up the binder into ready-made sections with dividers and train beneficiaries on how to file information for easy retrieval.

- Offer short seminars or informational sessions on a variety of benefits topics of interest to beneficiaries, families, and disability professionals. Keep the sessions short and provide plenty of notice so beneficiaries can plan ahead to attend. Schedule them in the evenings or on weekends to ensure that working individuals can attend.

- Include other concerned professionals in all training or information sessions. It’s important for disability professionals and special educators to have a basic understanding of public benefits and how earned income may affect these programs. Because so much misinformation gets passed around among professionals, investing time in teaching them the facts may pay significant dividends in the future.
• Encourage and support beneficiary participation in WISE events. Detailed information on WISE events conducted by the Ticket Program Manager (TPM) contractor is provided in Module 2.

Part of an individual’s path to financial independence includes reducing reliance on professional supports. Educating beneficiaries on how to manage their own benefits is a very important service CWICs can provide.

**Reporting Earnings**

Teaching beneficiaries how to correctly report earned income to Social Security and other agencies providing public benefits is an important job that CWICs perform. It’s essential to note that you aren’t responsible for reporting wages on behalf of beneficiaries. However, you should help beneficiaries develop methods for organizing wage information and assist in the preparation of earnings reports.

**Work Reports within the Title II Disability Program**

Advising Title II beneficiaries on when and how to report work is one of the greatest challenges you’ll face. As a general rule, beneficiaries must promptly report any changes in work activity. They must tell Social Security right away if:

• Work starts or stops;
• Duties, hours, or pay changes; or
• They stop paying for items or services they need for work due to the disability.

How work activity and earnings affect benefits varies with each beneficiary’s situation. Essentially, beneficiaries should report any change in work activity. The change may affect the beneficiary’s payments or work incentives status. For example:

• TWP months have been used or the TWP has been completed;
• Payments should be suspended during the EPE;
• Payments should be reinstated during the EPE;
• Payments should terminate because the EPE has been completed, and the person has demonstrated the ability to perform SGA;
• After termination of payments, a person should request Expedited Reinstatement (EXR) or reapply due to a drop in earnings.

Assisting beneficiaries in reporting work changes and helping them to understand how the changes may affect their benefit status is very important. Social Security’s work report and review processes can be confusing. Here are some of the reasons:

• Work decisions are almost always retrospective. Social Security reviews work activity that has already occurred. Social Security personnel try to reconstruct a pattern of past work activity to determine if a beneficiary was due payments or not. Your role, however, is to anticipate and help the beneficiary understand what may happen in the future, when and if work activity occurs. One of the challenges with this is that Social Security only applies work incentives like Impairment Related Work Expenses (IRWE) and subsidy once the person’s gross earnings have exceeded the applicable SGA guideline. If Social Security doesn’t approve the deductions, the person may be overpaid.

• The Title II program generally uses the amount a beneficiary earned in a month, rather than the amount he or she was paid when assessing whether or not work activity should affect payments. This can be confusing to beneficiaries. The pay stub itself is an easier measure to consider as a concept of earnings than a computation of hours worked multiplied by the hourly wage. The pay stub, however, would provide misleading information in situations where a person’s check represents work activity in more than one month, as often happens at the beginning or end of the month.

IMPORTANT NOTE: The Bipartisan Budget Act of 2015 simplifies post entitlement SGA determinations by allowing Social Security to presume earnings were earned in the month they were paid. However, prior to applying this paid versus earned assumption, Social Security personnel will evaluate any readily available earnings verification sources and determine when earnings were earned. If Social Security has no other readily available evidence to determine when earnings were earned, the agency will use other sources of earnings verification even if the earnings
source only documents when earnings are paid. This change in policy makes development of wages when earned during the TWP even more important for CWICs. Whenever possible, support beneficiaries to report wage information when earned as opposed to when paid.

- Different Social Security field offices may process work reports differently. In some offices, a particular workgroup or the WIL may process the work activity reports. In other offices, the workload is distributed alphabetically among all Title II CRs. Without knowledge of the office staff and how the work distribution occurs, you may not know the best contact person to receive a particular beneficiary’s report. The local office WIL can help you understand how each office operates.

- Beneficiaries don’t realize that telling Social Security about work is only a work activity report if a Social Security employee looks at the pattern of work, and makes a decision. They are unaware of the structure of the agency and often feel that calling the 800-number in one month and receiving their payment the next month means that Social Security properly processed the report.

- Even when a beneficiary reports work with pay stubs at the local office, the office staff doesn’t examine every month for effect on Title II benefits. Often, the Social Security employees taking reports aren’t the decision-makers. Instead, the front-line staff that takes the report gives the beneficiary a receipt and enters the data into the computer system, but they don’t examine it to determine if benefits should stop. Meanwhile, the beneficiary believes he or she has met all responsibilities to report work and assumes that the staff will determine any effect as soon as possible.

- eWorK is a system that Social Security employees use when making decisions about work activity. Prior to eWork they completed their decisions manually. The eWork system has significantly improved Social Security’s service to working beneficiaries. This system produces receipts when staff makes work reports and keeps track of the amounts the beneficiary earns. However, eWork doesn’t do anything more than store the reports until a Social Security employee looks at the work the
beneficiary reported, evaluates earnings and applicable work incentives, and makes a decision.

**New Reporting Option:** In September of 2017, Social Security released a new wage reporting application behind the *my Social Security* portal. Now, people who receive Social Security Disability Insurance (SSDI) benefits and their representative payees can report wages securely online. This new option makes it faster and easier than ever before for SSDI beneficiaries and their representative payees to report wages; they can avoid visiting a field office to report their wages in person and they can print or save a receipt of their report. When beneficiaries sign up for, or log into their *my Social Security* account, they will have access to this application on their desktop, laptop, and mobile device. After beneficiaries report their wages online, they can save or print a copy of their receipt. There are some limitations to using this online reporting information. To learn more about the New Wage Reporting Application, visit [blog.ssa.gov](https://blog.socialsecurity.gov/new-wage-reporting-application/).

**What CWICs Can Do**

Social Security is actively seeking solutions to the challenges outlined above. Until the time that the systems are perfected, however, you have to educate beneficiaries to make reports as painless as possible for everyone.

Here are some strategies for success:

- Get to know how the offices in your catchment area process work reports. This may mean frequent visits to talk with staff, to get to know them — particularly the WIL — and to ask in what manner they prefer beneficiaries to make reports effectively and efficiently.

- Explain to beneficiaries that work reports and reviews under the Title II programs are complex. Tell them that Social Security doesn’t rely on accessing earnings from the IRS records to make work decisions; instead, it’s up to the beneficiary to report work, provide wage data, and to report changes in work activity.

- Make sure that beneficiaries understand that in addition to reporting work, they must provide wage data, and receive a receipt. Also, teach beneficiaries to keep a good record of all contacts with Social Security. Whenever a beneficiary makes a
work report, have him or her keep all the receipts and pay stubs. Remind the beneficiary also to keep all of the IRWE receipts, letters regarding subsidy, or any other evidence that may help prove appropriate work incentives in the future. He or she should submit these at the same time he or she makes or repeats work reports. At the end of this module, there are worksheets you can use to facilitate reporting of the use of appropriate work incentives.

- As part of your WIP, make sure the beneficiaries know the “critical touch points” for their particular circumstances. When possible, map out the dates on the WIP when reports would be most effective.

- As part of your proactive follow-up plan, check with beneficiaries to ensure that they make reports when important events occur. For example, if you know that a beneficiary will complete his or her TWP in four months, put a mark on your calendar to check to make sure the beneficiary made the report. Did he or she keep receipts? Did he or she give Social Security receipts or other evidence to show that he or she used work incentives?

- Each beneficiary’s situation is unique. The critical piece is to educate beneficiaries, so that they can be proactive.

**When Work Reports Aren’t Timely**

One of the best tools you have to evaluate whether or not beneficiaries have reported work is the Benefits Planning Query (BPQY). The BPQY draws information directly from five different Social Security database records. The BPQY also provides IRS earnings information. Occasionally, you’ll find an extensive work history that the beneficiary hasn’t reported, or that Social Security hasn’t adjudicated to determine the effect on Social Security Title II payments. Use the BPQY as a tool to determine the need for reporting past work history.

The TWP information is one piece of information that is often incorrect on the BPQY. The BPQY shows the TWP dates from the most recent work CDR determination. A work CDR may be pending or overdue, so the dates on the BPQY may not be current. Here are some guidelines on how to use this information as part of your analysis:

Compare the TWP field to the earnings and:
• If earnings are present, and the TWP is showing as having been completed, it should be correct.

• If no earnings are shown or alleged by the beneficiary since the date the disability benefits began, and no TWP months are used, it’s likely to be accurate.

• If earnings are shown, but no TWP months are indicated, explore further.

It’s at this point that the beneficiary may need to report his or her earnings. The CWIC can be instrumental in helping this happen in a productive way, by helping the beneficiary gather evidence of work activity and work incentives to help the Social Security have all of the information necessary to make an appropriate decision, and help the beneficiary anticipate what might happen as a result of the work report.

Keep a few things in mind:

• Earnings may not show for the most recent calendar year because there may be a lag crediting the person’s earnings.

• Earnings that represent sick pay, separation pay, vacation, etc., aren’t counted during Title II work reviews. Often beneficiaries will show earnings the year after disability onset that may simply represent a payout of vacation or sick pay, or disability payments.

• If you look at the monthly breakdown of SSI earnings instead of the annual earnings, remember that the SSI program bases determinations on the wages received, not the wages earned in a month.

• Remember that the beneficiary should make self-employment reports when the work activity begins, but Social Security can only review work activity when the person’s self-employment tax return is complete. Social Security needs the self-employment schedules from the tax return to make accurate determinations.

• Social Security’s computer system will send alerts to the field offices when IRS recorded earnings show up on a disabled beneficiary’s record. It may take years for Social Security to act upon the alert, and that may mean an enormous overpayment. Instead, proactive intervention from you may expose
undeveloped past work earlier and will likely help the beneficiary in the long run.

Finally, remember CWICs don’t make these work decisions. Only Social Security personnel can make work activity determinations. Be careful about making predictions and don’t guarantee anything.

**A Note about Self-Employment**

If a beneficiary is self-employed, he or she should report the earnings when the work begins and when there is change. He or she should submit proof of the self-employment activity annually after completing his or her tax return.

If the beneficiary hasn’t completed the TWP, Social Security may also request a monthly breakdown of profit and loss. The tax return is critical, however, because it shows all of the deductions and the net profit, rather than an estimate. For this reason, it’s particularly important that beneficiaries who are self-employed report their tax liability to the IRS early in the next year. They can then take a photocopy of the finalized IRS 1040 and associated tax forms to the Social Security office, along with proof of deductions for IRWE, unpaid help, and unincurred business expenses.

**Reporting for the SSI Program**

SSI is a very different program, and requires different protocols for reporting wages or other income. Because SSI is income sensitive, frequent and timely reporting can help the beneficiary receive proper payment. One challenge with monthly reporting, however, is that it generates monthly notices that may confuse the beneficiary. If that is particularly stressful, the beneficiary may wish to estimate future income with Social Security.

It’s also valuable to keep in mind that self-employed beneficiaries should estimate their net earnings from self-employment (NESE) as accurately as possible. Remember, in the SSI program, NESE is always averaged over the entire calendar year, regardless of when the beneficiary earned the money in the calendar year. For this reason, estimates that significantly change annual self-employment income can drastically affect benefits, because they affect the entire year, rather than a single month.
Automated Wage Reporting

SSI beneficiaries now have two convenient ways to report monthly wages. The first is the SSI Telephone Wage Reporting system (SSITWR), which permits beneficiaries or their representatives to call a toll-free number to report the prior month’s gross wages. Second is a mobile application that allows for monthly wage reporting using smartphone technology. Beneficiaries can download and install the SSI Mobile Wage Reporting (SSIMWR) application on an Apple or Android device. Both systems will accept wage reports on any day during the current month, but you should advise beneficiaries to report wages during the first six days of the month to prevent improper payments. Regardless of which method a beneficiary chooses to report wages, he or she can sign up online to receive a monthly e-mail or text message wage-reporting reminder (http://www.socialsecurity.gov/disabilityssi/ssi-wage-reporting.html).

The use of the automated system is somewhat limited because it doesn’t permit deductions for the work incentives that beneficiaries may access. If a beneficiary doesn’t have work incentive deductions, use of this system is a valuable tool. The individual will be required to authenticate his or her Social Security number, name, and date of birth. The system will mail a wage receipt to the beneficiary or his or her representative payee (https://www.ssa.gov/disabilityssi/ssi-wage-reporting.html).

The wage reporting system works well for:

- Parents or spouses who aren’t disabled and need to report income that will be deemed to the beneficiary;
- SSI beneficiaries with no work incentive deductions other than the Student Earned Income Exclusion (SEIE); and
- Concurrent beneficiaries with no work incentive deductions other than the SEIE. (NOTE: Beneficiaries who only receive Title II benefits may not use the automated report.). Keep in mind that wage report made by the SSITWR only applies to SSI. Concurrent beneficiaries would still need to report the wages separately to the Title II disability program.

Those who may not use the wage reporting system:

- Beneficiaries who have Impairment Related Work Expenses (IRWE);
• Beneficiaries who meet the definition of statutory blindness;
• Beneficiaries who have a Plan to Achieve Self-Support (PASS);
• Beneficiaries who have deemed income;
• Beneficiaries contributing earnings to an Individual Development Account (IDA);
• Beneficiaries with more than one employer in a month; and

**IMPORTANT NOTE:** In September 2017, Social Security released the online wage-reporting tool "myWageReport" (myWR) behind the mySocial Security portal for SSDI beneficiaries and their representative payees. Effective June 2018, Social Security expanded availability of myWageReport (myWR) to SSI recipients and concurrent concurrent beneficiaries. Wage reporters using this tool provide information from individual pay stubs instead of calculating a monthly gross wage total. Once submitted, this information passes to eWork and the SSI claim system as applicable. MyWR also generates a wage receipt that wage reporters can print and save.

**Strategies for Success**

• Recommend that beneficiaries keep ALL correspondence they send to and receive from Social Security;
• Suggest beneficiaries use the form “Notice of Change in Earnings Status” to report work. This form can be found at the end of this unit;
• Demonstrate how to calculate wages in a month based on each program’s rules.
• Use “Reporting Tips for Beneficiaries” as an ongoing learning tool for beneficiaries. (Document is included in the Conducting Independent Research section of this unit.)
• Remind beneficiaries that the Title II program and the SSI program don’t always communicate with each other or share reported wage information. This is especially important for concurrent beneficiaries who will need to report separately to both programs.
The CWIC’s Role in Other Work-Related and Non-Work-Related Situations

Although the primary function of the CWIC is facilitating the use of necessary and appropriate work incentives, other events indirectly related to employment may require intervention. Beneficiaries may seek assistance from you on a wide range of benefit issues, regardless of whether they are related to work. To avoid becoming overwhelmed, you must learn when to provide limited assistance and when to offer full support. The following events are the most common in terms of requests for assistance:

- Notices of overpayment
- Medical CDRs
- Age 18 re-determinations
- SSI re-determinations
- Changes in in-kind support and maintenance (ISM)
- Changes in marital status or family composition
- Excess resources

While some of these events may appear to be completely unrelated to employment at first glance, some actually do have bearing on an individual’s ability to work. Here is an examination of each of these events individually that will show when intervention would or wouldn’t be appropriate and how much assistance you should offer.

Notices of Overpayment

Overpayments in the SSI and Title II disability programs are common and can affect an individual’s financial wellbeing. An overpayment exists when the individual receives a higher cash benefit than he or she was eligible for during a specified period of time. Overpayments may occur for a number of reasons, including, but not limited to:

- An SSI recipient had resources exceeding the allowable limits;
- An SSI recipient had additional earned or unearned income that wasn’t reported to or counted by Social Security in determining the cash benefit;
A Title II disability beneficiary received cash benefits after the TWP and after Social Security made an SGA determination;

SSI or Title II disability cash benefits were paid during a period of time that the individual wasn’t eligible due to medical recovery; and

An SSI or Title II cash benefit was paid during a period of time when the beneficiary didn’t meet the eligibility requirements.

Beneficiaries who don’t agree with the overpayment have the right to appeal this decision. CWICs may provide information to beneficiaries about the Social Security appeals process; however, they should refer individuals to other entities for assistance with appeals, such as PABSS and the state Protection & Advocacy (P&A) program.

As a result of consultations with P&A systems nationwide, Social Security agreed that a beneficiary’s anxiety about erroneous payments and decisions on program issues related to employment and earnings is a disincentive to work. By providing limited assistance to beneficiaries in these disputes with Social Security, P&A personnel may alleviate some of that anxiety.

**Medical Continuing Disability Reviews (CDRs)**

After Social Security finds that an individual is disabled, they periodically evaluate the impairment(s) to determine if the disability continues or ceases. Both Title II and SSI beneficiaries are subject to medical CDRs.

The CWIC’s role in medical CDRs is limited to explaining the process to the beneficiary. Many times the individual doesn’t understand that medical reviews are regular occurrences throughout the period of disability. Help them understand the notices that come from Social Security. You can help by guiding the beneficiary to gather the necessary information.

**Age 18 Re-determinations**

As previously discussed in unit 5 of Module 3, Social Security will conduct a re-determination review for all SSI recipients at some point in the year after their 18th birthday. The purpose of the age 18 re-determination is to ensure that the individual meets the more stringent disability eligibility criteria for adults receiving SSI. The local Social Security office will contact the recipient to initiate the process.
The potential loss of SSI as a result of the age 18 re-determination process holds significant implications for young adults and their efforts to become successfully employed. Consequently, CWICs, school personnel, and rehabilitation professionals should be proactive in working with youth, their families, and the Disability Determination Service to ensure Social Security makes an accurate determination of SSI eligibility for the adult program. The following guidelines are suggested:

- Provide information on the age 18 re-determination to SSI children and their families early in the transition process. Share information on how Social Security gathers and uses input in the work evaluation component of the process. You should also address the role of the individual, family, school professionals, and others in the process.

- Conduct a “check-up” to identify and proactively plan for any benefits changes that may occur upon turning 18 years of age, and review a summary with the student and family. Develop a plan of action for dealing with the anticipated change, and document it in the WIP. You will find a handy tool to help with age 18 benefits check-ups at the VCU NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=71).

### SSI Re-determinations

As described in Module 3, the SSI program involves periodic re-determinations of all eligibility factors. Social Security gathers information about the recipient’s unearned income, resources, living arrangement, and other factors to verify continued eligibility and accurate monthly payment amount. Social Security notifies the individual or the representative payee of the review by mail and asks him or her to complete standardized forms and submit required information.

Your role in the SSI re-determination process is minimal, as this isn’t an event related to employment. Provide summary information about the annual re-determination process to the beneficiary, and be available to answer questions or provide general guidance. You aren’t responsible for completing re-determination forms or for accompanying the beneficiary to any meeting with Social Security to review this information.
Changes in In-Kind Support and Maintenance

Many times when working with an SSI recipient, you’ll encounter in-kind support and maintenance (ISM) issues that require time and effort to resolve. Don’t ignore these issues, as they can have an effect on the individual’s overall employment plan. In-kind support and maintenance rules are complicated. Refer back to Module 3 for a full review of this concept.

Once Social Security has verified SSI benefits, it may be evident that there is ISM causing a reduction in cash payments. Social Security may be applying this ISM under either the Presumed Maximum Value (PMV) rule, or the Value of the One-Third Reduction (VTR) rule. Verify this with Social Security to find out exactly how ISM is affecting the SSI cash payment.

Occasionally, these rules are applied incorrectly or the beneficiary didn’t accurately report a change in his or her situation. Review the rules and encourage the beneficiary to promptly report any changes in living arrangement or payment for food and shelter.

Often, an SSI recipient who has ISM under the VTR rule returns to work and subsequently begins paying his or her pro-rata share of the household living expenses. Prompt the individual to report the change to Social Security as soon as possible, so Social Security can update the recipient’s record to the full Federal Benefit Rate. The bottom line is that you do have a role in these types of issues, although not directly related to work.

You can find detailed information about ISM on the VCU NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=19).

Marriage, Divorce, and Changes in Family Composition

Proactive benefits counseling begins with being prepared for a beneficiary’s life changes. While providing assistance with proper application of work incentives, be mindful of other non-employment-related transitions that could affect benefits and applicable work incentives. Some common situations that you should be on the alert for include:

- A CDB beneficiary planning to marry a person not entitled to a Title II payment; an SSI beneficiary planning to marry;
• The birth or adoption of children, or having a step-parent relationship of children who could be eligible for auxiliary benefits; or

• An SSI individual who is considering separation or divorce, or otherwise changing his or her marital status or living arrangement.

**Excess Resources**

Advising beneficiaries about resource limits for continued eligibility is more than simply quoting the allowable amount. As beneficiaries begin working, they may want to save their earnings. Sometimes excess resources become an issue when they inherit money. Simply spending the money isn’t the only option available. Explore the needs of the beneficiary and recommend productive ways to use the excess resources to purchase allowable items. For example, they could use excess resources to:

- Purchase a home;
- Purchase a car;
- Contribute to a PASS;
- Pay the pro-rata share if ISM is being assessed;
- Pre-pay rent and utility bills; and
- Pay off consumer debt.

Help beneficiaries understand what documentation Social Security may need regarding excluded resources.

**Entitlement to Other Benefits**

Many times individuals become entitled to other benefits that will alter the counseling and recommendations you’ve previously given. Transitions that you’ll need to consider are as follows:

- Parent of a minor SSI beneficiary becomes entitled to a retirement benefit, dies, or becomes disabled, and the individual becomes CDB eligible.

- An SSI-eligible individual earns sufficient work credits to become insured for SSDI on their own work record.
• A Title II beneficiary has had enough earnings to cause a recomputation of benefits resulting in a higher benefit check.

• An SSI beneficiary loses his or her job and may be eligible for unemployment insurance.

• A Title II beneficiary becomes dually entitled on two separate records.

• A beneficiary becomes eligible for workers’ compensation benefits.

These transitions will likely require that you update the BS&A and WIP.

**Conclusion**

This unit has covered much of the core work of a CWIC. It’s important to remember that while the creation of the Benefits Summary & Analysis report is a critical function, it’s only the beginning of services. Long-term case management is essential for beneficiaries to be successful over time. On-going follow up at critical junctures is paramount to a beneficiary’s forward progress along the employment continuum. Helping the beneficiary navigate his or her roadmap is the very essence of follow-up and facilitating the use of work incentives. Because every beneficiary will have his or her own unique set of circumstances, setting standard time frames, such as 30-, 60-, or 90-day intervals, isn’t the most effective way to provide follow-up services. Carefully analyze each individual situation, and adjust the future contact points accordingly.

**Conducting Independent Research**

- **Social Security Form SSA-3033 Work Activity Questionnaire used to gather information from employers about possible subsidy** (https://www.ssa.gov/forms/ssa-3033.pdf)

- **Social Security POMS citation regarding Monthly Wage Reporting** (https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820143)
Additional Resources

On the following pages, we have provided several useful resources:

- Templates CWICs can use to develop written requests for Subsidies, IRWEs, and BWEs. Remember that Social Security doesn’t require a standard form for these requests.
- A chart providing a comparison of EXR and reapplication.
- A useful handout explaining how to calculate earnings for wage reports.
- A handout to use when counseling beneficiaries, entitled “Reporting Tips for Beneficiaries of Social Security Disability Programs.”
- A Notice of Change in Earnings Status form beneficiaries can use to report changes to Social Security.
- A Wage and Benefits Tracking Form with a completed example.
Subsidy Special Conditions Request

Please accept this information as a formal request for consideration of Subsidy/Special Conditions.

Beneficiary/Recipient:

SSN:

Address: City/State/Zip Code:

Phone Number:

Representative Payee (if applicable):

Part 1: Brief description of current employment status (name and address of employing company, date of hire, job title, rate of pay, and hours worked per week).

Part 2: Itemized list and brief description of proposed Subsidy/Special Conditions. For each item/service, provide a brief explanation of how it meets the Social Security Administration’s criteria for subsidy/special conditions as summarized below:

Subsidy/special conditions defined by Social Security:

An employer may subsidize the earnings of an employee with a serious medical impairment by paying more in wages than the reasonable value of the actual services performed. When this occurs, the excess will be regarded as a subsidy rather than earnings.

1. **Employer Subsidy**: An employer who wants to subsidize the earnings of a worker with a serious medical impairment may designate a specific amount as such, after figuring the reasonable value of the employee’s services.

2. **Nonspecific Subsidy** (Employer Can’t Furnish a Satisfactory Explanation Identifying a Specific Amount as a Subsidy): In most instances, the amount of a subsidy can be ascertained by: comparing the time, energy, skills, and responsibility involved in the individual’s services with the same elements involved in the performance of the same or similar work by unimpaired individuals in the community; and estimating the proportionate value of the individual’s
services according to the prevailing pay scale for such work.

3. **Special Conditions:** Provided by Employers and/or Organizations other than the Individual’s Employer. Special conditions and certain special on-the-job assistance provided by an employer and/or organization(s) other than an individual’s employer must be considered whether or not the individual’s employer pays for the assistance directly.

(See POMS DI 10505.010 Determining Countable Earnings for specific information on how subsidy/special conditions provisions are applied to DI cases.)

<table>
<thead>
<tr>
<th>Itemized List of Proposed Subsidy/Special Conditions:</th>
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<tbody>
<tr>
<td><strong>Item/service/support 1:</strong></td>
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<tr>
<td>Cost (if possible):</td>
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<tr>
<td>Explanation of how this item/service meets subsidy/special conditions criteria:</td>
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</tbody>
</table>

**Item/service/support 2:**
Cost (if possible):
Explanation of how this item/service meets the subsidy/special conditions criteria:

**Item/service/support 3:**
Cost (if possible):
Explanation of how this item/service meets the subsidy/special conditions criteria:

**Item/service/support 4:**
Cost (if possible):
Explanation of how this item/service meets the subsidy/special conditions criteria:

(Attach additional pages as needed)

**Other information about this request:**
I understand that I am responsible for reporting any changes in any approved subsidy/special conditions to Social Security in a timely fashion.

Thank you for considering this request. I look forward to receiving written notice of the determination within 30 days. Please contact me if you have any questions or require more information to make a determination.

Signature:               Date:
Impairment Related Work Expense Request

This request should accompany wage reports made to the Social Security Administration if you are a beneficiary receiving a Social Security or SSI disability benefit, or Medicaid under the 1619(b) provisions.

You should include receipts, and proof of wages or your self-employment tax returns.

NOTE: Please don’t use this form if you are a blind individual who only receives SSI benefits.

Date:

Period Worked:

Beneficiary Name:

SSN:

Representative Payee (if applicable):

SSN on which payment is made (if different):

Type of Benefits Received:

□ SSI
□ Title II Disability Benefit (SSDI, CDB, DWB)

This is a request that the items described below be deducted as Impairment Related Work Expenses when you consider the work activity I am reporting. The items listed below meet the following requirements:

- They are necessary for my work activity or self-employment;
- They were paid by me, and not reimbursed by another source;
- They were not deducted as a business expense; and
- They relate to an impairment being treated by a health-care provider. For each expense, I will attach a receipt. I will be happy to provide additional documentation, if requested.

List of expenses for this report period that appear on my attached pay stubs:

NOTE: You can include monthly expenses for months when you worked, or you can include the cost of durable goods, either the down payment,
the monthly payment, or the total cost, depending on how you paid for the item. Durable expenses may be pro-rated over a 12-month period.

<table>
<thead>
<tr>
<th>Date of Payment</th>
<th>Amount of Expense</th>
<th>Impairment to which Cost is Related</th>
<th>Healthcare Provider Name and Type (Example: Dr. Smith, Chiropractor)</th>
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Thank you for your consideration of this request.

Beneficiary or payee signature:
Blind Work Expense Request

This request should accompany wage reports made to the Social Security Administration if you are a blind individual receiving an SSI benefit, or Medicaid under the 1619(b) provisions. You should include receipts, and proof of wages or your self-employment tax returns.

Date:

Period Worked:

Beneficiary Name:

SSN:

Representative Payee (if applicable):

Contact Phone Number:

This is a request that the items outlined on this document be deducted as Blind Work Expenses when you consider the work activity I am reporting. The items listed below meet the following requirements:

• They are necessary for my work activity or self-employment;
• They were paid by me, and not reimbursed by another source;
• They were not deducted as a business expense;
• I will be happy to provide additional documentation, if requested.

List of expenses for this report period that appear on my attached pay stubs:

NOTE TO BENEFICIARY: You can include the cost of services or perishable goods for months when you worked, or you can include the cost of durable goods, either the down payment, the monthly payment, or the total cost, depending on how you paid for the item. Durable expenses may be pro-rated over a 12-month period.
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<tr>
<th>Pay Date</th>
<th>Federal Taxes</th>
<th>State Taxes</th>
<th>Local Taxes</th>
<th>Social Security Taxes</th>
<th>Mandatory Dues or Pension Costs</th>
<th>Other</th>
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List of other work expenses such as: Transportation, childcare, disability-related expenses, meals consumed at work, uniforms, etc. I have attached receipts, where possible as verification.

<table>
<thead>
<tr>
<th>Date of Payment</th>
<th>Type of Expense</th>
<th>Amount of Expense</th>
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</table>

Thank you for your consideration of this request.

Beneficiary or payee signature:
### Comparison of EXR and Reapplication

<table>
<thead>
<tr>
<th>Issue</th>
<th>Benefit</th>
<th>Expedited Reinstatement</th>
<th>Re-application</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provisional payments</strong></td>
<td>All benefits</td>
<td>Up to six months while disability decision is made.</td>
<td>Not payable under re-application.</td>
</tr>
<tr>
<td><strong>TWP</strong></td>
<td>SSDI, CDB, DWB</td>
<td>Eligible for TWP after 24 months of payments in the initial re-instatement period (IRP).</td>
<td>Eligible for TWP as soon as entitlement begins.</td>
</tr>
<tr>
<td><strong>Payment Amount</strong></td>
<td>SSDI</td>
<td>Adds COLAs and re-computations with recent earnings.</td>
<td>Adds COLAs only if termination was less than 12 months, but will re-compute with recent earnings. Calculation is different because of additional years added into the calculation and different computation year.</td>
</tr>
<tr>
<td><strong>Payment Amount</strong></td>
<td>CDB</td>
<td>Based on worker’s record, so re-computation isn’t applicable. COLAs will apply for all years. Family Maximum won’t affect provisional payment amount, so overpayments are possible if Family Maximum is involved.</td>
<td>Based on someone else’s work, so re-computation isn’t applicable. All COLAs will be applied. Family Maximum applies with first month of payments.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Issue</th>
<th>Benefit</th>
<th>Expedited Reinstatement</th>
<th>Re-application</th>
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<table>
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<tr>
<th>Issue</th>
<th>Benefit</th>
<th>Expedited Reinstatement</th>
<th>Re-application</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payment Amount</strong></td>
<td>SSI</td>
<td>Amount based on current income, living arrangement, and resources. Payments may begin with month after request.</td>
<td>Payments based on current income, living arrangements, and resources. Payments may begin the month after application.</td>
</tr>
<tr>
<td><strong>Medicare</strong></td>
<td>SSDI, CDB, DWB</td>
<td>Coverage begins with provisional payments. Denial of EXR request will terminate any remaining Extended Period of Medicare Coverage.</td>
<td>If within five years of prior termination, Medicare begins with the first month of entitlement after medical decision of approval is made.</td>
</tr>
<tr>
<td><strong>Medicaid</strong></td>
<td>SSI</td>
<td>Begins with first month of provisional payments in states where Medicaid is tied to SSI. May require separate application in some states.</td>
<td>Begins with the month after the month of application in states with Medicaid eligibility tied to SSI entitlement. May require a separate application in some states.</td>
</tr>
<tr>
<td><strong>Other Work Incentives</strong></td>
<td>SSDI, CDB, DWB</td>
<td>Begin after consumer completes 24 months of non-SGA work after reinstatement under EXR.</td>
<td>Begin immediately upon entitlement.</td>
</tr>
<tr>
<td><strong>Other Work Incentives</strong></td>
<td>SSI</td>
<td>Begins first month of provisional payments.</td>
<td>Begin with first month of eligibility.</td>
</tr>
</tbody>
</table>
How to Calculate Earnings for Wage Reports

Important Points

Supplemental Security Income (SSI) program:

- SSI counts income in the month that it’s received or first available for use, NOT when it’s earned. For example, if your check is dated January 2 for the pay period ending December 26, that check will count for January, not December.
- SSI will look at earned and unearned income each month.
- Keep any receipts for applicable Impairment Related Work Expenses or Blind Work Expenses.

Title II Disability Benefits (SSDI, CDB, DWB):

- Title II counts income in the month that it’s earned, NOT when it’s received. For example, if your check is dated January 2 for the pay period ending December 26, that check will count for December, not January.
- Keep any receipts and documentation for applicable Impairment Related Work Expenses or Subsidies.
- Once you have completed your Trial Work Period, you must complete an SSA Form 821 Work Activity Report and forward it to the local Social Security Field office, to the attention of the Title II Post Entitlement Representative, or make an appointment to take your documentation in and have an interview in eWORK.

Both programs:

- KEEP ALL OF YOUR PAYCHECK STUBS!
- Keep any receipts and documentation for applicable work incentives.

How to Report

1. Complete the Notice of Change in Status form.
2. Add up the GROSS earnings for each check received in the month reporting.
3. Write in the month and the total earnings in the earnings section. For example: January earnings - $425.00.
4. Fill in any special work incentives being used, if applicable. For example: IRWE (Impairment Related Work Expenses), BWE (Blind Work Expenses), SEIE (Student Earned Income Exclusion), PASS (Plan for Achieving Self Support), or 1619(b).

5. Be sure to complete and attach the appropriate paperwork to document special work incentives.

6. Sign the form.

7. Make a copy of the report form and your paycheck stubs.

8. Mail the original report form and a COPY of your paycheck stubs to Social Security.

9. File a copy of the report and your original paycheck stubs for yourself.
What information am I supposed to report to Social Security?
The answer depends on the type of benefits you get. The SSI program involves a lot more reporting than the Social Security Title II disability programs like SSDI because the SSI program has strict rules about how much income and resources you can have. Keep in mind that for the SSI program, these reporting requirements apply not only to the SSI eligible individual, but also to the parents of SSI recipients under 18 and to the spouse of SSI eligible individuals.

Supplemental Security Income (SSI)
- Unearned income including things like other Social Security payments, child support payments, or any other cash received that isn’t earned income.
- Any gross wages/earnings and net earnings from self-employment. This includes in-kind items received instead of wages (like room and board).
- In-kind support and maintenance received from others. This includes any assistance with food and shelter provided by another person.
- Change of address.
- Changes in living arrangements.
- Changes in marital status.
- Resources or assets received that cause total countable resources to be over the $2,000 limit.
- Use of any specific work incentives.

Title II Disability Programs (SSDI, CDB, DWB)
- Any gross wages/earnings and net earnings from self-employment. This includes in-kind items received instead of wages (like room and board).
- Changes in marital status (only applies to CDB and DWB – not SSDI).
• Change of address.
• Receipt of any public disability benefit such as Worker’s Compensation.
• Use of any specific work incentives.

**NOTE:** Unearned income and resources aren’t considered by the Title II disability programs, thus aren’t required to be reported to Social Security.

**How am I supposed to report this information?**
Theoretically, there are many ways to report information to Social Security, but some methods are more reliable than others. Tips for reporting relevant information include:

• SSI recipients may report earned income using a special toll free automated system. To access the system, SSI recipients may call 1-866-772-0953. You can report wages using this method any day during the current month, but report during the first 6 days of each month to prevent improper payment of SSI benefits. When calling the automated system, recipients must be ready with their Social Security number and the total amount of gross wages for the month. If you miss reporting wages during the first 6 days of the month, you can report the wages directly to your local Social Security office. You can’t use this line to report anything except wages and if you use work incentives such as Impairment Related Work Expenses (IRWEs), you can’t use the Telephone Wage Reporting System.

• Individuals may also use a new mobile application for monthly wage reporting. The SSI Mobile Wage Reporting (SSIMWR) application can be downloaded and installed free on an Apple or Android mobile device. It works the same as the telephone reporting system, except the individual submits wage data by entering it on the application screens instead of using the phone. You can find more information about [SSI reporting options](https://www.ssa.gov/disabilityssi/ssi-wage-reporting.html).

Always follow-up phone or mobile application reporting with written wage information sent to the local Social Security field office. While the automated wage reporting system is a convenient way for some SSI recipients to report wages, it’s still important to provide written verification of wages.
• SSI recipients who need to report something other than wages, or who use work incentives, have to report their information directly to the local Social Security field office. You may submit the information in writing through the mail or visit the field office and deliver the information in person.

• As of January of 2018, SSI recipients and Title II disability beneficiaries may report earned income using a new wage reporting application behind the “my Social Security” online portal. Social Security calls this application myWage Reporting or myWR. When you sign up for or log in to your my Social Security account, you’ll have access to this application on your desktop, laptop, and mobile device. After you report your wages online, you can save or print a copy of your receipt. To sign up for an account, go to www.ssa.gov/myaccount/

• Title II disability beneficiaries (SSDI, CDB, DWB) may not use the SSI telephone wage reporting system. If not using myWR to report, Title II disability beneficiaries should either mail written information to the local field office, or visit the local field office and deliver the information in person. While it’s possible to report earnings by calling Social Security’s main toll free line, we don’t recommend doing that. The best way to report earnings is to provide written information to Social Security so that a paper trail of documentation is established.

• Federal law requires Social Security to issue a receipt when they receive a report of a change in work activity or earnings status from a disabled beneficiary, or their representative. The receipt acknowledges that the beneficiary (or representative) gave Social Security information about a change in his or her work or earnings, and documents the date that we received the report. Be sure to request a receipt whenever you report work activity to your local field office.

• Keep a copy of all correspondence you send to or receive from Social Security.

• When reporting employment initially, or employment changes, always send a letter describing the critical information Social Security needs. This includes:
- Your name, address, phone number and Social Security Number
- Type of Social Security benefits you are receiving
- Name, address and phone number of employing company
- Name of direct supervisor
- Date of hire/date of termination
- Pay rate and average number of hours worked per week
- Pay dates
- Job title

- After the initial letter reporting employment or an employment change, keep all of your pay stubs or other wage documentation. Local Social Security field offices vary in terms of how often they want you to mail in your pay stubs to verify your earnings. Check with your Claims Representative BEFORE you start mailing in pay stubs. Be sure to make a copy of the pay stubs before you mail them in.

- SSI recipients generally have to report earnings more frequently than Title II beneficiaries. SSI recipients should submit their pay stubs to the local Social Security office by the 10th day of the month after the month in which the wages were paid. Some field offices may ask you to mail pay stubs less often. If you don’t report each month, make sure your estimated earnings are correct so you won’t be overpaid.

- Don’t assume that the check you receive from Social Security is correct and has had wages accounted for. You need to know what your check should be and watch to make sure Social Security makes the necessary adjustments.

- If you receive both SSI and a Title II disability benefit, make sure both programs are aware that you are working. Your report of earnings receipt should indicate both benefits. If your receipt doesn’t mention both benefits, contact your local office immediately.
• If you are getting checks or direct deposits that you think you may not be entitled to – don’t spend them. Deposit them in the bank while you work with Social Security to get the record updated.

• If you are self-employed, you need to report that to Social Security – even if you aren’t making a profit. Be sure to file your taxes promptly with the IRS and send a copy of your tax returns to the local field office. Get help from your local WIPA project to make sure you are keeping proper records.

• Keep receipts for all of the specific work incentives you are claiming. SSI recipients should submit receipts during periodic redeterminations. Title II beneficiaries should submit receipts when Social Security conducts a work review.
Notice of Change in Earnings Status

Beneficiary Name:

SSN:

Type of Social Security benefit: (check all that apply)
- □ SSI
- □ CDB
- □ SSDI
- □ DWB

Type of Change: (check one)
- □ Start employment, effective date
- □ Stop employment, effective date
- □ Change in earnings, effective date

Additional Information Regarding Change
(for employment start or stop please list employing company, immediate supervisor name and contact information, job title, rate of pay and pay dates. For earnings change, please describe the change in salary/wage, hours worked or other relevant change):

Applicable Work Incentives
(please indicate which work incentives this individual is eligible for, will be requesting a determination on, or is currently utilizing. Please attach written requests for work incentives that require approval from Social Security personnel):
- □ Impairment Related Work Expenses (IRWE)
- □ Student Earned Income Exclusion (SEIE)
- □ Blind Work Expenses (BWE)
- □ Plan for Achieving Self-Support (PASS)
- □ Subsidy/ Special Conditions – wage employment
- □ Subsidy/Special Conditions – self-employment (unpaid help or unincurred business expense)
- □ No specific work incentives are applicable at this time
This individual is receiving vocational rehabilitation and/or employment services from the following agency. Please provide the following:

Agency Name:
Address:
Contact Person:
Phone No:
E-mail Address:

Signature of Beneficiary or Representative Payee:
Date:
Wage and Benefits Tracking Form

Beneficiary Name:

SSN:

Counting Wages for Title II: Total gross earnings by pay period in the month worked. Title II considers when work was performed, not when paid.

Counting SSI Wages: Total gross earnings by month received, NOT by pay period. SSI counts income in the month it’s received.

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>Wages for Title II</th>
<th>Title II Benefit Status</th>
<th>Wages for SSI</th>
<th>SSI Status</th>
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Sample Wage and Benefits Tracking Form

SCENARIO:

Brian is a concurrent beneficiary who has completed his Trial Work Period and began his Extended Period of Eligibility (EPE) in January 2006. He has already used his cessation and grace months. Note how his benefits change monthly as earnings fluctuate. For this example, assume that Brian’s base SSI rate is the full FBR for 2017 ($735) and he has no IRWE or PASS deductions. He receives $450.00 in SSDI/month.

Beneficiary Name: Brian

Counting Wages for Title II: Total gross earnings by pay period in the month worked. Title II considers when work was performed, not when paid.

Counting SSI Wages: Total gross earnings by month received, NOT by pay period. SSI counts the income in the month it’s received.

<table>
<thead>
<tr>
<th>Month /Year</th>
<th>Wages for Title II</th>
<th>Title II Benefit Status</th>
<th>Wages for SSI</th>
<th>SSI Benefit Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan. 2017</td>
<td>$1458.00</td>
<td>EPE-no SSDI check, over SGA</td>
<td>$1254.00</td>
<td>Check due, $150.50</td>
</tr>
<tr>
<td>Feb. 2017</td>
<td>$762.00</td>
<td>Under SGA- SSDI check of $450</td>
<td>$970.00</td>
<td>No check, 1619(b) status</td>
</tr>
<tr>
<td>March 2017</td>
<td>$1205.00</td>
<td>No SSDI check, over SGA</td>
<td>$942.00</td>
<td>Check due, $306.15</td>
</tr>
<tr>
<td>April 2017</td>
<td>$1136.00</td>
<td>No SSDI check, over SGA</td>
<td>$999.00</td>
<td>Check due, $278.50</td>
</tr>
<tr>
<td>May 2017</td>
<td>$742.00</td>
<td>Under SGA, SSDI check of $450</td>
<td>$782.00</td>
<td>No check, 1619(b) Status</td>
</tr>
</tbody>
</table>
Competency Unit 6 – Effective Time Management Strategies for CWICs

Introduction

CWICs have many different tasks to accomplish, including providing high-quality WIPA services to beneficiaries and their stakeholders, maintaining professional competence, complying with project data collection activities, and meeting programmatic requirements of their employing agencies. Balancing all of these demands can become overwhelming, and it may seem as if there aren’t enough hours in the day to accomplish everything. CWICs who don’t manage time well will provide less service or lower-quality services than those who work efficiently. Poor time management isn’t just a minor issue — it can seriously decrease productivity of the entire WIPA project and diminish outcomes for beneficiaries. Time management matters!

Proven Time Management Strategies

CWICs aren’t the only professionals to face challenges with time management. This is a common concern in for-profit business as well as in human services agencies. Busy professionals always seem to have more work to do than available hours in the day, and effective time management is one hallmark of a successful and satisfying career. Fortunately, there is a wealth of information available on time management strategies that can apply to any profession, including Work Incentives Planning and Assistance.

Here are some proven strategies for managing the competing demands for time, as they would apply to the work of CWICs:

Plan

- Plan out your day or week in advance. Use tools such as to-do lists, calendars, or priority lists to help you plan.
- Make a plan and stick to it! When things come up to sidetrack you, stay focused on the task at hand. For example, if your plan
for the first half of the day is to complete a certain number of BS&As, don’t answer the phone. Let calls go to voice mail, and plan time directly afterwards to collect messages and return calls within 24-48 hours.

- Prioritize your plan using the four Ds:
  - Do It – This needs to be done immediately.
  - Delegate It – It needs to be done, but someone else can take care of it.
  - Defer It – It needs to be done, but it can wait.
  - Dump it – It isn’t important, so get it off your plate.

**Simplify**

- Are some of your tasks unnecessary or redundant? If so, look at ways to be more efficient and to simplify the work you are doing. Remember the saying, “Work smart, not hard.” Are you driving all over town to meet with different beneficiaries or stakeholders? If so, consider alternate methods of contact such as conference calls, email, mailing, etc.

- Can one strategically planned task accomplish the same goal as multiple tasks? Look for ways to collapse multiple steps into the fewest number you need to accomplish a quality outcome. If the step doesn’t add value to your work and help you meet the mission of WIPA services, stop doing it, or decrease the time you spend doing it.

- Divide large tasks into small ones to get a better sense of accomplishment as you complete each step. In addition, when you are interrupted in the middle of a task, it’s much easier to get back on track and regain your focus.

**Delegate**

- Don’t feel like you personally have to hold your beneficiary’s hand through every step of the process. When possible and practical, delegate appropriate tasks to other members of the employment support team.
• Teach the beneficiary or other family members or support providers to manage their own benefits. Give them the training, tools, and support to be self-sufficient. Use calendars that show steps from the WIP clearly marked on the dates that they need to be completed.

• Perhaps your team can develop group training events for beneficiaries to teach specific benefits literacy topics, such as reporting to Social Security and other public benefits agencies, maintaining work incentive documentation files (receipts, etc.), tips for communicating effectively with Social Security, etc.

**Set Time Limits and Enforce Them**

• If you are conducting a phone meeting with a beneficiary, set a time frame and have an agenda. Stick to your agenda and stay focused on the issues at hand.

• Calls with beneficiaries and other stakeholders should be all business. Limit the small talk; those few minutes can add up quickly.

• Avoid walk-ins! If someone walks in and wants to discuss an issue, politely redirect them to schedule a time for a call or appointment to review the concern.

• Don’t under or over-estimate time that tasks will consume. Overestimating time makes it difficult to fit all your tasks into your daily schedule, while underestimating cuts your day short and makes it impossible to complete your schedule. However, do be generous with your time allotments. It’s much easier to fit a small task into extra time than it is to try to make up for lost time.

**Review and Re-Evaluate**

• Make time at the beginning of each week to review your previous week. This shouldn’t take more than about 15 minutes. Take a look at what you accomplished and what you were unable to complete.

• Identify when you were working at peak performance. What factors contributed to your high level of productivity? Conversely, when did you experience low productivity? What
factors came into play at that time? Evaluating these things can help you to continue to manage your plan and become more productive. It can also help you to re-evaluate how you plan your week going forward, and what changes you implement.

**Learn to say “No!”**

- You can’t be everything to everybody. Identify the “time bandits” in your work, and evaluate whether or not they are directly related to your mission of promoting employment and enhancing financial stability for the beneficiaries you serve. Hold yourself accountable for decreasing the amount of time you spend doing things that aren’t directly related to the mission of WIPA services.

- Give yourself permission to say “no” and don’t feel guilty about doing that. Frequently, we consider that saying “no” is discourteous, but you can be frank without being rude. “I can’t now, but I could (insert when)” or “I’m sorry, but I just can’t manage that today” is just good time management.

- Face-to-face meetings are a major “time bandit.” This includes agency or other stakeholder group meetings, unnecessary trips to Social Security offices with beneficiaries, travel between appointments, unnecessary outreach, assisting with unauthorized services, serving ineligible individuals, etc. Make a point of limiting the amount of work you conduct in person, and focus on working more efficiently by phone, email, and other distance communication techniques.

**Use Effective Scheduling Techniques**

- Use a calendar program that has prompts and reminders, such as Microsoft Outlook to manage appointments.

- Use a calendar or some other mechanism to schedule reminders of when to do pro-active follow-up with beneficiaries. For example, “Let’s see, Stacy, you should get your second paycheck on October 30th. I’m going to make a note that you’ll contact me before November 5th, or I will call you on that date so that we can talk about how reporting those wages went.”
• Delegate tasks in advance to reduce the amount of time needed for appointments; don’t work in isolation.

• Be prepared for each contact point.

• Arrange your weekly schedule by types of contact beneficiaries need.

• Leave time to handle unexpected issues.

**Specific Time Management Issues for WIPA Projects and CWICs**

When we talk about effective time management within the WIPA program, you need to consider two different areas. First, CWICs need to focus the bulk of their time performing activities that are "important" relative to the mission of the WIPA initiative, and minimize time spent on activities that are less important. Second, CWICs need to be efficient in the performance of their duties, which means they work in ways that reduce wasted time and effort. Importance is all about WHAT activities you perform, while efficiency is related to HOW you complete tasks. These are very different concepts, but both are essential to effective time management.

Let's tackle the concept of "importance" first. Unit 1 of this module presented information about "urgency" and "importance" as described by Steven Covey in his famous book, "Seven Habits of Highly Effective People." Covey describes "urgency" as something that requires immediate attention. Urgent matters are usually very visible. They press on us and insist on action. In contrast, he describes "importance" as being related to results. When something is important, it contributes to your mission, your values, and your high-priority goals. Covey's premise is that too many people focus too much time on activities that may be urgent but aren't actually important.

If we apply Covey's concepts to WIPA services, presenting needs that beneficiaries have will fall into one of four distinct categories. The best way to think about this is to visualize a square divided into four quadrants:
<table>
<thead>
<tr>
<th>Quadrant 1</th>
<th>Quadrant 3</th>
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<tbody>
<tr>
<td>Low Importance – Low Urgency</td>
<td>High Importance – Low Urgency</td>
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<tr>
<td>Quadrant 2</td>
<td>Quadrant 4</td>
</tr>
<tr>
<td>Low Importance – High Urgency</td>
<td>High Importance – High Urgency</td>
</tr>
</tbody>
</table>

CWICs who manage their time effectively try to minimize activity in Quadrants 1 and 2 while maximizing activity in Quadrants 3 and 4. The objective is to focus more on the importance of an activity rather than the urgency of an activity. Every minute you spend on urgent issues that aren’t important relative to the WIPA mission takes precious time away from acting on issues that are important to the mission of the WIPA initiative.

In order to spend time wisely on the most important tasks, WIPA Project Managers and CWICs need to evaluate their efficiency and identify practices that may be wasting time and diminishing results. To assess whether or not you are focusing your time on truly important WIPA work, research the following questions:

- **How much time do you spend on people who aren’t actually eligible for WIPA services?** Are ineligible beneficiaries able to access you directly, or is a process in place to handle beneficiary screening and triage before contact with individual CWICs?

- **How much time do you spend working with eligible beneficiaries who are a low priority under the WIPA service model?** Does your WIPA project have an efficient way of determining which beneficiaries meet the criteria for Priority Groups 1 and 2 before you plan for or provide services?

- **How much time do you spend delivering generic I&R services?** Under the current WIPA service design, Social Security expects CWICs to use most of their time delivering individualized WIPA services instead of generic I&R services. If you are providing more I&R services than this, you need to rethink your processes. Are you referring beneficiaries to the Ticket to Work Help Line to get basic I&R needs met, or handling these calls yourself? Are you only providing I&R services to people who really need individualized services and should be enrolled in WIPA?
• How much time do you spend with eligible beneficiaries working on non-employment related issues? Are there ways to refer beneficiaries to other services to get some of these needs met? Are there ways you could teach beneficiaries to handle these issues more independently rather than relying on you to resolve them? Are you clear about the parameters of WIPA services? Are you providing support in areas that are clearly outside of the role of the CWIC?

• What process do you use to determine which beneficiaries receive a detailed BS&A report and written Work Incentives Plan? How much time do you spend developing BS&As and WIPs? Individualized benefits analysis and work incentives counseling is the core component of WIPA services and requires a significant investment of your time.

• How much time are you spending in crisis management with beneficiaries? Do there always seem to be emergencies that you need to deal with? Could you avoid or minimize these crises with more proactive follow-up service?

• How much time are you spending on proactive follow-up activity? Remember, under the current WIPA service design, you should be serving fewer people who have higher priority needs. In particular, employed beneficiaries require ongoing follow-up to make sure they are reporting and that Social Security is adjusting their benefits accordingly. Follow-up is important work relative to the mission of WIPA services.

• How much are you doing for beneficiaries as opposed to teaching them to do for themselves? Are you supplying beneficiaries with Web links, packets of information, handouts, videos, or any other materials they can use to learn about various work incentives?

These questions may also help you identify the areas in which you need to invest MORE time. For example, if you are constantly dealing with benefits emergencies, it may be that you need to provide more proactive follow-along service as a preventive measure. If very few of the beneficiaries you serve are utilizing work incentives such as IRWE or PASS, you may need to spend more time explaining these provisions early on and probing to see if they might apply. Working efficiently isn’t
just about working quickly — it’s about focusing your energies on the most IMPORTANT tasks relative to the mission of WIPA services.

Now, let’s turn our attention to the issue of “efficiency.” It’s important for you to perform your work in ways that reduce wasted time and effort. This means you have processes in place that minimize duplication of effort and unnecessary tasks that don’t contribute to your mission or the quality of your work. Even though you might be very good about spending your time on the most important activities, if you are inefficient in the way you perform them, you’ll still waste precious time. To assess whether or not you are working efficiently, research the following questions:

- Are you spending a lot of time trying to make initial contact with referrals? Are you trying multiple forms of contact at varying times of day and documenting your efforts? Does your project have a clear and consistent policy on how to handle non-responsive beneficiaries?

- Under the current WIPA service model, Social Security encourages WIPA projects to conduct services using distance communication techniques rather than face-to-face meetings, whenever possible. How much time are you still spending on transportation to and from meetings with beneficiaries or community agency personnel?

- How do you go about verifying benefits, and how much time do you spend performing benefits verification? Are you using the most efficient methods of getting information from Social Security? Have you met with Social Security Field Office Managers or the local Work Incentives Liaisons (WILs) in your area to discuss which methods they prefer for getting critical information released? Do you understand when to contact the Area Work Incentives Coordinator (AWIC) to get benefits issues or questions resolved when progress isn’t being made at the field office level?

- How are you interacting with Social Security personnel, and which staff members are you dealing with? Are you using phone calls, email, and faxes, or are you going to local offices in person? Are you accompanying beneficiaries to Social Security
field office visits, or are you teaching beneficiaries to conduct visits independently?

- How much time do you spend sorting out how the other federal benefits (Medicaid, HUD, TANF, SNAP) will affect paid employment? Have you received adequate training on how the state operates these programs? How much effort have you put into developing knowledgeable contact people within these state agencies? Are you working collaboratively with other WIPA projects and staff within the state to obtain state-specific benefits information, or is the project working in isolation?

- When a Social Security work incentives question arises, how do you go about resolving it? Are you searching the POMS, calling or emailing your VCU Technical Assistance Liaison, asking other knowledgeable WIPA staff, or requesting help from Social Security personnel? How much time do you spend per week finding answers to questions or researching benefits issues?

- How much time do you spend on record keeping and data tracking? Are there any forms, paperwork procedures, or data entry procedures that your WIPA team could discontinue or make more efficient? Are you spending the amount of time necessary to stay current on your data tracking responsibilities, or are you playing catch up at the end of every month?

- How much time do you spend on non-service oriented activities such as outreach, presentations, and agency meetings? Are there ways that you could reduce the time you spend in these activities?

Analyzing the answers to these questions can help you identify where problems exist that waste valuable time. Once you identify the problem areas, CWICs and WIPA Project Managers should work together to develop strategies for streamlining process and eliminating unnecessary steps.

**Meetings and Face-to-Face Contact with Beneficiaries**

Meetings can be “time vampires” that consume huge chunks of your workday without providing a satisfactory return on that investment of time. This may include agency staff meetings, project meetings, and meetings with beneficiaries and other members of their employment
support teams. Remember, Social Security now expects WIPA personnel to limit the amount of face-to-face service they provided to beneficiaries.

Before you agree to attend meetings, you should seriously consider the following factors:

- Is attending this meeting necessary to meet the mission of WIPA services to promote employment and enhance financial stability? Is the meeting critical to the success of the beneficiary reaching his or her employment goals, and do you have a defined role to play at this meeting?
- Does the meeting require your physical attendance, or can you attend via phone or web-conferencing?
- How much transportation time will the meeting require, and is the outcome of the meeting really worth the time and expense involved in getting there?

When meetings aren’t directly related to achieving the mission of WIPA services, or when you may use another communication method as effectively as a face-to-face meeting, don’t feel bad about declining to participate. Your time is a precious resource that you must allocate in the most effective and efficient manner possible. It’s acceptable to say “no” to requests for meetings when they aren’t an appropriate use of your time.

**When Beneficiaries Need Help Making a Field Office Visit**

There will be times when beneficiaries have problems they can’t resolve without going to the local Social Security field office. Any number of issues could require a visit to the field office, including problems with claiming or documenting a work incentive, resolving problems with an SGA determination, or sorting out adjusted SSI payments. In some cases, the beneficiary will request that the CWIC accompany him or her to the office to provide support and assistance. While there is no rule prohibiting this activity, it’s extremely time consuming, and you should avoid it when possible.

CWICs should follow this protocol to determine when a field office visit is necessary:

1. Prepare the beneficiary to conduct the visit independently by explaining what to expect and listing questions that he
or she needs to ask. You may even want to role-play to practice ways to communicate effectively with Social Security employees. The objective here is to teach the beneficiary as much as possible about the issues in question and how to work with Social Security to resolve problems.

2. If the beneficiary isn’t capable of managing the visit alone, check for a family member, friend, advocate, or other professional who can help. Provide the same preparation to the person who will be helping that you would provide to the beneficiary. A three-way phone call works well for this, as it allows you to share information with the beneficiary and the helper at the same time.

3. Follow up by phone with the beneficiary (and the helper as applicable) after the field office visit to find out how things went, determine whether the field office resolved the beneficiary’s issues, answer remaining questions, or plan for future actions.

4. If the beneficiary is unable to manage the visit alone and there is no one available to provide assistance, you may need to accompany the beneficiary to the field office. Remember — CWICs should attend meetings like this only as an absolute last resort, if ever.

**NOTE:** A personal visit might not be necessary if you have a good working relationship with the local WIL or AWIC. You can resolve many benefits problems or issues by phone if you have done the work to build those important relationships in advance. Remember that you’ll need a signed SSA-3288 Release of Information form detailing the information you need to gather from Social Security before the WIL or AWIC speaks with you.

**Effective Use of Distance Communication Techniques**

While the current WIPA service design doesn’t prohibit face-to-face contact with beneficiaries, it does encourage CWICs to apply use distance communication techniques whenever possible. This includes email, teleconferencing, videoconferencing, Skype, FaceTime, and related technologies to “virtually” meet in secure environments with beneficiaries.
This emphasis on distance technology reflects Social Security’s recognition that WIPA resources and staff time are limited and that high-quality WIPA services aren’t dependent on face-to-face interaction. Here are some practical tips for using distance communication techniques when delivering WIPA services:

**Initial Information Gathering**

- Conduct information-gathering sessions by phone. You may need to make an appointment for the session, because you never know what you might be interrupting when you make that first phone contact with a beneficiary.
- Explain to the beneficiary the purpose and intent of the call, and the time allowed. For example, you might say, “I want to take a few minutes to gather some basic information, introduce you to our services, and determine whether you might benefit from our services. At the end of the call, I will schedule an appointment for you to help you understand the effect of work on the benefits you receive, and also help connect you to services and supports you need to make a successful transition back to work.”
- Respectfully stick to your agenda. Beneficiaries are often upset when they call, or they have had difficult experiences that are outside the scope of WIPA services. Be respectful of the individual’s need to talk, but try to guide the interview back to the goals that you need to accomplish. For example, you could say something like, “Thanks for sharing that information. I am concerned, though, about getting back to the services I can provide. So, have you worked since you became entitled to benefits?”
- Keep your phone sessions to an hour or less. It’s really difficult for most people to attend longer than that. You may need several sessions to gather all of the necessary information from the beneficiary.
- Gather email addresses and all phone numbers, and ask how the beneficiary prefers to communicate with you. If you get an email address, ask the beneficiary is he or she checks it on a daily or regular basis. If the beneficiary provides you with a cell phone number, be sure to ask if he or she prefers calls or text
messaging. Make sure you check on convenient times for you to call.

- Don’t interrogate the beneficiary. Have a friendly conversation and try to get to know the individual. The goal is to establish trust and rapport while gathering the information you need to deliver individualized benefits counseling.

- Send all release forms to the beneficiary after the initial information-gathering session. You can scan the forms and send them by email if the forms do not include any PII. If you are sending release forms or other information with PII, you will need to send them via encrypted email. You may also use the postal service when sending forms with or without PII. Include a self-addressed stamped envelope if using mail. Be sure to explain how important these forms are and WHY they are needed.

- Mark your calendar to contact the beneficiary if you haven’t received signed forms within 10 days. Send reminders as needed by phone, text, email, mail, or multiple ways.

**Verifying Benefits**

- Support the beneficiary to verify his or her own benefits whenever possible and practical. This may include gathering necessary documentation from the agencies administering the benefits and forwarding this information on to you. Check to see if the beneficiary has award letters or other correspondence that he or she can use to verify benefits. It may be that additional contact with the administering agency isn’t necessary.

- It’s possible for beneficiaries to request their own BPQYs from the local field office or by calling the toll-free line (1-800-772-1213). To speed up the process, the beneficiary can request to have the BPQY mailed or faxed directly to you, the CWIC.

- Explore the availability of online account options for benefits verification, and help beneficiaries sign up for and use online accounts. There’s no need for signed releases of information when beneficiaries provide verification directly to you.

- Once you receive the BPQY and other verification documents, make sure you review this information with the beneficiary to
identify and discuss any discrepancies between what the beneficiary reported to you and what shows on the BPQY.

**Individualized Benefits Analysis and Work Incentives Counseling**

- Begin sharing summary work incentives information with the very first call. Again, try to keep your counseling sessions limited to one hour. Most beneficiaries would have difficulty processing more than an hour’s worth of detailed information at a time.

- Start with a general overview of how employment affects benefits. Be careful about overwhelming the beneficiary with too much detail all at once. You can always go over concepts in greater depth at a later date.

- Reinforce your phone conversations with written information (fact sheets, brochures, Redbook, etc.). You can send these by web link, email or postal service. SSA publications are available at [www.ssa.gov/pubs/](http://www.ssa.gov/pubs/).

- You may also want to suggest that the beneficiary watch YouTube videos produced by Social Security ([https://www.youtube.com/channel/UCNm7O9WmYwy_CuU7YEg8UOA](https://www.youtube.com/channel/UCNm7O9WmYwy_CuU7YEg8UOA)).

- Once you have provided the general overview of how work will affect benefits and have verified all benefits, begin providing case-specific individualized benefits counseling. At each step, probe for questions. Be open to explaining concepts multiple times in different ways to ensure that the beneficiary has a solid understanding of what to expect.

- Send the completed BS&A report to the beneficiary by email or mail. Always go over the report by phone to explain it and answer questions.

**NOTE:** CWICs may only send PII as an encrypted attachment to an email message. You’ll need to give the password for the encryption to the beneficiary in a phone call or a separate email. Don’t send PII in the body of the email message!
Providing Proactive Follow-Up

• The WIP should provide you with a good outline of when you need to make contact and how often you should reach out to the beneficiary. With employed beneficiaries, be sure to follow up on a regular basis to ensure that the beneficiary is retaining documentation of work incentives usage and reporting earnings correctly.

• If you use the phone to check in on beneficiaries, make sure you time those calls wisely. If beneficiaries are working, they probably can’t take calls during work hours. You may need to make follow-up calls after regular work hours.

• Some beneficiaries will prefer that you make contact using text or emails message. These are also good ways to set appointments for phone conversations when you need to discuss or explain something.

• Be responsive to high-priority beneficiaries who are trying to contact you. You should respond to phone calls, texts, or email messages within 48 hours whenever possible.

• If you receive no response despite repeated attempts to make contact using multiple methods, follow-up with letters by mail. Make an extra effort with the highest priority beneficiaries — individuals who are employed.

Setting Aside Time for Professional Development

Another important demand on a CWIC’s time relates to professional development. The current WIPA project cooperative agreements require CWICs to earn a minimum of 18 Continuing Certification Credits (CCC) each year following full certification in order to retain their certification and authority to work with beneficiaries. By requiring ongoing continuing education, Social Security has taken another major step to improve the quality and consistency of WIPA services.

The primary mechanism through which CWICs meet this professional development requirement is participation in NTDC supplemental trainings and completion of supplemental training assessments. VCU’s NTDC delivers these trainings in a variety of formats — teleconferences, webinars, online courses, and archived supplemental trainings — and on a wide range of subjects relevant to the work of CWICs and WIPA.
leadership personnel. NTDC personnel have designed the trainings to meet the needs of novice, intermediate, and advanced skill levels. Track your successful completion of a training event through the “myNTC” feature on the VCU NTDC website.

With so many training opportunities available on so many different topics, CWICs need to be strategic when determining which events to participate in. Before you register for an event, consider whether or not it’s well suited to your skill level. An experienced master CWIC probably wouldn’t benefit from participating in a training event designed for newly certified WIPA personnel. Think about the areas in which you require competency building, and allocate your training time to those subjects you are weakest in.

You also need to consider the time commitments involved in completing the various training opportunities. Live teleconference or webinar events are short in duration (2 hours or less), but these events are only offered on specific dates and times. You’ll need to block that time out on your calendar to avoid conflicts. Also, you have a limited window of time to complete the assessment in order to get credit for the training. You need to plan ahead to make sure you have afforded the time necessary to participate in the event and complete the assessment. If participating in the live training events isn’t convenient, keep in mind that most conference call events are archived on the VCU NTDC website (https://vcu-ntdc.org/training/initial/archives.cfm). These archived events now have assessments provided so CWICs can gain CCCs by completing them independently.

Web courses generally cover deeper and more complex subject matter, but they typically are 4-6 weeks in duration. On the positive side, web courses offer tremendous flexibility, and you can complete the course work from any computer at any time of the day. Professional development is an extremely important activity for CWICs. Only by constantly building your skill will you be able to provide the highest-quality WIPA services to beneficiaries.

The Importance of Record Keeping and Data Tracking

With all of the competing demands for your time, you need to plan carefully to make sure you meet any applicable data tracking and paperwork completion requirements. It’s all too easy to put off mundane
administrative tasks when there are so many beneficiaries to serve. Here are some practical tips to help you be successful in this area:

- Block time out on your calendar at least weekly (and preferably DAILY) to complete data tracking and record keeping tasks, and don’t allow others to interrupt you during these times. Let your calls go to voice mail, and close your office door to reduce possible distractions. Make sure your colleagues know that your schedule includes certain times when you aren’t available. Some people find that setting aside an hour each morning or afternoon for paperwork works well, while others find that completing these tasks on Friday afternoon or Monday morning is best. Every CWIC needs to find the method that works best and be disciplined about reserving that time for important administrative tasks.

- WIPA Project Managers should check data tracking for each staff person on a regular basis to ensure that CWICs aren’t getting behind. It’s virtually impossible to be accurate and complete if you wait 30 days or more to record data. Trying to play catch up will result in the loss of valuable performance data.

- An important part of your job is developing BS&A reports and WIPs. You need quiet time to get this done, so don’t forget to include this task in the time you set aside for completing paperwork.

**Important Time Management Reminders**

- Referrals generated by the Ticket to Work Help Line are a high priority for WIPA projects. Social Security expects WIPA projects to assign or reply to encrypted referral emails within 48 hours. Social Security requires that CWICs attempt to contact beneficiaries referred by the Help Line **within 5 business days of the referral** and make a minimum of 3 contact attempts.

- Please don’t leave messages on your voice mail stating that you are unable to take new referrals, or that there will be a long delay returning calls. If the CWIC responsible for returning initial calls is out of the office, have another CWIC make initial
calls to beneficiaries and schedule appointments for the CWIC as appropriate.

- If you have subcontractors providing WIPA services, remember that it’s your responsibility as the recipient of the Social Security WIPA cooperative agreement to ensure that all parts of the service area are being served adequately and appropriately.

- If you are short-staffed, temporarily reassign existing CWICs to cover additional service areas. When it’s necessary, heighten your awareness of case priorities, and serve only the highest-priority beneficiaries for the short-term, and start a waiting list for individuals with a lower-priority service need. Remember to let your Social Security Project Officer know if this is the situation you are experiencing.

- Balance your outreach with your workload. It’s acceptable to significantly reduce the number of outreach appearances you make. In fact, outreach should encompass no more than 10 percent of your workload. Direct services to beneficiaries are the WIPA project’s primary business. You must serve beneficiaries with a potential for work to meet the goals of the WIPA program — positive employment outcomes.

- Review the referrals you get from various sources. If you have particular sources that tend to send you referrals that aren’t appropriate, take some up-front time and work with that referral source to help the source better understand your services. Provide the source with pamphlets to distribute that adequately describe what WIPA projects do so that the majority of your referrals are individuals who are appropriate for intensive back-to-work services.

**Conclusion**

Time management often brings a picture to mind of a daily planner with every minute plotted from the time your alarm clock sounds until the time you crawl into bed. However, time management experts suggest that planning only 50 percent of your time leaves you time to relax as well as time to cope with the unexpected. Developing effective time management techniques is similar to planning a budget. Just as the goal
of a budget is to put you in control of your money, your goal in time management is to regain control of your time. With a little bit of focus and effort, you can balance all of the competing demands of your job and experience success as an effective provider of WIPA services.

**Conducting Independent Research**

*The Seven Habits of Highly Effective People*

(https://www.stephencovey.com/7habits/7habits.php)
Module 7 – WIPA Standards and Quality Considerations for CWICs
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Module 7 – WIPA Standards and Quality Considerations for CWICs

Introduction

Social Security made quality assurance a cornerstone of the development of the WIPA program. Without an emphasis on quality, beneficiaries would be at risk of being harmed by receiving inaccurate or misleading information.

This module focuses on planning and implementing quality improvement activities that enable CWICs and WIPA projects to provide state-of-the-art services to beneficiaries. Unit 1 describes the first step in quality assurance - compliance with basic requirements established by Social Security for all WIPA projects. Unit 2 describes strategies for providing WIPA services with a focus on quality. Unit 3 offers specific information about providing WIPA services that accommodate disabilities, and respect cultural differences. Unit 4 describes a set of ethical standards that CWICs must follow in the performance of their duties.

CWIC Core Competencies

- Demonstrates an understanding of the minimum compliance requirements for WIPA projects as stated in the WIPA Cooperative Agreement.
- Provides WIPA services in a manner that strictly protects beneficiary personal information and adheres to Social Security’s data security requirements.
- Identifies and describes indicators of high-quality WIPA services and demonstrates an understanding of the CWIC’s role in achieving these indicators.
- Provides culturally sensitive and competent work incentive counseling services that enable the beneficiary to access and benefit from the WIPA program, regardless of the need for communication or program accommodations for persons with
disabilities, diverse cultural or linguistic backgrounds, or geographic location of residence.

• Consistently uses an array of available training and technical support resources (POMS and other online resources, WIPA project networking, assistance from Regional TA Liaisons, VCU NTDC supplemental trainings) in order to develop and enhance professional knowledge and skills in order to improve the quality of WIPA services.

• Maintains the highest ethical standards in all dealings with Social Security’s beneficiaries. This includes, but is not limited to, the right to decline to serve beneficiaries unwilling to report wages, other income, or any changes in beneficiary circumstances that affect the beneficiary’s eligibility or benefit amount.
Competency Unit 1 – WIPA Quality Assurance Baseline

Introduction

WIPA projects operate under a written cooperative agreement with Social Security that outlines Social Security’s requirements in the Terms and Conditions of the award. These requirements represent the minimum standards for WIPA services. The cooperative agreement documents outline minimum requirements for the three topics we will discuss in this section:

- Staff training and certification;
- WIPA service delivery; and
- Beneficiary confidentiality and privacy.

These requirements relate specifically to CWICs and the daily work they perform in providing WIPA services.

Staff Training and Certification

CWICs deal with critical issues relating to personal finances and health coverage that can have a profound impact on a beneficiary’s economic and physical well-being. In order to provide sound advice and avoid harming a beneficiary, CWICs must acquire and maintain a high level of knowledge and skill and apply this knowledge and skill accurately and effectively. The WIPA Terms and Conditions state:

“WIPA grantees must send staff designated to be CWICs to the official Social Security-approved initial CWIC training. Staff must attend initial training and successfully complete provisional certification in order to serve beneficiaries. Subsequent to provisional certification, staff must complete and retain full certification in order to continue to work on the WIPA cooperative agreement. An SSA Project Officer must approve any exceptions.”
Social Security requires all CWICs to complete the WIPA initial training program and successfully complete a series of competency-based assessments to be certified to provide Work Incentives Planning and Assistance services to beneficiaries. The competency assessment and certification processes are directly linked to the WIPA initial training program. CWICs receive training on each of the core competencies addressed in this manual during the 5-day initial training program. CWICs participate in the assessment activities to certify their competency in each of these main competency areas immediately following the training.

Beginning with initial training classes held after July 1, 2016, WIPA trainees must also successfully complete a web course that covers the other federal benefits prior to achieving full certification. The WIPA National Training and Data Center (NTDC) at Virginia Commonwealth University (VCU) offers this web course.

Completing the CWIC initial training and certification process ensures that all WIPA personnel providing direct services to beneficiaries attain a baseline of knowledge and a starting point upon which to build competency. This initial training provides CWICs with the minimum competency level necessary to ensure that beneficiaries receive accurate and timely information. Next, the Terms and Conditions document requires that CWICs build competency in several key areas beyond those covered during initial training. It states that:

“In addition to meeting the Continuing Certification Credit requirements for state and local benefit training, WIPA Directors must provide training opportunities and technical assistance for all CWICs on applicable State and local programs and the effect that beneficiary employment has on these programs. Directors shall encourage WIPA staff to attend State and local training opportunities as part of their duties and shall provide resource materials for CWICs to investigate State and local benefit situations. It is the WIPA Director and CWIC’s responsibilities to obtain, learn and maintain expertise on the specifics of the State and local benefits programs and employment supports in the service area.”

In addition to the initial training and Other Federal Benefits web course, Social Security expects CWICs to access state-specific information about
other federal or state specific programs such as Medicaid, Worker’s Compensation, Unemployment Insurance, Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Programs (SNAP), federal and state housing assistance programs, federal and state veterans’ programs, federal, state or local Individual Development Account (IDA) programs, and other federal and state benefit programs. While the federal parameters for these programs are described in Module 5 and covered in detail in the required Other Federal Benefits web course, there are many additional state and local rules that will vary based on beneficiary location. CWICs must take the initiative to build competency in all of the state-specific benefits that a beneficiary’s employment could potentially affect. Social Security requires all WIPA projects to ensure that staff members are fully trained on the state specific benefits and the effect of paid employment on these benefits.

Finally, Social Security expects CWICs to build professional competency over time by participating in supplemental training and technical assistance opportunities offered by VCU’s NTDC. Social Security requires CWICs to complete a specified number of continuing certification credits (CCCs) each year to maintain the CWIC certification credential. The 2019 Terms and Conditions document states that:

“Fully certified CWICs must accrue a minimum of eighteen (18) Continuing Certification Credits (CCC), as defined by Social Security, to enhance their skills and retain certification. Certified staff must meet this requirement annually during each grant year.”

This requirement applies to all fully certified WIPA CWICs and Project Managers providing WIPA benefits counseling services, regardless of their date of initial certification. Fully certified WIPA personnel must complete the continuing certification requirements within each performance period (award or grant year). Social Security requires certified WIPA staff to earn credits in three areas:

1. Twelve credits of training provided by VCU’s NTDC. Social Security may provide three CCCs in lieu of three VCU NTDC training credits for conference attendance under certain prescribed circumstances. The WIPA Project Director submits a request for approval using the CCC template to the Social Security Project Officer after staff attends the conference.
2. Three credits for state and local training events approved by the Social Security Project Officer; and

3. Three credits for the submission and approval of a Benefits Summary and Analysis (BS&A) report. All fully certified WIPA staff working as CWICs must submit one BS&A report at least once every three years as part of the continuing certification requirement. Certified CWICS and Project Directors must earn three additional supplemental training credits in years in which they are not required to submit a BS&A.

WIPA Project Managers who serve as CWICs must meet the CWIC certification requirements described above. Project Managers who don’t provide direct services to beneficiaries are not required to meet the three (3) credit BS&A requirement, but must submit written documentation describing efforts to retain benefits planning knowledge and skill in lieu of a BS&A.

Community Partner Work Incentives Counselors (Community Partners) who participated in the initial training and successfully completed all requirements for full certification must also complete specified training to retain certification, and to retain access to technical assistance provided by VCU’s NTDC. To retain Community Partner certification, and to continue to access technical assistance and training from VCU, fully certified Community Partners must successfully complete eighteen (18) credits annually. The annual certification period is from July 1 through June 30, and participants must earn all 18 credits during this period each year. Community Partners may not use any training other than the training offered by VCU NTDC to meet the requirements.

VCU’s NTDC has developed an online tracking system for Continuing Certification Credits for certified WIPA staff and Community Partners. Fully certified WIPA personnel and Community Partners are able to log into their myNTC account on the VCU NTDC website to view and manage progress towards meeting continuing certification requirements.
WIPA Service Delivery Requirements

A number of requirements in the 2019 Terms and Conditions document describe how Social Security expects CWICs to deliver WIPA services to beneficiaries. First, Social Security requires WIPA Projects to:

“Provide SSDI and SSI beneficiaries with disabilities work incentives planning and assistance services to support their efforts to acquire, retain, and increase meaningful employment and improve financial independence. Such services include timely, accurate, and comprehensive WIPA services. (Note: WIPA staff may not represent beneficiaries in appeals. Instead, WIPA staff may inform beneficiaries of their right to appeal and help them understand options to mitigate or respond to overpayments (i.e. requesting appeals, waivers, or payment plans).”

Social Security goes on to state that WIPA projects must:

“Provide comprehensive, proactive guidance to beneficiaries to:

- Help them anticipate and plan for changes in their benefits;
- Facilitate use of and access to available Federal, State, and local work incentives including, but not limited to, Plans to Achieve Self-Support (PASS), the Ticket to Work (TTW), and Impairment Related Work Expenses (IRWE);
- Encourage retention of appropriate documentation in order to report wages and ensure access to work incentives;
- Encourage and support accurate and timely reporting to reduce the size or likelihood of overpayments; and
- Offer information and connect beneficiaries to supports they need to access services to make a successful transition to employment.”
These instructions clearly define the role of CWICs as promoting employment and improving financial independence. This role is discussed at length in Unit 1 of Module 1. The requirements also specify services that Social Security prohibits — namely, representing beneficiaries in overpayment and appeals. CWICs have an obligation to focus their efforts on activities that Social Security authorizes and prioritizes.

**Outreach Requirements**

There are several important requirements related to CWICs conducting outreach activity that are covered in detail in Module 2. In summary, these include:

- Limiting outreach activity to 10 percent of work effort and expenditures;
- Including the Ticket to Work Help Line (TtW Help Line) contact information as the primary contact for beneficiaries on websites, in brochures, and within presentations to the greatest extent possible consistent with the WIPA business model; and
- Submitting all marketing or public information materials used in outreach activity to Social Security for review and approval.

**Service Priorities**

Social Security also provides direction on which beneficiaries they view as the highest priority for WIPA services. CWICs are required to prioritize WIPA services to beneficiaries who are employed or actively pursuing employment as described in Unit 1 of Module 6. In addition, Social Security has instructed CWICs to spend the bulk of their time in delivering individualized, intensive work incentives counseling to high-priority beneficiaries as opposed to providing generic, short-term information and referral services to beneficiaries who are a lower priority. Starting with contract year 2016 and subsequent years, Social Security requires projects to limit I&R services to 10 percent of their total effort. For an in-depth discussion of these requirements, refer to Unit 2 of Module 6.

**Collaborative Relationships**

As described in Module 1, Social Security views WIPA services as an essential component within a larger collaborative effort to promote employment among disability beneficiaries. As part of the collaboration
and coordination requirements for the WIPA program, Social Security expects CWICs to develop functional working relationships with the local Social Security offices, AWICs, and PASS cadre staff. Social Security also requires CWICs to become familiar with the Employment Networks (ENs) and refer beneficiaries as appropriate to the Protection & Advocacy agency within their service area. Social Security expects CWICs to work cooperatively with federal, state, local, and private agencies, and other organizations that serve beneficiaries with disabilities seeking employment.

**Other WIPA Service Requirements**

Finally, Social Security has specific expectations in several additional areas:

- WIPA projects are required to provide WIPA services that accommodate disability and respect cultural differences. This topic is covered fully in Unit 3 of this module.

- WIPA project staff shall maintain the highest ethical standards in their dealings with Social Security’s beneficiaries. This includes avoiding all potential conflicts of interest. This manual discusses ethical standards for CWICs at length in Unit 4 of this module.

**Compliance with Social Security’s Policy on Confidentiality and Privacy**

WIPA projects must collect and report beneficiary data as required by Social Security. This data is for evaluation, program performance, and statistical purposes only. CWICs must keep all beneficiary information strictly confidential at all times. Social Security requires CWICs to abide by the following policies:

- WIPA projects may not maintain beneficiary Personally Identifiable Information (PII) in any data collection system other than systems Social Security specifies. It’s important to understand what Social Security means by the terms “Personally Identifiable Information (PII)”, and “data system”. PII is a beneficiary’s name, address, phone number, Social Security Number (SSN), or any information, or combination of
pieces of information that could identify a person. Protecting PII has always been a Social Security priority, but it is especially critical in today’s electronic environment. Similarly, it is important to understand that storing information in a data system or any electronic media that may be vulnerable to hacking is just as risky as leaving a file open where people can see it. Social Security does not permit WIPA projects to use online data systems that the agency did not approve simply because they may be vulnerable to attack. Social Security requires WIPA projects to be very careful to store any electronic information only on the encrypted storage devices Social Security provides, in hard-copy in locked file cabinets, or, in any approved, secure systems Social Security provides for WIPA use. Social Security also requires the following:

- CWICs may not send PII via email unless it is in a password-protected, encrypted attachment;
- WIPA staff must not include the password in the same email with the attachment. Instead, send it in a separate email, or call the beneficiary with the password.
- WIPA staff should never send PII in the body of an email. Make sure beneficiary data contained in paper files is only available to project personnel.
- WIPA staff must keep files and encrypted storage devices in locked file cabinets when not in use.
- WIPA projects may only release personal information when a beneficiary signs a release of information form that identifies an individual or an organization with whom to share it and the personal data to be shared. WIPA projects must carefully consider the extent of information they release and should limit the release to only what is necessary to provide knowledge about work incentive options available to the beneficiary.
- WIPA projects may only release information that they generate such as BS&A reports, WIPs, intake interviews, or case notes. The exception is when a release specifies the entity responsible for the data. WIPA projects may only share information with entities that the beneficiary has given specific, written
authorization for release of information. They must remove all PII, such as the beneficiary’s full name or SSN, before sending.

- Reports should include only identifying information that is absolutely necessary to provide quality services. Beneficiaries or their legal guardians can view the WIPA file at any time. In addition, they have the right to make copies of all documents in the file and release that information to another agency at their own discretion.

- Social Security requires all WIPA personnel providing services, and anyone within the organization listed on the WIPA cooperative agreement with access to beneficiary data to successfully complete a Social Security suitability clearance. New staff, without exception, may not access information through the WIPA data system until they successfully complete the suitability clearance process. WIPA personnel should direct questions about specific strategies to protect information to the Social Security Office of Employment Support (OES) Project Officer.

An attachment to the WIPA Terms and Conditions detailing all responsibilities regarding PII is provided at the end of this unit.

**Conclusion**

WIPA projects operate under a cooperative agreement with Social Security. As the primary funding and administering agency, Social Security is responsible for outlining the quality assurance requirements. Compliance with minimum requirements is only the first step in the quality assurance process. High-quality WIPA services require much more effort than just meeting these basic standards.

**Conducting Independent Research**

Consent for Release of Information - Form SSA-3288 (7-2013)
Effective (7-2013): [socialsecurity.gov](https://www.socialsecurity.gov/forms/ssa-3288.pdf)
GRANTEE RESPONSIBILITIES REGARDING PERSONALLY IDENTIFIABLE INFORMATION (PII)

The following award condition shall be followed for the Work Incentive Planning and Assistance (WIPA) program.

1. Definition of Personally Identifiable Information (PII).

SSA follows the definition of PII provided by the Office of Management and Budget in OMB Memorandum M-06-19:
“Personally Identifiable Information means any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, social security number, date and place of birth, mother’s maiden name, biometric records, etc., including any other personal information which is linked or linkable to an individual.”

Other examples of PII may include: Social Security benefit data, date of birth, official State or government issued driver’s license or identification number, alien registration number, government passport number, employer or taxpayer identification number, home address, and medical information. Within this clause, “PII” shall specifically mean PII as defined above that: (1) the Government has a primary responsibility for protecting under this grant/cooperative agreement and (2) is made available to the grantee and/or any grantee subcontractor, including their respective employees, in order to perform under this grant/cooperative agreement (e.g., under the grant/cooperative agreement, the Government directly furnishes PII to the grantee/grantee subcontractor, or the grantee/grantee subcontractor, on behalf of SSA, collects PII from outside sources, such as in a public survey).
2. Applicability. This award condition applies to all grantee employees and grantee subcontractors in either of the following two situations:

   a) The grantee/grantee subcontractor is furnished PII by the Government under this Grant/Cooperative Agreement, or

   b) The grantee/grantee subcontractor collects PII while carrying out project responsibilities under this Grant/Cooperative Agreement.

Wherever grantee employees are referenced in this award condition it also applies to grantee subcontractors at any tier.

3. Grantee Employee Responsibility in Safeguarding PII.

   a) General. The grantee shall take reasonable measures to ensure that its employees properly safeguard PII from loss, theft or inadvertent disclosure for PII either: 1. furnished by the Government under this Grant/Cooperative Agreement, or 2. collected while carrying out project responsibilities under this Grant/Cooperative Agreement. The grantee shall make every reasonable effort to ensure that its employees understand that they are responsible for safeguarding this information at all times, regardless of whether or not the grantee employee is at his or her regular duty station. Examples of proper actions include, but are not limited to: not sharing one’s password with others or writing it down, verifying the identity of individuals before disclosing information to them, preventing others in the area from viewing PII on one’s computer screen, consistently locking or logging off one’s workstation when one is away, and ensuring that PII is appropriately returned or upon Government permission, destroyed when no longer needed. The applicable Federal records retention regulations provide guidance concerning this topic.

   b) Transporting Information Outside a Secure Area. The grantee shall take reasonable measures to ensure that its employees make every reasonable effort to safeguard equipment, files or documents containing PII when transporting information from a secure area. The grantee employee should ensure that laptops and other electronic devices/media are encrypted and/or password protected. The grantee employee must use
common sense when transporting PII, e.g., storing files in a locked briefcase, not leaving files and/or equipment in plain view.

c) Emailing PII. PII about an individual in electronic form must be protected to the extent that a paper record is protected under the Privacy Act of 1974. Protected citizen and programmatic information may be transmitted via email for official business purposes only. The grantee shall make every reasonable effort to ensure that, when sending email containing PII (either in the body or in an attachment), its employees do so only by secure methods, which encrypt the message and comply with SSA policy and procedure. In order to ensure security of the Agency's information, the Agency requires all employees to adhere to the following requirements:

- Sensitive data that is to be transmitted in either direction beyond the SSA Network, (i.e., external to the firewall) must be encrypted or otherwise protected as approved by SSA's Chief Information Security Officer (CISO).

- Media that contains sensitive data that is transported or stored off site must be encrypted or otherwise protected as approved by CISO. This includes but is not limited to PCs, PDAs, USB flash drives, CDs, DVDs, floppies or tapes containing sensitive information.

- Encryption-related information (such as keys) must be secured when unattended or not in use.

- Unauthorized decryption of encrypted information is strictly prohibited.

- The encryption method employed must meet acceptable standards designated by the National Institute of Standards and Technology (NIST). The recommended encryption method to secure data in transport for use by SSA is the Advanced Encryption Standard (AES) or triple DES (DES3) if AES is unavailable. Those considering the use of other algorithms must submit them with a request for exception to the SSA Office of Systems Security Operations Management (OSSOM). Email addresses not considered acceptably secure by SSA shall not
contain PII in the body of the message or in an unencrypted attachment.

4. Procedures for all grantee employees for reporting the loss or suspected loss of PII.

The grantee shall make every reasonable effort to ensure that its employees working under this Grant/Cooperative Agreement follow the following procedures for reporting lost or possibly lost PII that was in their possession at the time:

a) When a grantee employee becomes aware of the possible or suspected loss of PII, he/she shall have an employee of the awarded grantee organization provide immediate notification of the incident to the primary Government manager contact person specified by the SSA Grants Management Office. Examples of incidences indicating possible or suspected loss of PII include missing equipment (including laptops, and removable storage devices such as USB flash or “thumb” drives, CDs, DVDs, etc.) and/or paper documents potentially containing PII.

b) If the primary Government manager is not readily available, the grantee employee shall immediately notify, depending upon availability, one of two Government alternates designated by the primary Government manager for reporting such incidents. Prior to commencing work on the Grant/Cooperative Agreement, each grantee employee shall know who the primary and alternate Government contacts are and how to contact them. Whenever the grantee employee removes PII from the Government facility or is collecting PII under this Grant/Cooperative Agreement away from the Government facility, he/she must have current contact information for the primary Government manager and the two alternates.

Table description: Primary Government manager and two alternates contact information

<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
<th>Email Address</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gov't Manager</td>
<td>Kevin Muniz</td>
<td><a href="mailto:Kevin.Muniz@ssa.gov">Kevin.Muniz@ssa.gov</a></td>
<td>410-966-3297</td>
</tr>
<tr>
<td>Alternate 1</td>
<td>Audrey Adams</td>
<td><a href="mailto:Audrey.Adams@ssa.gov">Audrey.Adams@ssa.gov</a></td>
<td>410-965-9469</td>
</tr>
</tbody>
</table>
c) The grantee employee shall provide updates as they become available to the primary Government manager or the alternate, as applicable, but shall not delay the initial report.

d) The grantee employee shall provide complete and accurate information about the details of the possible PII loss to assist the Government manager/alternate. The grantee employee shall include the following information:

I. Contact information.

II. A description of the loss or suspected loss (i.e., nature of loss, scope, number of files or records, type of equipment or media, etc.) including the approximate time and location.

III. What safeguards were used, where applicable (e.g., locked briefcase, redacted personal information, password protected, encrypted, etc.).

IV. Which SSA components have been involved or affected.

V. Whether any external organizations (i.e., other agencies, law enforcement, press, etc.) have been contacted or contacted the grantee employee.

VI. Whether any other reports have been filed (i.e., Federal Protective Service, local police, and SSA reports).

VII. Any other pertinent information. The grantee employee shall use the worksheet (or copy thereof), as amended, following this award condition to quickly gather and organize information about the incident.

e) Once the grantee has notified the primary Government manager or his/her alternate, that manager or alternate will assume responsibility for making the formal report in accordance with Agency procedures.

f) There may be rare instances outside of business hours when the Grant/Cooperative Agreement employee is unable to reach
either the primary Government manager or any of the alternates immediately. In such a situation, the grantee employee shall call SSA’s National Network Service Center (NNSC) toll free at 1-877-697-4889. The grantee employee shall document the call with the CAPRS (Change, Asset, and Problem Reporting System) number that the NNSC will assign. He/she shall retain this number and provide it to the primary Government manager, or, if unavailable, one of the alternates to this manager as described above for later contacts with the NNSC when additional or updated information on the incident becomes available.

g) The grantee employee shall limit disclosure of the information and details about an incident to only those with a need to know. The PII reporting process will ensure that Government’s reporting requirements are met and that incident information is only shared as appropriate.

5. The grantee shall include this award condition in all resulting subcontracts whenever there is any indication that the subcontractor engaged by the grantee and their employees or successor subcontractor(s) and their employees will or might have access to PII furnished by the Government or collected while carrying out project responsibilities under this Grant/Cooperative Agreement.

6. The grantee shall ensure that its subcontractor(s) and their employees or any successor subcontractor(s) and their employees with access to PII furnished by the Government or collected while carrying out project responsibilities under this Grant/Cooperative Agreement know the rules of conduct in protecting and reporting the loss or suspected loss of PII as prescribed in this award condition.

7. Confidentiality of Information:

   a) Confidential information, as used in this award condition, means personally identifiable information or data of a personal nature about an individual, such as name, home address, and social security number, or proprietary information or data submitted by or pertaining to an institution or organization, such as employee pay scales and indirect cost rates.
b) The grantee/grantee subcontractor must not disclose any confidential information, as defined in paragraph 7.a. of this award condition, without the prior written consent of the individual, institution, or organization.

8. For knowingly disclosing information in violation of the Privacy Act, the grantee and grantee employees may be subject to the criminal penalties as set forth in 5 U.S.C. Section 552(i)(1) to the same extent as employees of the Social Security Administration. For knowingly disclosing confidential information as described in section 1106 of the Social Security Act (42 U.S.C. 1306), the grantee and grantee employees may be subject to the criminal penalties as set forth in that provision.

9. The grantee shall ensure that each grantee employee with access to confidential information knows the prescribed rules of conduct, and that each grantee employee is aware that he/she may be subject to criminal penalties for violations of the Privacy Act and/or the Social Security Act.

10. Performance of this Grant/Cooperative Agreement may involve access to tax return information as defined in 26 U.S.C. Section 6103(b) of the Internal Revenue Code (IRC). All such information shall be confidential and may not be disclosed without the written permission of the Social Security Administration Grants Officer. For willfully disclosing confidential tax return information in violation of the IRC, the grantee and grantee employees may be subject to the criminal penalties set forth in 26 U.S.C. Section 7213.

11. The Government reserves the right to conduct on-site visits to review the grantee’s documentation and in-house procedures for protection of confidential information.
Competency Unit 2 – Providing WIPA Services with a Focus on Quality

Introduction

When we talk about “quality” in the context of WIPA services, we mean a measure of excellence or a state of being as free as humanly possible from mistakes, deficiencies, and significant variations in work incentives counseling. CWICs deliver high-quality WIPA services by strict and consistent commitment to standards. Quite simply, it’s doing the right things, in the right way, to the best of your ability.

Providing excellent WIPA services is something CWICs should strive for every day during each interaction with beneficiaries and other stakeholders. This unit will help you understand the competencies you need to provide quality services.

Quality Assurance for CWICs – Understanding the CWIC Core Competencies

It’s worth repeating that quality, from a CWICs perspective, is doing the right things, in the right way, as much as humanly possible. The question then becomes, what are those right things, and what exactly is the right way to do them? Social Security provides helpful direction in this area by establishing a standard set of core competencies that they expect all CWICs to master. These competencies define high-quality WIPA services and drive all of the training and technical assistance provided to CWICs. A CWIC who delivers services in alignment with the standard core competencies will meet Social Security’s quality requirements.

Competency Areas

The CWIC core competencies are grouped into seven main categories that correspond with the modules in this manual. Those areas are:
1. Supporting Increased Employment and Financial Independence Outcomes for Social Security Beneficiaries

2. Partnering with Social Security and Community Agencies to Conduct Community Outreach

3. Understanding Social Security Disability Benefits and Associated Work Incentives

4. Healthcare Planning and Counseling

5. Understanding Other Federal Benefits and Associated Work Incentives

6. Providing Effective WIPA Services that Promote Employment and Increase Financial Independence

7. Understanding WIPA Standards, Data Collection Requirements, and Quality Considerations for CWICs

Within each of these seven areas, there are very specific performance standards or competencies for which Social Security holds CWICs accountable. These competencies are listed at the beginning of each module in this manual.

**Building the Quality of your Work**

CWICs can build the quality of their daily work by taking three simple steps:

1. **Make quality a priority:** To really be good at your job, you have to believe that it’s important to deliver high-quality services. You have to WANT to do the right things, in the right way, as much as humanly possible. Excellence and accuracy must be your goal every time you interact with a beneficiary.

2. **Seek honest evaluation of your work, and be willing to accept feedback:** In order to build the quality of your work, you have to recognize you need to improve. It takes maturity and honesty to go through this type of evaluation. CWICs have several avenues for getting constructive feedback, which include WIPA Project Managers, co-workers with advanced experience and skills,
and VCU NTDC Technical Assistance Liaisons. CWICs who want to improve must actively seek out feedback and be willing to listen to and act on criticism.

3. **Access the training and technical support you need to build competence:** Social Security provides CWICs with an incredible amount of training and technical support through their contract with VCU’s NTDC as well as support provided by the Project Officers at OES. A CWIC who is motivated to build competence has a great many resources at his or her disposal including live teleconference training, archived training, scores of resource documents and tools, independent research using the POMS, and individualized technical assistance provided by phone or email. CWICs who consistently avail themselves of training and technical support develop the knowledge base and counseling skills necessary to deliver excellent WIPA services.

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**Conclusion**

Your responsibility for providing high-quality WIPA services is something you must take very seriously. This is because providing incomplete or incorrect information can cause real harm to beneficiaries. In order to provide excellent WIPA services, you must focus on developing full competency in the seven key areas we have described throughout this manual. If you invest your time and energy in building competency, you will meet Social Security’s expectations for quality.
Competency Unit 3 – Providing WIPA Services that Accommodate Disability and Respect Cultural Differences

Introduction

Social Security requires WIPA projects to provide services that are fully accessible and usable to all eligible population groups. This includes the many disability groups, as well as groups with cultural and linguistic differences. The 2019 WIPA Terms and Conditions document states the following:

“WIPA grantees must have accessible facilities, materials, meeting places, and communication. This includes ensuring physical, transportation, language, and material access to all beneficiaries in their service area. WIPAs shall be mindful of the following:

- Monitoring and modifying physical access to barrier-free offices and meeting places;
- Availability of offices in locations with access to public transportation;
- Distance communication methods accessible to individuals requiring adaptive technology;
- Creating websites and other electronic information and communication options that meet or exceed compliance with Section 508 of the Rehabilitation Act;
- Providing materials in alternate media such as Braille, large print, or other electronic formats;
- Providing services and publications in alternate languages including sign language; and
- Providing services and publications in languages that reflect the demographic distribution of the service area.”

Clearly, Social Security expects WIPA projects to find ways to attract and accommodate ALL beneficiaries who are eligible for WIPA services. This unit examines the many responsibilities WIPA projects have in this regard and provides clear strategies for meeting accommodation requirements.
A Word about Disability Awareness and Cultural Sensitivity

CWICs encounter individuals from the broadest spectrum of American society in the performance of their duties. As a CWIC, you need to have an understanding of the various disabilities and must also demonstrate respect for diverse ethnic, cultural, and linguistic traditions. It’s virtually impossible to serve such a wide beneficiary base in an inclusive manner without formal training.

Given that the subject matter is far too broad to be covered in the initial CWIC training, WIPA projects will need to find training in these areas from sources outside of the VCU NTDC. There are many affordable sources for this training, including classroom-based training and Internet-based courses. WIPA Project Managers are encouraged to research available options and to make arrangements for all staff to receive this training.

Performing Outreach Activities that Accommodate Disability and Respect Differences in Culture and Language

If WIPA projects hope to serve all of the diverse subgroups within the larger Social Security disability beneficiary population, they'll need to make a concerted effort to connect with these groups through targeted outreach activities.

Tips for Conducting Outreach to Disability and Cultural Subgroups

- You need to have a solid understanding of the local communities you serve in terms of ethnic and cultural subgroups that may exist. Similarly, you need to be aware of the local agencies that serve hard-to-reach or low-incidence disability groups. Invest the time necessary to get to know your local service area so that you don’t ignore disability and cultural subgroups.
• Disability and cultural subgroups are hard to reach when communication or transportation barriers exist. This means that you must make notices of outreach activities and other marketing information available in alternate formats or in different languages. You must make this information readily available in the neighborhoods where the target population lives, works, and shops. Whenever possible, you should hold outreach activities within the local neighborhoods and at times when you could expect members of the targeted group to attend.

• You must establish relationships with leaders within isolated communities to help spread the word about the value of WIPA services. These leaders will vary depending on the community, but could include religious leaders, elected officials, community leaders, prominent business people, teachers, or respected service providers.

• You need to make a concerted effort to understand cultural traditions or values. This may affect how you organize outreach activities and provide WIPA services. If outreach activities reflect an understanding and accommodation of cultural traditions, beneficiaries within that culture will be more likely to participate.

• When WIPA projects organize outreach events to target a specific disability or ethnic group, it’s important to be prepared to communicate with attendees. This means that enough interpreters must be on site. If a local area has a large population that speaks another language or requires some other communication accommodation, the WIPA project should make an effort to hire bilingual staff.

• WIPA projects need to make sure all outreach activity occurs in facilities that are fully accessible for individuals with mobility limitations or sensory impairments such as blindness. Project personnel should visit facilities prior to the outreach event, and a qualified individual should thoroughly assess accessibility.

• You can arrange accessibility reviews by contacting the local Center for Independent Living or State VR agency.
• You should have a selection of informational materials in alternate formats or languages on hand at outreach events targeted toward hard-to-reach groups. Make sure WIPA project contact information is available in an understandable format for ALL beneficiaries.

Providing Accessible Outreach Presentations

If the outreach activity involves making a presentation to an audience, there are some additional considerations to take into account. The following tips come from “Disability Etiquette – Tips for Speaking Engagements” by Beth Loy, Ph.D., a document that is available from the Job Accommodation Network at dms.myflorida.com (https://www.dms.myflorida.com/content/download/129860/806892/Disability_Etiquette_Tips_for_Speaking_Engagements.pdf):

• When talking to a person with a disability, look at and speak directly to that person, rather than through a companion or attendant.

• When referring to a person with a disability, make reference to the person first, then the disability. Use “people first” terminology such as “a person with a disability” rather than a “disabled person.”

• To accommodate individuals with learning disabilities and vision impairments when using presentation slides, be sure to explain what is on the slide. Highlight points and convey enough information to describe pictures to someone who has no vision. Also, provide information in several types of alternative formats (tapes, Braille, CD). Watch for inadequate lighting that inhibits communication by people who have hearing and learning limitations.

• Don’t touch a service animal, or the person the animal assists, without permission. Noises may distract the animal from doing his or her job, and feeding the service animal may disrupt the animal’s schedule.

• Listen attentively when talking with a person who has a speaking impairment. Keep your manner encouraging rather than correcting. Exercising patience rather than attempting to speak for a person may be helpful. When necessary, ask short
questions that require short answers or a nod or a shake of the head. Never pretend to understand if you are having difficulty doing so.

- To get the attention of a person with a hearing impairment, tap the person on the shoulder or wave your hand. Look directly at the person, and speak clearly, naturally, and slowly to establish if the person can read lips. Not all individuals with hearing impairments can lip-read. Those who can will rely on facial expressions and other body language to help in understanding.

- Show consideration by placing yourself facing the light source and keeping your hands away from your mouth when speaking. Shouting probably won’t help, but written notes may. To facilitate conversation, be prepared to offer a visual cue to someone with a hearing impairment or an audible cue to someone with a visual impairment, especially when more than one person is speaking.

- When talking with a person who uses a wheelchair or scooter for more than a few minutes, use a chair whenever possible in order to place yourself at the person’s eye level. This facilitates conversation. Don’t move a wheelchair, crutches, or other mobility aid out of reach of a person who uses them. Also, don’t push a mobility aid without first asking the occupant if you may do so, lean on a person’s mobility aid when talking, or pat a person who uses a wheelchair or scooter on the head. Make sure that audiovisual equipment doesn’t block the view of people who use accessible seating. Clearing the aisles of excess debris for the use of mobility aids may be useful. Be alert to the possible existence of architectural barriers.

When in doubt about the best way to accommodate the needs and preferences of any particular beneficiary group, ask members of this group for advice. WIPA projects need to be prepared to receive constructive criticism and make every reasonable effort to implement the suggestions offered.
Ensuring Access to WIPA Services

For those of us who haven’t experienced a disability, it’s sometimes difficult to recognize or understand all of the barriers people with disabilities face just accessing services in the community on a day-to-day basis. The word “accessibility” has many meanings when we apply it to individuals with disabilities.

Physical Accessibility and Universal Design

Perhaps the most common usage of the word “accessibility” refers to physical accessibility of facilities where services are provided. When applied to facilities, the word “accessible” refers to spaces that are free from architectural barriers. Architectural barriers are physical features that limit or prevent people with disabilities from obtaining the goods or services that are offered. These barriers can include parking spaces that are too narrow to accommodate people who use wheelchairs; steps at the entrance or to part of the selling space of a store; round doorknobs or door hardware that is difficult to grasp; aisles that are too narrow for a person using a wheelchair, electric scooter, or a walker; a high counter or narrow checkout aisles at a cash register; and fixed tables in eating areas that are too low to accommodate a person using a wheelchair or that have fixed seats that prevent a person using a wheelchair from pulling under the table.

The key to making WIPA services physically accessible is to follow the rules of “universal design.” This simply means that the physical layout or design of buildings or spaces is usable by anyone and everyone — no matter what! For WIPA Project Managers who are unsure whether their location is truly accessible to all beneficiaries regardless of disability type, a great place to start is by having an accessibility review that identifies the aspects of the buildings, physical environment, and surrounding areas that might pose barriers.

Getting Help with Accessibility

To learn more about universal design and how to make changes to better accommodate beneficiaries with disabilities, contact the nearest Center for Independent Living (CIL) or your State Independent Living Council. If there is no designated independent living agency in your area, ask for assistance from the State Vocational Rehabilitation agency. You can also obtain assistance from the regional ADA Technical Assistance Center. The
National Institute on Disability and Rehabilitation Research (NIDRR) has established 10 regional centers to provide information, training, and technical assistance to employers, people with disabilities, and other entities with responsibilities under the ADA. The centers act as a “one-stop” central, comprehensive resource on ADA issues in employment, public services, public accommodations, and communications. Each center works closely with local business, disability, governmental, rehabilitation, and other professional networks to provide ADA information and assistance. Programs vary in each region, but all centers provide the following:

- Technical assistance
- Education and training
- Materials dissemination
- Information and referral
- Public awareness
- Local capacity building

In addition to ADA services, the centers assist individuals and entities in better understanding related disability legislation that may affect their rights or responsibilities. The centers can typically provide information on the Rehabilitation Act, the Family Medical Leave Act, the Workforce Innovation and Opportunity Act (WIOA), and others. To find the center that serves your area, visit [adata.org](https://adata.org/).

**Overcoming Communication Barriers**

Accessibility also refers to having referral, intake, and interview processes that don’t pose barriers to people who experience disabilities or those who may not speak or understand English. In some cases, it may mean arranging for an interpreter to help beneficiaries for whom English is a second language. In addition, some beneficiaries who have hearing or speech disabilities may need to communicate with WIPA personnel without using speech. The method of communication will vary depending upon the abilities of the beneficiaries and on the complexity of the required communications. For example, some people who are deaf are able to use speech but are unable to understand words spoken by others, while other people who are deaf aren’t able to communicate with speech. People with speech or hearing disabilities may require extra time to complete their message or extra attention by staff to understand what is being said. When communication by speech isn’t possible, simple questions, such as the type of benefits received, you may handle with
pen and paper by exchanging written notes or a mixture of speech and written notes. Staff should be aware of the need to use notes or both speech and communication with pen and paper. It’s appropriate to ask the beneficiary what he or she prefers for simple communication.

**Interpreting Services**

When you need more complex or lengthy communications (such as when you are explaining the effect of work upon disability benefits), generally, you’ll need to provide a sign language interpreter. It’s important to understand what you are required to do in order to comply with the Americans with Disabilities Act (ADA) when serving beneficiaries with disabilities. Under the ADA, you must provide effective communication when providing public services. The ADA doesn’t specifically state that you must offer an interpreter as the method of providing effective communication; however, it’s important to assess when an interpreter is the appropriate choice for accommodation. WIPA projects need to know where to access sign language interpreter services and need to budget sufficient funds to pay for this necessary expense. You can find information on how to locate interpreter services at [myaccount.rid.org](https://myaccount.rid.org/Public/Search/Interpreter.aspx).

Some people who are deaf or hard of hearing or who have speech disabilities use a TTY instead of a standard telephone. This device has a keyboard for entering messages and a visual display to view the content of a conversation from another person using a TTY. To make it easy for people who use a TTY to communicate with businesses and individuals who don’t have a TTY, the ADA established a free state-by-state relay network nationwide that handles voice-to-TTY and TTY-to-voice calls. Beneficiaries who use a TTY to make telephone calls may telephone your business using a relay network. The relay consists of an operator with a TTY who translates TTY and voice messages. For example, a caller using a TTY calls the relay operator who then calls your business. The caller types the message into the TTY and the operator reads the message to you. The person being called responds by talking to the operator, who then enters your message into the TTY.

Many individuals who use American Sign Language (ASL) use Video Relay Service (VRS) to communicate with voice telephone users through video equipment, rather than through typed text. Video relay calls are made using a high-speed or broadband Internet connection (i.e., DSL, cable, or T1 line) and a videophone connected to a TV, or through a personal
computer equipped with a Web camera and video relay software. The person who is deaf signs to a video interpreter, who then communicates with a hearing person via a standard phone line by relaying the conversation between the two parties. For information, visit Video Relay Services FCC Consumer Facts found at fcc.gov (http://www.fcc.gov/cgb/consumerfacts/videorelay.html).

When working with beneficiaries who don’t speak English, WIPA projects have several options. First, Social Security encourages WIPA projects to hire multilingual CWICs when needed. This may be particularly useful for areas with high concentrations of people who speak a certain language — in particular, Spanish. Another option is to locate and contract with local English interpreter services. WIPA projects should investigate the providers of such services in their local area and be prepared to contract for services as needed. Finally, there are several national companies that provide telephone interpreting services for a wide variety of languages. These services charge fees for their services at varying rates. One service WIPA projects have used successfully is the Language Line. More information can be found at languageline.com (http://www.languageline.com/).

❖ Written Information

Finally, providing written information is a common part of WIPA services, because it’s important for beneficiaries to have something to refer back to when questions arise. WIPA personnel need to remember that not all beneficiaries will be able to use standard written information due to visual impairments, or when English is their second language. In these cases, it’s necessary to provide the written materials in alternate formats, which may include translations into another language, providing materials in large type or in electronic formats, or even converting materials into Braille. Most Social Security publications are already available in Spanish and in audio format, and in some cases, these materials are in Braille. Social Security publications are available online at ssa.gov (http://www.ssa.gov/pubs/).

CWICs may need to convert written materials to another language before sharing them with the beneficiary. A good practice is to ask all beneficiaries how they prefer to receive written materials. The costs of providing alternate formats to beneficiaries is the WIPA project’s responsibility, and is essential to providing WIPA services. WIPA projects may not charge beneficiaries fees for any portion of WIPA services.
Supporting Beneficiaries to Successfully Participate in WIPA Services

CWICs work with a wide range of beneficiaries when they provide WIPA services, and some individuals will need more support than others to fully benefit from this service. The information you provide to beneficiaries about the effect of paid employment on Social Security benefits and other income support programs can be terribly complex and confusing. The nature of the individual’s disability can further complicate this fact, particularly when an intellectual or emotional impairment exists.

Individuals with intellectual impairments may require significant support to understand the effect that work will have upon benefits. Many beneficiaries with intellectual impairments will have Social Security-appointed representative payees who help them manage their Social Security benefits, or even may have legal guardians appointed by a court of law. In other cases, these beneficiaries will have significant involvement with disability services organizations and may have a designated case manager or services coordinator who assists with financial issues. You’ll need to coordinate your planning and counseling services with these support providers to make sure that a responsible party is serving the beneficiary’s interests and noting the critical information. There will be times when a beneficiary with an intellectual impairment has no support to rely upon when it comes to financial matters. Accommodate this by keeping your explanations short and focused on the most critical points. You may need to repeat the most essential points over numerous meetings or conversations. If you feel that the beneficiary is at risk due to lack of support with financial matters, then you may need to provide counseling about arranging for a representative payee.

Additionally, individuals with psychiatric impairments may require special accommodation in order to benefit from WIPA services. In some cases, beneficiaries with mental illness may experience periods of time when the symptoms of their illness increase. This may cause problems with keeping appointments or make it more difficult for you to communicate clearly with the individual. In other cases, the mental illness may cause the beneficiary to become distraught or upset over minor benefit issues, or to be unable to focus on the work incentives advice you are offering. The best course of action in these cases is to be patient and to slow down
the pace of the planning and counseling services you provide. There may even be times when you should advise the beneficiary to contact a mental health professional for assistance.

When in doubt, the best strategy for dealing with any individual difference caused by disabilities is to ask the beneficiary what accommodations he or she feels will be necessary or prefers. You might be surprised at how readily beneficiaries respond to such questions and how much they know about accommodating their own disability. In some cases, individuals with disabilities will have significant involvement with agencies that provide disability services and supports. Working in partnership with these agencies is critical for success over time. Disability professionals are also an excellent source of information about how to accommodate and support people with various disabling conditions. WIPA projects may want to seek training from agencies in order to work more effectively with individuals who have specific disabilities.

**Conclusion**

Providing WIPA services that fully accommodate disabilities and respect cultural differences is a core requirement of WIPA projects imposed by both federal law as well as the Cooperative Agreements WIPA projects hold with the Social Security Administration. WIPA Project Managers must actively make sure that WIPA services are fully accessible to ALL Social Security disability beneficiaries. Promoting employment and enhancing financial stability for Social Security disability beneficiaries is a goal for ALL eligible beneficiaries, not just those who are easiest to connect with and serve. WIPA services must be fully inclusive in order to meet this goal for the entire spectrum of individuals receiving disability benefits from Social Security.
Competency Unit 4 – Professional Ethics for CWICs

Ethics as a Quality Issue

Professional ethics are at the core of all human service professions. As in all counseling fields, work incentives planning and assistance involves helping vulnerable people with critical and sensitive life issues. CWICs face numerous situations in their daily work requiring a high degree of discretion, judgment, maturity, and the ability to balance competing interests. It isn’t enough for CWICs to understand how paid employment affects the various benefits. CWICs must also uphold stringent ethical standards in performing their job duties by applying the information contained in this manual in a morally responsible and ethical manner.

The ethical guidelines presented in this unit represent a set of standards of conduct that WIPA personnel must consider in their daily work and when difficult ethical dilemmas challenge them. The purpose of this code of ethics is to:

- Define acceptable behavior for CWICs and their managers;
- Promote high standards of practice;
- Establish a framework for professional CWIC behavior and responsibilities; and
- Provide a benchmark for WIPA personnel to use for self-evaluation.

Simply developing a written code of ethics doesn’t guarantee ethical behavior. Moreover, a code of ethics won’t resolve all ethical disputes or capture the complexity involved in striving to make responsible choices. Rather, a code of ethics sets forth broad values, principles, and standards. WIPA staff should strive to meet those standards, and WIPA management should create policies and provide oversight that supports those standards.
A Code of Ethics for CWICs

These five ethical principles form a unique code of ethics for WIPA services.

**Principle 1: Treating Beneficiaries with Dignity and Respect**

CWICs are required to treat each beneficiary in a caring and courteous manner. This includes the following practices:

**Accommodating Individual Differences:** You must view each person you serve as an individual and not merely as a member of a disability group. Beneficiaries have unique interests and goals and require benefits counseling based on those personal preferences. CWICs must not deliver WIPA services in a “one size fits all” manner. CWICs should take a customized approach to work incentives planning and assistance and provide accurate and complete information to allow beneficiaries to take the “next step” toward their employment goal.

**Supporting Beneficiary Empowerment and Choice:** Sound WIPA practices provide beneficiaries with the information necessary to make fully informed choices about employment. CWICs should also explain why one course of action might be preferable to another by comparing the costs and benefits of various options. It’s important to remember, however, that the ultimate decision belongs to the beneficiary. CWICs should encourage beneficiaries to make choices about work that are in the best interests of the individual; CWICs should not impose their own opinions.

**Maintaining a Non-Judgmental Approach:** While CWICs may offer advice based upon their benefits expertise, it’s inappropriate to express judgments about a beneficiary’s choices. CWICs must understand that the WIPA program doesn’t judge individuals who decide not to pursue employment or who opt to work at levels below their capability. Furthermore, the WIPA program doesn’t place a higher value on individuals who earn more, work at higher levels, or work for longer periods. The role of the CWIC is strictly a positive one.
— to encourage, promote, assist, and support forward movement along the employment continuum.

**Protecting Beneficiary Privacy and Confidentiality:** In order to provide effective services, CWICs often must gather a wide range of financial and personal data about the beneficiary. In some cases, this also includes information about the individual’s disability found in medical records. CWICs must keep all WIPA records strictly confidential and you may not disclose them to any external party, intentionally or unintentionally, without express written permission from the beneficiary. Furthermore, CWICs should not discuss confidential information in any public setting unless privacy can be assured. This includes areas such as hallways, waiting rooms, elevators, and restaurants. CWICs must also be careful to ensure the confidentiality of information sent to other parties using computers, electronic mail, facsimile machines, telephones and telephone answering machines, and other electronic or computer technology. Any records, whether in electronic or paper format, must be held strictly confidential available only to authorized WIPA personnel. This means that file cabinets holding paper records must be locked at all times with only authorized persons allowed access. For electronic records, security measures must be in place to prohibit anyone other than authorized individuals from obtaining beneficiary information.

**IMPORTANT:** The 2019 WIPA Cooperative Agreement requires that WIPA grantees protect Personally Identifiable Information (PII) of all beneficiaries served and carefully guard the confidentiality of beneficiary information at all times. WIPA projects are instructed to work with Social Security to establish, implement, and monitor rigorous protocols for security.

**Principle 2: Maintaining Professional Competency**

CWICs are exposed to critical information relating to an individual’s health conditions, personal finances, and health care coverage that can have a profound impact on a beneficiary’s economic and physical well-being. Even a small benefits counseling error can have a disastrous effect on an individual’s ability to pay for food, housing, utilities, or essential medical services. It’s crucial that CWICs recognize the power they wield through the information and advice they offer. In order to provide sound advice
and avoid harming a beneficiary, CWICs must attain and maintain a high level of professional knowledge and skill.

Professional competence also includes the wisdom to recognize the limitations of one’s knowledge. In order to identify areas in which external consultation, referral, or additional training may be necessary, CWICs must conduct a thorough and honest self-assessment of their skills and competencies. Taking personal responsibility for developing professional skills isn’t optional — it’s a requirement to stay current and informed of the latest regulations, payment amounts, and provisions. CWICs have a professional responsibility to know in which competency areas they require support, and must request assistance in those areas.

**IMPORTANT:** Social Security requires CWICs to meet Continuing Certification Credit (CCC) requirements. Certified CWICs must accrue a minimum of 18 CCC to enhance their skills and retain certification each year.

CWICs have many options for learning and developing skills. The WIPA National Training & Data Center (NTDC) at VCU provides self-paced archived training events, Internet-based classes, and short teleconference trainings on an ongoing basis. Many local and national entities involved with Social Security issues also may hold training events or periodic meetings that contain informational and training components. Seek out these resources and use them. A CWIC MUST build in time for continuing education efforts — this isn’t something optional that only applies when there is “down time.”

Finally, CWICs must provide professional services in a courteous, prompt, well planned, and thorough manner. Every transaction with a beneficiary is a reflection of the CWIC’s professional competence. While the demand for WIPA services is high, CWICs still need to return phone calls and respond to email inquiries in a reasonable amount of time. They must treat beneficiaries with respect and work to gain their trust. The information they provide to beneficiaries must be correct, complete, and individualized to meet the beneficiary’s unique set of circumstances.
Principle 3: Serving Beneficiary Interests While Promoting Employment and Enhancing Financial Stability

CWICs must focus on serving the best interests of beneficiaries, but must balance this focus with the primary objective of the WIPA program — promoting employment and enhancing financial stability. In most cases, these two goals work in tandem, but on occasion, they can stand in conflict with one another.

It’s important for CWICs to balance the WIPA emphasis on paid employment with a healthy dose of common sense. There will occasionally be times when working at a certain level or working to the point of benefit termination wouldn’t be in the best interests of the beneficiary. For example, an individual who relies on a Medicaid waiver program to pay for attendant care services would typically not be able to replace this benefit if it were lost due to excess resources or income. Advising a beneficiary to engage in employment that would jeopardize an irreplaceable and possibly life-sustaining benefit would be unethical. It would also be unethical to discourage a beneficiary from working if an alternative existed that might meet the beneficiary’s needs, like a Medicaid buy-in. Failing to explore alternatives, or neglecting to warn a beneficiary when an employment or earnings goal would cause financial harm are also unethical. CWICs have a responsibility to help beneficiaries improve financial well-being through work, while retaining critical services.

While it may not be in the best interests of some individuals to terminate from benefits due to work, this is certainly NOT the case for all beneficiaries, or even most beneficiaries. Terminating from benefits isn’t a universally “bad” thing and isn’t harmful in the majority of cases. CWICs must be careful that they aren’t presenting this outcome in a negative fashion when counseling beneficiaries. In fact, individuals with the capacity to generate earnings sufficient to cause benefits to terminate may be better off financially by doing so — as long as beneficiaries consider all costs of employment and they continue to meet their healthcare needs. The goal is to work with each beneficiary individually to set employment goals that result in the highest earnings potential possible within the framework of those goals. Counseling techniques or messages that discourage beneficiaries from working or frighten them
into retaining attachment to public benefits is contrary to everything the WIPA program is trying to achieve.

Finally, WIPA personnel must remain clear about who the primary beneficiary is. The CWIC’s job is to advocate for what the adult beneficiary desires, not what the parent, representative payee, job coach, residential services provider, vocational rehabilitation counselor, or Social Security claims representative thinks is best. There will be times when it is very difficult to balance the competing desires of all involved parties. The best plan is to always stay focused on the primary recipient of your services (the beneficiary) as well as the primary objective of the WIPA program — providing accurate information to promote employment and increase financial stability!

**Principle 4: Avoiding Conflicts of Interest**

A potential conflict of interest arises any time the CWIC, or his or her employer, has a real or apparent interest that may be at odds with the interests of the beneficiary. This may occur when an agency responsible for determining the beneficiary’s right to a particular benefit employs the CWIC. Another possible conflict might arise when a CWIC has a business relationship with the person at Social Security or another agency responsible for deciding issues related to the beneficiary’s case.

Another potential conflict of interest would exist when the CWIC, or his or her employing company, is in a position to profit from the beneficiary’s work activity and benefit status. This would be the case whenever WIPA services are provided by an approved EN under Social Security’s Ticket to Work program.

Similarly, since Protection and Advocacy for Beneficiaries of Social Security (PABSS) projects may provide advocacy in situations when WIPA services do not meet requirements, Protection and Advocacy organizations housing WIPA projects must also submit a plan to avoid conflicts of interest. Social Security provides very specific direction for avoiding or eliminating conflicts of interest in these cases in the 2019 Terms and Conditions document:

> “WIPA grantees shall submit a written protocol outlining how to prevent or eliminate conflicts of interest for a grantee that houses or administers either a WIPA project and an EN, or both a WIPA project and a (PABSS) project.
a. Within 30 days of this continuation award, organizations that house both a WIPA and an EN must review and provide any updates to their previously approved written protocol containing at minimum all of the following elements:

- Description of the separation of all administrative, budgeting, and direct service duties of the WIPA cooperative agreement and the EN agreement staff and services, including assurances that the same individuals do not serve as employees of both the WIPA and the EN.
- Detailed explanation of how issues will be resolved when a beneficiary, EN, or other service provider lodges a complaint against a CWIC or against the WIPA.
- Assurances that WIPA staff will provide beneficiaries comparable information on all available public and private service providers, including the full complement of ENs in their community.
- Assurances that beneficiaries will not be automatically referred or unduly influenced to assign their tickets to the grantees’s EN.
- Assurances that beneficiaries receiving services from the WIPA will receive advice about all available work incentive programs, even if those programs may delay payments of milestone or outcome payments under the Ticket to Work program for the EN housed within their organization.

Unlike prior iterations of the WIPA program, we will not consider any exceptions to the firewall requirement between a WIPA and an EN. The WIPA must qualify as an autonomous program independent of the sponsoring or parent agency.

**Note:** If, at any time during this award, an entity housing a WIPA elects to enter into an agreement with Social Security so that the recipient organization becomes an EN the WIPA project must submit the statements described above within 30 days of notice of the EN award, and must update them annually, as needed.

b. Within 30 days of this award, Protection and Advocacy (P&A) organizations housing WIPA programs must review and submit any
updates to previously approved protocols containing at minimum the following elements:

- A description of the separation of PABSS client files and WI PA beneficiary files; direct service staff; intake procedures; case management procedures; and complaint processes. Direct service staff includes individuals with one-to-one, ongoing contact with beneficiaries and supervisors with access to case files.

- Projects may exclude in the above description Executive and Administrative staff that do not have direct contact with beneficiaries and do not access WI PA or PABSS case files.

- If projects wish to add staff with direct service responsibilities or staff with access to beneficiary information on both WI PA and PABSS awards, the project shall submit a written request for formal approval to their Project Officer for an exception regarding the separation of direct service personnel. The request should describe why this individual’s service on both awards is necessary and how the P&A organization will ensure that there are no actual or perceived conflicts of interest.”

The best approach is to avoid any real or perceived conflicts when providing WI PA services. In cases where this exists, the CWIC should disclose the potential problem and continue to work with the beneficiary only if he or she agrees despite the conflict. The CWIC should confirm in writing the disclosure and subsequent approval to continue services, to avoid future misunderstandings, and to ensure that both parties are committed to working together.

**Principle 5: Maintaining Personal Integrity**

Beneficiaries and their family members often place CWICs in a position of tremendous trust and confidence. The ultimate source of such trust is the CWIC’s personal integrity. In deciding the proper course of action in any counseling situation, a CWIC must always rely on his or her own internal moral compass or conscience.

While CWICs must pursue beneficiaries’ interests, they must meet this goal within the bounds of what is otherwise legal and ethical. CWICs aren’t expected to pursue the beneficiary’s interests if Social Security’s
(or another government entity’s) laws, regulations, and policies clearly preclude them. Whenever it appears that what the beneficiary wants and what you know is proper are in conflict, you are obligated to make it clear that you cannot pursue an unethical course of action. While CWICs are obligated to inform the beneficiary of actions that are potentially illegal or improper as well as the consequences of pursuing such courses, they may not ethically report confidential information to Social Security or any other agency. If a beneficiary insists on pursuing an improper course of action, it’s best for the CWIC to inform the beneficiary that WIPA services will discontinue. Social Security clearly describes the CWIC’s role in upholding ethical standards in the 2019 Terms and Conditions document:

“WIPA project staff shall maintain the highest ethical standards in their dealings with Social Security’s beneficiaries. This includes, but is not limited to, the right to decline to serve beneficiaries unwilling to report wages, other income, or any changes in beneficiary circumstances that affect the beneficiary’s eligibility or benefit amount.”

CWICs may avoid many ethical dilemmas by planning for such issues in advance and entering into written agreements with beneficiaries at the outset of the counseling relationship. This agreement should spell out the beneficiary’s rights under the CWIC’s code of ethics as well as responsibilities for complying with all applicable Social Security laws, regulations, and policies. Outlining who is responsible for what actions and what your limitations are will also clearly define your relationship with the beneficiary. When a beneficiary knows what he or she can expect from the CWIC and what the CWIC requires of the beneficiary, they can avoid many ethical dilemmas.

**Conclusion**

The CWIC code of ethics presented in this unit offers a set of values, principles, and standards to guide decision-making and conduct when ethical issues arise. It doesn’t provide a precise set of rules that prescribe how CWICs and their managers should act in all situations. Specific applications of the code must take into account the context in which it is being considered and the possibility of conflicts among the code’s values, principles, and standards. Furthermore, the code doesn’t prioritize values, principles, and standards in instances when they conflict
and reasonable differences of opinion can and do exist among WIPA personnel. Therefore, CWICs must use informed judgment in making ethical decisions and consider seeking peer feedback to ensure they apply ethical standards.

Ethical decision-making is a process, not an end in itself. There are many instances where simple answers aren’t available to resolve complex ethical issues. CWICs must continually evaluate the extent to which their work is characterized by ethical principles, and managers must assess staff performance with these principles in mind.

**Conducting Independent Research**

- **The Ethics Resource Center** (http://www.ethics.org/)
- **The International Business Ethics Institute** (http://www.business-ethics.org/)
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<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<td>ABLE</td>
<td>Achieving a Better Life Experience</td>
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<td>AC</td>
<td>Appeals Council</td>
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<td>ACA</td>
<td>Affordable Care Act</td>
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<td>ADA</td>
<td>Americans with Disabilities Act</td>
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<td>AFI</td>
<td>Assets for Independence</td>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>AJC</td>
<td>American Job Center</td>
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<td>ALJ</td>
<td>Administrative Law Judge</td>
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<td>ALS</td>
<td>Amyotrophic Lateral Sclerosis</td>
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<td>AWICs</td>
<td>Area Work Incentives Coordinators</td>
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<td>BBA</td>
<td>Balanced Budget Act</td>
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<td>BEP</td>
<td>Break-even Point</td>
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<td>BIA</td>
<td>Bureau of Indian Affairs</td>
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<td>BPQY</td>
<td>Benefits Planning Query</td>
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<td>BS&amp;A</td>
<td>Benefits Summary &amp; Analysis</td>
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<td>Client Assistance Program</td>
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<td>Continuing Disability Review</td>
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<td>CFR</td>
<td>Code of Federal Regulations</td>
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<td>CHIP</td>
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<td>Countable Income</td>
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<td>CILs</td>
<td>Centers for Independent Living</td>
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<td>CMHS</td>
<td>Center for Mental Health Services</td>
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<td>ESRD</td>
<td>End-Stage Renal Disease</td>
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<td>Expedited Reinstatement</td>
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<td>PDP</td>
<td>Prescription Drug Provider</td>
</tr>
<tr>
<td>PESS</td>
<td>Property Essential to Self-Support</td>
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<tr>
<td>PHA</td>
<td>Public Housing Agency</td>
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<tr>
<td>PIA</td>
<td>Primary Insurance Amount</td>
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<td>PII</td>
<td>Personally Identifiable Information</td>
</tr>
<tr>
<td>PMV</td>
<td>Presumed Maximum Value</td>
</tr>
<tr>
<td>POMS</td>
<td>Program Operations Manual System</td>
</tr>
<tr>
<td>POS</td>
<td>Point of Service</td>
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</tbody>
</table>
POWs  Prisoner of War
PPO  Preferred Provider Organization
PSC  Payment Service Center
QCs  Quarters of Coverage
QDWI  Qualified Disabled and Working Individuals
QI  Qualified Individual
QMB  Qualified Medicare Beneficiaries
RIB  Retirement Insurance Benefits
RMA  Retrospective Monthly Accounting
RO  Regional Office
RP  Representative Payee
RSA  Rehabilitation Services Administration
SAH  Specially Adapted Housing
SAMHSA  Substance Abuse and Mental Health Services Administration
SBA  Small Business Administration
SBDC  Small Business Development Centers
SCORE  Service Corps of Retired Executives
S-DVI  Service-Disabled Veterans Insurance
SDX  State Data Exchange
SE  Self-Employment
SECA  Self-Employment Contribution Act
SEI  Self-Employment Income
SEIE  Student Earned Income Exclusion
SEP  Special Enrollment Period
SGA  Substantial Gainful Activity
SHIP  State Health Insurance Assistance Programs
SILCs  Statewide Independent Living Councils
SLMB  Specified Low-Income Medicare Beneficiaries
SMC   Special Monthly Compensation
SMI   Supplemental Medical Insurance
SNAP  Supplemental Nutrition Assistance Program
SSA   Social Security Administration
SSB   Special Separation Benefits
SSDI  Social Security Disability Insurance
SSI   Supplemental Security Income
SSIMWR SSI Mobile Wage Reporting
SSN   Social Security Number
SSP   State Supplement Payments
SVRAs State Vocational Rehabilitation Agencies
TA    Technical Assistance
TANF  Temporary Assistance for Needy Families
TCC   Transitional Computation Cycle
TTW   Ticket to Work
TTY   Text Telephone
TWP   Trial Work Period
TWWIIA Ticket to Work and Work Incentives Improvement Act
UI    Unemployment Insurance
USDA  United States Department of Agriculture
UWA   Unsuccessful Work Attempt
VA    Veterans Administration
VBA   Veterans Benefits Administration
VHA   Veterans Health Administration
VR    Vocational Rehabilitation
VR&E  Vocational Rehabilitation and Employment
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>VRC</td>
<td>Vocational Rehabilitation Counselor</td>
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<td>VSI</td>
<td>Voluntary Separation Incentives</td>
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<td>VSO</td>
<td>Veterans Service Organization</td>
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<td>VTR</td>
<td>Value of the One-Third Reduction</td>
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<td>W/E</td>
<td>Wage-Earner</td>
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<td>WAGES</td>
<td>Work and Gain Economic Self-Sufficiency</td>
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<td>WIA</td>
<td>Workforce Investment Act</td>
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<td>Widow(er)s Insurance Benefits</td>
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<td>Workforce Investment Boards</td>
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<td>Work Incentive Liaisons</td>
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<td>Work Incentives Plan</td>
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<td>Work Incentives Planning and Assistance</td>
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<td>WISE</td>
<td>Work Incentives Seminar</td>
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<tr>
<td>YTD</td>
<td>Youth Transition Demonstration</td>
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